It is the Proposer's position that the data contained in pages:

- Appendix E: Pages App E-1 to App E-76
- Appendix F: Pages App F-15 to 54, App F-67 to App F-166, App F-177 to App F-254, App F-267 to App F-340
- 2.10.2.2 Staff Experience and Organizational Structure: Page 2.10.2.2-3
- 2.10.3 Enrollee Value-Added Benefits: Pages 2.10.3-3 to 2.10.3-8
- 2.10.7 Provider Network: the folder containing the Provider Network Listing Response Template and the Provider Network Capacity Response Template
- 2.10.13 Claims Management and Systems and Technical Requirements: Pages 2.10.13-7 to 2.10.13-8
- 2.10.14 Program Integrity: Page 2.10.14-2
- 2.10.15 Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative): Pages 2.10.15-1 to 2.10.15-3
- Attachment B: Page Att B-2123 to Att B-2150
- Attachment C: Page Att C-1 to Att C-7

of the proposal has been submitted in confidence and contains trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions.

2.2.1 Table of Contents

Aetna supports Louisiana's state health assessment priority of promoting healthy lifestyles across all of Louisiana's diverse parishes. During the 2018 open enrollment period, Aetna promoted our Ted E. Bear, M.D. Kids Club on transit buses in cities around the state. Ted E. Bear, M.D. Kids Club promotes healthy lifestyles and physical activity to children. They have the opportunity to meet Ted E. Bear, M.D. at festivals, fairs, and health and wellness events throughout the state.

Table of Contents

Attachments

2.2.2 Cover Letter

Each year, Aetna chooses schools in underserved communities to support throughout the school year. In the spring we help to restock the school supplies that many teachers are replacing with their own money for their classroom. Not only do we bring the basics such as crayons, markers, and pencils, but we help to replace other much-needed supplies like copy paper, tissue, hand sanitizers, and cleaning supplies. In 2018, we served Donaldsonville Elementary School, providing essential items to over 300 students.

Randy J. Hyun
Director & President
Aetna Better Health, Inc.
Chief Executive Officer
Aetna Medicaid
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
(602) 659-1160
HyunR@aetna.com

Teresa Bravo
Louisiana Department of Health
Bureau of Health Services Financing
628 N 4th Street, 6th Floor
Baton Rouge, Louisiana, 70802

April 29, 2019

RE: Aetna Better Health,® Inc. dba Aetna Better Health of Louisiana
Response to RFP 3000011953, Louisiana Medicaid Managed Care Organizations
Due April 29, 2019

Dear Ms. Bravo:

Aetna Better Health of Louisiana is pleased to present its response to the Louisiana Department of Health (LDH)'s Request for Proposal (RFP) for Louisiana Medicaid Managed Care Organizations.

We consider it a privilege to serve Healthy Louisiana and its most vulnerable citizens. As a current partner of LDH, we have provided Medicaid services in Louisiana since 2015. Our staff members live and work in the communities we serve, giving us an understanding of the State's people, providers, and health care landscape.

Pursuant to the requirements of Section 2.2.2 of the RFP, we submit the following:

2.2.2.1 Location of administrative office with full time personnel;

2400 Veterans Memorial Boulevard, Suite 200,
Kenner, Louisiana 70062.

1000 Perkins Rowe, 5th Floor
Baton Rouge, Louisiana 70812

2.2.2.2 Name and address of corporate principal office registered with the Louisiana Secretary of State, email address, website URL, and telephone number;

Corporate principal office registered with the Louisiana Secretary of State:	2400 Veterans Memorial Boulevard, Suite 200 Kenner, Louisiana 70062.
Email address:	AetnaBetterHealth-LA-Compliance@AETNA.com
Website URL:	www.aetnabetterhealth.com/louisiana
Telephone number:	(855) 242-0802.

2.2.2.3 Name and address for the purpose of issuing checks and/or drafts;

Aetna Better Health of Louisiana
2400 Veterans Memorial Blvd., Suite 200
Kenner, Louisiana 70062

2.2.2.4 Any other name(s) under which the Proposer does, or has done within the last ten (10) years, business;

In the past ten years, Aetna Better Health, Inc., has done business under the dba Aetna Better Health® of Louisiana. It may also have done business under the name Aetna Better Health.

2.2.2.5 Ownership status (whether the bidding organization is publicly traded or privately held). If privately held, a statement listing name(s) and address(es) of principal owners who hold five percent (5%) interest or more in the organization;

Aetna Better Health of Louisiana is not publicly traded. It is a privately held company; a subsidiary of a publicly traded company, CVS Health Corporation. The names and addresses of the principal owners that hold a five percent (5%) interest or more in Aetna Better Health of Louisiana are as follows:

Aetna Better Health of Louisiana is 100% owned by:
Aetna Health Holdings, LLC
151 Farmington Avenue
Hartford, Connecticut 06156

2.2.2.6 The type of legal entity (for example, corporation (profit or not for profit), limited partnership, general partnership, or trust), and the state where the entity is organized, including any parent organization;

Aetna Better Health of Louisiana is a for-profit corporation incorporated in Louisiana. Its direct parent is Aetna Health Holdings, LLC, which is incorporated in Delaware. Its ultimate parent is CVS Health Corporation, which is incorporated in Delaware.

2.2.2.7 If out-of-state Proposer, name and address of local representative; if none, so state;

Aetna Better Health of Louisiana is an in-state proposer.

2.2.2.8 If any of the planned personnel is a current Louisiana state employee, or was employed by the State of Louisiana within the past two (2) years, provide a listing to include the employee name, state agency, and termination date, if applicable;

Former Louisiana State Employee	State Agency	Termination Date
Ausbon, ShanDreka	Louisiana Department of Children & Family Services	September 28, 2018
Votaw, Molly	Louisiana Department of Health, Office of Public Health, HIV/STD Program	March 27, 2019

2.2.2.9 Proposer's state and federal tax identification numbers, LaGov vendor number, and Louisiana Department of Revenue number, if available;

State and federal tax identification number: 80-0629718
LaGov vendor number: 310173193
LDR number: 800629718

2.2.2.10 A graphical summary of whether Proposer meets mandatory and preferred qualifications to propose, as identified in Sections 2.9.1, 2.10.2.1.2, and 2.10.2.5.1;

Requirement		Aetna Meets Mandatory and Preferred Requirements
2.9.1.1	**Meet the federal definition of an MCO, as defined in 42 C.F.R. §438.2;**	✓
2.9.1.2	**Have the capacity and willingness to perform all functions in this RFP and in the Model Contract;**	✓

Requirement		Aetna Meets Mandatory and Preferred Requirements
2.9.1.3	Not be an excluded individual or entity as described in 42 C.F.R. §438.808	✓
2.9.1.4	Have a license or certificate of authority issued by the Louisiana Department of Insurance (LDI) to operate as a Medicaid risk bearing "prepaid entity" pursuant to La. R.S. 22:1016 and submit with the proposal response;	✓
2.9.1.5	Comply with all Louisiana Department of Insurance applicable standards. Information can be found at LDI's website: www.ldi.louisiana.gov. The MCO must meet solvency standards as specified in 42 C.F.R. §438.116 and Title 22 of the Louisiana Revised Statutes;	✓
2.9.1.6	Have a minimum of five (5) years of experience as an MCO for a Medicaid managed care program prior to the deadline for receipt of proposals;	✓[1]
2.9.1.7	Have, within the last thirty-six (36) months, been engaged in a contract or awarded a new contract as a Medicaid MCO in a state with a Medicaid population equal to or greater than that of Louisiana;	✓[2]
2.9.1.8	Have its principal place of business be located inside the continental United States; and	✓
2.9.1.9	Have not had a contract terminated, withdrawn in lieu of termination, or not renewed for non-performance or poor performance within the past ten (10) years.	✓
2.10.2.1.2.1	Have a minimum of seven (7) years of experience in providing health care services for a Medicaid managed care program prior to the deadline for receipt of proposals; and	✓[3]
2.10.2.1.2.2	Have, within the last twelve (12) months, been engaged in a contract or awarded a new contract as a Medicaid MCO in a state with a Medicaid population equal to or greater than that of Louisiana.	✓[4]
2.10.2.5.1	The Proposer should provide a copy of its certificate of accreditation by the National Committee for Quality Assurance (NCQA) for each of its Medicaid managed care contracts. If the Proposer is not accredited in Louisiana, the Proposer should provide a specific timeline outlining the Proposer's plan to achieve full accreditation in Louisiana as soon as possible after the execution of a contract. It is preferred, though not mandatory, that Proposers be accredited by NCQA as a Medicaid managed care organization in Louisiana or in another state prior to the deadline for receipt of proposals.	✓

[1] With over 30 years of experience, Aetna's Medicaid organization exceeds the minimum required five years of experience delivering innovative, quality, and efficient services to complex Medicaid populations. Aetna Better Health of Louisiana has proudly served Louisiana's most vulnerable populations since 2015.

[2] As discussed more fully in our proposal, within the last 36 months, affiliates of Aetna Better Health of Louisiana have been engaged in Medicaid contracts in states with Medicaid populations equal to or greater than that of Louisiana.

[3] With over 30 years of experience, the Aetna Medicaid organization far exceeds the minimum of seven years of experience in providing services for a Medicaid managed care program prior to the deadline for receipt of proposals. Aetna Better Health of Louisiana has proudly served Louisiana's most vulnerable populations since 2015.

[4] As discussed more fully in our proposal, within the last 12 months, affiliates of Aetna Better Health of Louisiana have been engaged in Medicaid contracts in states with Medicaid populations equal to or greater than that of Louisiana

2.2.2.11 A brief statement of the Proposer's involvement in litigation related to the delivery of Medicaid benefits in the last ten (10) years;

Aetna Better Health of Louisiana has been involved in only three litigation matters related to the delivery of Medicaid benefits in the past ten years. Two of those cases involve members' claims for benefits. The third case, which involves a dispute between a provider and its successor-in-interest, names Aetna Better Health of Louisiana as a defendant for purposes of notification to pay the successor and not the provider.

2.2.2.12 A brief statement of the Proposer ever having had (1) a contract terminated or not renewed for non-performance or poor performance and/or (2) a contract terminated on a voluntary basis prior to the contract end date. The Proposer must provide the name and contact information of the lead program manager of the contracting entity;

Aetna Better Health of Louisiana has not had, within the last ten years, a Medicaid managed care contract terminated or not renewed for non-performance or poor performance and/or terminated on a voluntary basis prior to the contract end date.

2.2.2.13 The stipulation that the proposal is valid for a period of at least ninety (90) calendar days from the date of submission; and

Aetna Better Health of Louisiana stipulates that its proposal is valid for a period of at least ninety calendar days from the date of submission.

2.2.2.14 A positive statement of compliance with the contract terms defined in the Model Contract.

Aetna Better Health of Louisiana will comply with the contract terms defined in the Model Contract.

We are excited to continue our collaboration with LDH, meeting program objectives—now and into the future—with the provision of services and supports, technology, community relationships, and other resources necessary to achieve a coordinated system of care focused on improving quality, access, and efficiencies for Bayou Health members.

Sincerely,

Randy J. Hyun
Director & President
Aetna Better Health, Inc. dba
Aetna Better Health of Louisiana
Chief Executive Officer
Aetna Medicaid
4500 E. Cotton Center Blvd.
Phoenix, Arizona 85040
(602) 659-1160
HyunR@aetna.com

Richard C. Born
Chief Executive Officer
Aetna Better Health, Inc. dba
Aetna Better Health of Louisiana
2400 Veterans Memorial Boulevard, Suite 200
Kenner, Louisiana 70062
(855) 242-0802
BornR@aetna.com

STATE OF LOUISIANA

LDH Medical Vendor Administration
REQUEST FOR PROPOSAL

RESPONSES WILL BE PUBLICLY OPENED
04/29/2019
03:00 PM CST

SUBMIT NON-ELECTRONIC RESPONSE TO: MEDICAL VENDOR ADMIN BUDGET & CONTRACTS
PO BOX 91030
BATON ROUGE LA 70821

RFx Number: 3000011953
Version: 2
Buyer: CHRISTIE MCCOLLOUGH
Buyer Phone: 225-219-1318
E-Mail: christie.mccollough2@la.gov
Scheduled Begin Date:
Scheduled End Date:
T-Number:

Vendor No.: 310173193
Solicitation: 3000011953
Opening Date: 04/29/2019

Vendor Name and Address: (to be completed by Vendor)

Aetna Better Health, Inc. dba Aetna Better Health of Louisiana
2400 Veterans Memorial Boulevard, Suite 200
Kenner, Louisiana 70062

Ship To Address:
Invalid Delivery Address
Invalid, LA 99999-9999

Name of Solicitation: Managed Care Organization RFP

Notice to bidder:
Addendum 1 - Representative of an "RFP Coordinator" change within section 2.1.1 and section 2.6.2 of the RFP.

****Clarification to information provided in this announcement. The proposals submitted in response to this Request for Proposals (RFP) will NOT be publicly opened due to the complexity of the requested services. Proposals will be privately opened upon receipt and within the noted timeline. Additionally, non-electronic responses, if required by the RFP, must be submitted to the address specified in the RFP.****

Please refer to the document "Request for Proposal" for all requirements to submit a proposal.

The purpose of this (RFP) is to obtain competitive proposals from qualified Proposers who are interested in providing risk-bearing, managed care organization (MCO) health care delivery system that provides specified covered services to Medicaid enrollees, utilizing the most cost-effective manner and in accordance with the terms and conditions set forth in the RFP.

RFx text:
This Request for Proposal form is an internal form only. Please refer to the Request for Proposal for all requirements to submit a proposal.

VENDOR TELEPHONE NUMBER: **504-667-4580** FAX NUMBER: **504-667-4730**	TITLE **Chief Executive Officer, Aetna Medicaid**	DATE **April 18, 2019**
Signature of Authorized Bidder	Name of Bidder (Typed or printed) **Randy J. Hyun**	

Included documents listed below:

RFP
Appendix A: LDH Standard Contract Form (CF-1)
Appendix B: Model Contract
- Attachment A: MCO Covered Services
- Attachment D: Provider Network Standards
- Attachment E: Table of Monetary Penalties
- Attachment G: Quality Performance Measures
- Attachment H: HIPAA Business Associate Addendum

Appendix C: Proposal Compliance Matrix
Appendix D: Certification Statement
Appendix E: Medicaid Ownership and Disclosure Form
Appendix F: Material Subcontractor Response Template
Appendix G: Veteran and Hudson Initiatives

LINE	Description	Quantity	Unit	Unit Price	Extended Amount
1	**Product Category:85101700** SFY 20 **Required:** 01/01/2020-12/31/2022	N/A	N/A	N/A	
2	**Product Category:85101700** SFY 21 **Required:** 07/01/2020-12/31/2022	N/A	N/A	N/A	
3	**Product Category:85101700** SFY 22 **Required:** 07/01/2021-12/31/2022	N/A	N/A	N/A	
4	**Product Category:85101700** SFY 23 **Required:** 07/01/2022-12/31/2022	N/A	N/A	N/A	

STATE OF LOUISIANA

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PO BOX 91030
BATON ROUGE LA 70821

Vendor No.: 310173193
Solicitation: 3000011953
Opening Date: 04/29/2019

RFx Number: 3000011953
Version: 3
Buyer: CHRISTIE MCCOLLOUGH
Buyer Phone: 225-219-1318
E-Mail: christie.mccollough2@la.gov
Scheduled Begin Date:
Scheduled End Date:
T-Number:

Vendor Name and Address: (to be completed by Vendor)

Aetna Better Health, Inc. dba Aetna Better Health of Louisiana
2400 Veterans Memorial Boulevard, Suite 200
Kenner, Louisiana 70062

Ship To Address:
Invalid Delivery Address
Invalid, LA 99999-9999

Name of Solicitation: Managed Care Organization RFP

Notice to bidder:
Addendum 2 - Questions and Answers

Addendum 1 - Representative of an "RFP Coordinator" change within section 2.1.1 and section 2.6.2 of the RFP.

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RFx text:

VENDOR TELEPHONE NUMBER: **504-667-4580** FAX NUMBER: **504-667-4730**	TITLE **Chief Executive Officer, Aetna Medicaid**	DATE **April 18, 2019**
Signature of Authorized Bidder	Name of Bidder (Typed or printed) **Randy J. Hyun**	

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3	**Product Category:85101700** SFY 22 **Required:** 07/01/2021-12/31/2022	N/A	N/A	N/A	
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STATE OF LOUISIANA

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Vendor No.: 310173193
Solicitation: 3000011953
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RFx Number: 3000011953
Version: 4
Buyer: CHRISTIE MCCOLLOUGH
Buyer Phone: 225-219-1318
E-Mail: christie.mccollough2@la.gov
Scheduled Begin Date:
Scheduled End Date:
T-Number:

Vendor Name and Address: (to be completed by Vendor)

Aetna Better Health, Inc. dba Aetna Better Health of Louisiana
2400 Veterans Memorial Boulevard, Suite 200
Kenner, Louisiana 70062

Ship To Address:
Invalid Delivery Address
Invalid, LA 99999-9999

Name of Solicitation: Managed Care Organization RFP

Notice to bidder:
Addendum 3 - Additional RFP Revisions

Addendum 2 - Questions and Answers

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VENDOR TELEPHONE NUMBER: **504-667-4580** FAX NUMBER: **504-667-4730**	TITLE **Chief Executive Officer, Aetna Medicaid**	DATE **April 18, 2019**
Signature of Authorized Bidder	Name of Bidder (Typed or printed) **Randy J. Hyun**	

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3	**Product Category:85101700** SFY 22 **Required:** 07/01/2021-12/31/2022	N/A	N/A	N/A	
4	**Product Category:85101700** SFY 23 **Required:** 07/01/2022-12/31/2022	N/A	N/A	N/A	

2.3.3 - Certified Copy of Board Resolution Granting Signature Authority

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ASSISTANT SECRETARY'S CERTIFICATE

Aetna Better Health, Inc.

(a Louisiana corporation)

The undersigned, Edward C. Lee, does hereby certify that he is a duly elected officer of Aetna Better Health, Inc., a Louisiana corporation (the "Company"), having knowledge of the records of the Company and authorization to execute this certificate on behalf of the Company, does hereby certify that:

A copy of the board of directors' resolution electing Randy J. Hyun as President was adopted on December 20, 2018. This resolution gave Mr. Hyun signature authority on behalf of Aetna Better Health, Inc. (a Louisiana corporation).

IN WITNESS WHEREOF, the undersigned has executed and delivered this Certificate on this 13th day of March, 2019.

Edward C. Lee
Vice President and Assistant Secretary

Witness: WendyAnn Cianci

Witness: Caitlin Gould

Subscribed and sworn to this 13th day of March, 2019, and known to me to be Vice President and Assistant Secretary of Aetna Better Health, Inc., a Louisiana corporation.

Witness My Hand and Official Seal

Cynthia Montano
Notary Public

My Commission expires: 3-31-21

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

December 20, 2018

AETNA BETTER HEALTH INC.
(a Louisiana corporation)

WRITTEN CONSENT OF THE BOARD OF DIRECTORS
TO ACTIONS WITHOUT A MEETING

The undersigned, constituting the entire Board of Directors for Aetna Better Inc., a Louisiana corporation (the "Company"), by consent in writing without the formality of convening a meeting, does hereby consent to the following actions:

Removal of an Officer

RESOLVED: That Laurie A. Brubaker is a hereby removed as President for the Company; and further

Election of an Officer

RESOLVED: That effective the date hereof, the following person is, elected as President of the Company, to serve until their successor is duly elected and qualified or their earlier resignation or removal:

Randy J. Hyun

RESOLVED: That all of the lawful and proper actions of the officers of the Company heretofore taken hereby are confirmed, ratified and approved in all respects; and further;

RESOLVED: That the officers of the Company are authorized and directed to execute and deliver, in the name of and on behalf of the Company all instruments, agreements and documents and to take all action that may be necessary or appropriate to carry out the intent and accomplish the purposes of the foregoing resolutions.

Dated as December 20, 2018

Debra J. Bacon

Janet R. Grant

Randy J. Hyun

December 20, 2018

AETNA BETTER HEALTH INC.
(a Louisiana corporation)

WRITTEN CONSENT OF THE BOARD OF DIRECTORS
TO ACTIONS WITHOUT A MEETING

The undersigned, constituting the entire Board of Directors for Aetna Better Inc., a Louisiana corporation (the "Company"), by consent in writing without the formality of convening a meeting, does hereby consent to the following actions:

Removal of an Officer

RESOLVED: That Laurie A. Brubaker is a hereby removed as President for the Company; and further

Election of an Officer

RESOLVED: That effective the date hereof, the following person is, elected as President of the Company, to serve until their successor is duly elected and qualified or their earlier resignation or removal:

Randy J. Hyun

RESOLVED: That all of the lawful and proper actions of the officers of the Company heretofore taken hereby are confirmed, ratified and approved in all respects; and further;

RESOLVED: That the officers of the Company are authorized and directed to execute and deliver, in the name of and on behalf of the Company all instruments, agreements and documents and to take all action that may be necessary or appropriate to carry out the intent and accomplish the purposes of the foregoing resolutions.

Dated as December 20, 2018

_____
Debra J. Bacon

Janet Grant
Janet R. Grant

_____
Randy J. Hyun

December 20, 2018

AETNA BETTER HEALTH INC.
(a Louisiana corporation)

WRITTEN CONSENT OF THE SOLE SHAREHOLDER
TO ACTIONS WITHOUT A MEETING

The undersigned, being the authorized person of Aetna Health Holdings, LLC, a Delaware limited liability company and sole shareholder of Aetna Better Health Inc., a Louisiana corporation (the "Company"), by consent in writing without the formality of convening a meeting, does hereby consent to the following actions:

Removal of a Director

RESOLVED: That Laurie A. Brubaker is a hereby removed as a Director for the Company; and further

Election of a Director

RESOLVED: That effective the date hereof, the following person is, elected as Director of the Company, to serve until their successor is duly elected and qualified or their earlier resignation or removal:

Randy J. Hyun

RESOLVED: That all of the lawful and proper actions of the officers of the Company heretofore taken hereby are confirmed, ratified and approved in all respects; and further;

RESOLVED: That the officers of the Company are authorized and directed to execute and deliver, in the name of and on behalf of the Company all instruments, agreements and documents and to take all action that may be necessary or appropriate to carry out the intent and accomplish the purposes of the foregoing resolutions.

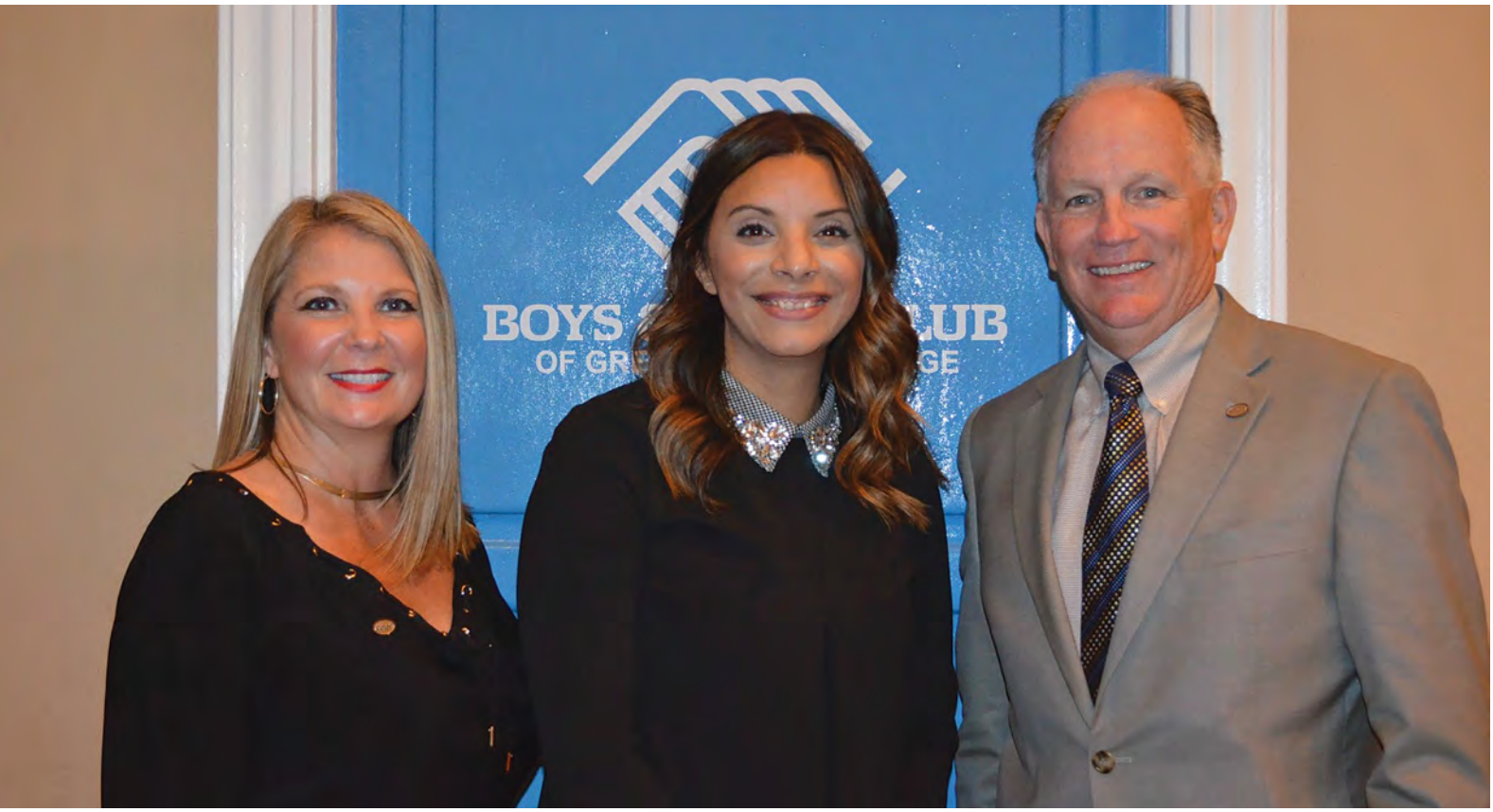
Aetna Health Holdings, LLC

By:_____
Name: Edward C. Lee
Title: Vice President and Secretary

Being the sole shareholder of
Aetna Better Health Inc. (LA)

Dated as December 20, 2018

2.9 Business Proposal Requirements



As an avid supporter of healthy lifestyle afterschool activities for children of all ages, Aetna partners with the Boys & Girls Clubs of America to celebrate and recognize all of the hard work the Clubs do throughout the school year. Aetna CEO Rick Born is a board member of the Baton Rouge Boys & Girls Club and supports several programs for school-aged youth focused on academics, health, and character.

2.9.1 Mandatory Qualifications

Aetna employees help the members of our community with housing needs, through the health plan's collaboration with Habitat for Humanity.

2.9.1 Mandatory Qualifications

Aetna Better Health, Inc. dba Aetna Better Health of Louisiana (Aetna)[1] demonstrates that it meets the mandatory requirements as follows:

- Aetna **meets the federal definition of managed care organization (MCO)** as defined in **42 C.F.R. §438.2(2)**, in that Aetna is a private entity that meets the advance directives requirements, provides covered services to our enrollment as accessible as those provided to other Medicaid enrollees within Louisiana, and meets the solvency standards of **§438.116**, as stated below.
- As shown throughout our proposal, Aetna has the **capacity and willingness to perform** all functions in the **RFP** and in the **Model Contract**, having served Healthy Louisiana enrollees since 2015, met the capacity, and performed all functions required by that RFP and the current contract.
- We certify that Aetna is **not an excluded entity—**it is not excluded, debarred, suspended, or prohibited from contracting with the federal government or receiving federal funds, either directly or indirectly as described in **42 C.F.R. §438.808(b)**.
- Aetna has a **certificate of authority** issued by the Louisiana Department of Insurance (LDI) to operate as a Medicaid risk-bearing "prepaid entity" pursuant to **La. R.S. 22:1016**. A copy of the certificate of authority is attached as **Attachment A**.
- Aetna **complies with all LDI applicable standards** and meets solvency standards as specified in **42 C.F.R. §438.116** and **Title 22** of the **Louisiana Revised Statutes**. Aetna Better Health has an active license and certificate of authority issued by the LDI, which regulates the MCO with respect to licensure and financial solvency, pursuant to **La. R.S. 22:1016**. Our plan exceeds the minimum standard of financial health for an MCO because our assets exceed requirements:
  - As noted in the Minimum Capital and Surplus section of Aetna Better Health of Louisiana's financial statements provided in our response to **Section 2.9.5 of the RFP**, at December 31, 2017 and 2016[2], Aetna Better Health of Louisiana's capital and surplus exceeded the requirement of established and maintained capital and surplus in the amount of $3 million.
  - At December 31, 2017 and 2016, Aetna Better Health of Louisiana had capital and surplus that exceeded the highest threshold specified by the National Association of Insurance Commissioners (NAIC) and the State for risk-based capital (RBC). At December 31, 2018, our unaudited financial statements indicate that we still exceed the NAIC and State RBC requirements.
- With over 30 years of experience, Aetna's Medicaid organization **exceeds the minimum required five years of experience** delivering innovative, quality, and efficient services to complex Medicaid populations. Aetna has proudly served Louisiana's most vulnerable populations since 2015.
- Within the last 36 months, affiliates of Aetna Better Health of Louisiana have been **engaged in Medicaid managed care contracts** in the following states with Medicaid populations equal to or greater than that of Louisiana[3]: LA (1.4M), AZ (1.7M), CA (11.8M), FL (4.2M), IL (2.8M), MI (2.3M), NJ (1.7M), NY (6.5M), OH (2.7M), PA (2.9M), and TX (4.8M)[4].
- Aetna Better Health of Louisiana's **principal office is located inside the continental United States** at 2400 Veterans Memorial Boulevard, Suite 200, Kenner, Louisiana 70062.

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[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the Proposer, its indirect parent Aetna Inc. and/or any Aetna Inc. subsidiary that conducts Medicaid/CHIP business or participates in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Louisiana to refer to the Proposer and Aetna Inc. to refer to one of Aetna Better Health of Louisiana's indirect parents.

[2] Aetna Better Health of Louisiana's 2018 audited financial statements will not be available until 6/1/19.

[3] December 2018 Medicaid & CHIP Enrollment Data Highlights: accessed March 25, 2019; https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[4] Aetna's contract engagement in Arizona is through an administrative services contract (ASC) to provide administrative services to an unaffiliated health plan that holds risk-bearing contracts with applicable agencies. Our Texas experience includes both an ASC and risk-bearing contracts that an affiliated health plan holds directly with the state agency.

2.9.2 Conflict of Interests

Ted E. Bear, M.D. and local chef Jay Ducote promote healthy eating and cooking lessons utilizing fresh ingredients to create healthier versions of Louisiana classic dishes.

2.9.2 Conflict of Interests

Aetna Better Health, Inc. dba Aetna Better Health of Louisiana (Aetna Better Health of Louisiana) submits this signed certification attesting to the following:

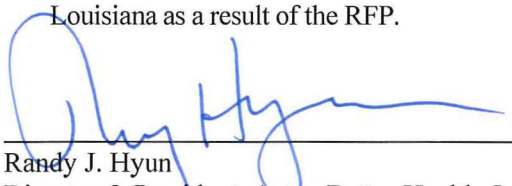
1. Neither it nor any of its proposed subcontractors has any interest that will conflict, as determined by the Louisiana Department of Health (LDH), in any manner or degree with the performance of services required under this RFP.
2. Neither it nor any of its proposed material subcontractors have any financial, legal, contractual, or other business interest in LDH's Enrollment Broker Contractor, or in such vendor's subcontractors, if any.
3. Neither it nor any of its proposed subcontractors, including their affiliates, partners, parent(s), subsidiaries and related organizations, if any, have any financial, legal, contractual, or other business interests that may affect or impact performance under the Contract.

   Notwithstanding the above, we note that given CVS Health Corporation's (CVS) recent acquisition of Aetna Inc., Aetna Better Health of Louisiana is now an affiliate of PCS Health L.L.C. (Caremark), a CVS subsidiary which may provide pharmacy benefit management services in Louisiana for Aetna Better Health of Louisiana and its competitors. This relationship does not pose any actual or potential conflict of interest given that the business relationship between Caremark and Aetna Better Health of Louisiana will be conducted at arm's-length and given the safeguards the combined Aetna and CVS organizations have implemented to ensure appropriate separation of the two organizations.

   Integrity is a core value of the combined Aetna-CVS enterprise. Where an Aetna Medicaid organization health plan engages affiliates to perform services in support of its operations, it does so pursuant to a formal, arm's-length contract either directly with the health plan or downstream with an affiliate of the health plan. All such contracts are submitted to the appropriate regulators for review and approval, as applicable. That will be the case here, as well.

   We also separate and restrict communication and information exchange across our many business units and affiliates by implementing firewalls to prevent the sharing of member data and competitive information. In addition, we fully comply with the requirements of the Health Information Portability and Accountability Act (HIPAA) to ensure privacy of protected health information, and every employee is required to complete annual training on these requirements. Finally, our mandatory corporate integrity training contains a specific module on the identification of potential conflicts of interest and actions employees are required to take if faced with a potential conflict situation, including reporting potential conflicts to the Compliance department.

   These policies will prevent any actual conflict of interest and maintain fairness, independence, and objectivity.
4. There is no other information that may be relevant to the Proposer's or any material subcontractor's financial, legal, contractual, or other business interests as they relate to the RFP and any Contract awarded to Aetna Better Health of Louisiana as a result of the RFP.
5. Aetna Better Health of Louisiana agrees to submit any additional information requested by LDH that in LDH's judgment may be relevant to Aetna Better Health of Louisiana's financial, legal, contractual, or other business interests as they relate to the RFP and any Contract awarded to Aetna Better Health of Louisiana as a result of the RFP.



April 18, 2019

Randy J. Hyun — Date
Director & President, Aetna Better Health, Inc. dba Aetna Better Health of Louisiana
Chief Executive Officer, Aetna Medicaid

2.9.3 Moral or Religious Objections

Following the state's priorities to address obesity and unhealthy eating through the elimination of food deserts, Aetna provides the resources for the creation of community gardens and offers healthy eating options in local schools, community centers, and places of worship. We celebrate the collaboration and coordination to create community gardens in public spaces in low-income neighborhoods.

2.9.3 Moral or Religious Objections

Aetna attests that we have no moral or religious objections to providing any managed care organization covered services described in the **Model Contract, Part 2, Services**.

2.9.4 Material Subcontractors

Aetna employees volunteer with Habitat for Humanity to help the members of our community with housing needs.

2.9.4 Material Subcontractors

Aetna Better Health of Louisiana will use material subcontractors to provide certain functions that relate to the delivery or payment of managed care organization (MCO) covered services under the Contract, and identify them in **Table 2.9.4-1**.

Table 2.9.4-1: Material Subcontractors Performing Delivery or Payment of MCO Covered Services

Subcontractor Name[1]	Program Area or Function	Address	Telephone Number
Aetna Medicaid Administrators LLC, an affiliated subcontractor	Enrollment processing, claims payment, internal audit, executive oversight, information systems, actuarial, procurement, insurance, risk management, and pharmacy prior authorization	4500 E. Cotton Center Blvd; Bldg. 1; Phoenix, AZ 85040	(602) 659-1100
Aetna Health Management, LLC, an affiliated subcontractor	After-hours call center services for physical and behavioral health, credentialing for certain types of network providers, Health Information line (Nurse line) services	151 Farmington Ave.; Hartford, CT 06156	(860) 273-0123
Caremark Health, L.L.C. (Caremark PCS), an affiliated subcontractor	Pharmacy benefit management services such as pharmacy claims adjudication; retail, mail order and specialty pharmacy network management; and safety monitoring programs	9501 E. Shea Blvd.; Scottsdale, AZ 85260	(480) 391-4600
DentaQuest USA Insurance Company, Inc.	Early and periodic screening, diagnostic, and treatment (EPSDT) dental benefit administration[2]	465 Medford Street; Boston, MA 02129-1454	(800) 417-7140
eviCore healthcare MSI, LLC	Radiology management services	400 Buckwalter Pl. Blvd.; Bluffton, SC 29910	(800) 918-8924
Firstsource Transaction Services, LLC	Overflow claims management	1661 Lyndon Farm Court; Louisville, Kentucky 40223	(502) 499-0855
LogistiCare Solutions, LLC	Non-emergency medical transportation	1275 Peachtree Street, 6th Floor; Atlanta, GA 30309	(404) 888-5800
Superior Vision Benefit Management, Inc.	Vision benefit management, including provider network, claims, and enrollee services	939 Elkridge Landing Road, Suite 200; Baltimore, MD 21090	(443) 422-4744

Certification Regarding Use of Material Subcontractors

Aetna Better Health, Inc. dba Aetna Better Health of Louisiana (Aetna Better Health of Louisiana) submits this signed Proposer's Certification attesting that it:

1. Acknowledges it will not be relieved of any legal obligations under any Contract resulting from this RFP as a result of any contracts with subcontractors, that it shall be fully responsible for the subcontractor's performance, and that all partnership agreements, subcontracts, and other agreements or arrangements for reimbursement will be in writing and will contain terms consistent with all terms and conditions of the Contract; and
2. Acknowledges that proposals to use subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.

April 18, 2019

Randy J. Hyun — Date
Director & President, Aetna Better Health, Inc. dba Aetna Better Health of Louisiana
Chief Executive Officer, Aetna Medicaid

[1] We provided Appendix F, Material Subcontractor Response Template, for certain entities proposed to perform value added services in compliance with **Section 2.10.2.3**. Because such entities will not provide services relating "to the delivery or payment of MCO covered services," they are outside the scope of **Section 2.9.4** and are not listed here..

[2] As reflected in **RFP Section 2.10.2.3** and **Appendix F**, DentaQuest will also perform value-added adult dental benefit administration.

2.9.5 Financial Condition

Aetna and March of Dimes support healthy babies throughout Louisiana.

2.9.5 Financial Condition

The Aetna Medicaid organization, our parent organization, and material subcontractors are in sound financial condition. In the unlikely event that any significant financial problems are identified in the future, they will be addressed with appropriate corrective measures. Aetna Better Health of Louisiana (Aetna[1]) submits copies of its audited financial statements for each of the last three years[2], as well as that of our ultimate parent organization, CVS Health Corporation (CVS Health), and any material subcontractors[3], as **Attachment B**.

CVS Health acquired Aetna Inc. on November 28, 2018. Attached are CVS Health's 2018 audited financial statements, which include financial information for Aetna Inc. and its subsidiaries, including the Proposer, Aetna Better Health of Louisiana. Also attached are CVS Health's audited financials for 2016 and 2017, which represent the company's financials prior to the acquisition of Aetna Inc. and its subsidiaries. To support our commitment to full transparency and to ensure that LDH has all financial documentation that may be relevant to confirming the fiscal soundness of our business, we have provided audited Aetna Inc. financial statements for 2016 and 2017, as Aetna Inc. was the ultimate parent for Aetna Better Health of Louisiana for those reporting years, as shown in **Table 2.9.5-1.**

Table 2.9.5-1: Audited Financial Statements Related to Proposer

Entity	Relationship to Proposer	Year	Item
Aetna Better Health of Louisiana	Proposer	2015	Audited financials
Aetna Better Health of Louisiana	Proposer	2016	Audited financials
Aetna Better Health of Louisiana	Proposer	2017	Audited financials
CVS Health	Ultimate parent, post-acquisition	2016	Audited financials
CVS Health	Ultimate parent, post-acquisition	2017	Audited financials
CVS Health	Ultimate parent, post-acquisition	2018	Audited financials
Aetna Inc.	Ultimate parent, pre-acquisition	2016	Audited financials
Aetna Inc.	Ultimate parent, pre-acquisition	2017	Audited financials

In addition, we present a certificate from the Louisiana Department of Revenue attesting that Aetna is not in default of any obligation under Louisiana tax laws as **Attachment B**.

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the Proposer, its indirect parent Aetna Inc. and/or any Aetna Inc. subsidiary that conducts Medicaid/CHIP business or participates in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Louisiana to refer to the Proposer and Aetna Inc. to refer to one of Aetna Better Health of Louisiana's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Louisiana. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health and to the CVS Health subsidiary that is expected to provide pharmacy benefits management services for any contract awarded as a result of this RFP as CaremarkPCS Health, L.L.C. or CaremarkPCS.

[2] Aetna Better Health of Louisiana's 2018 audited financial statements will not be available until June 1, 2019, so we provide audited financial statements for the last three years that are currently available—2015, 2016, and 2017. We will submit the statements for 2018 when they are available.

[3] **Section 2.10.2.3** requires bidders to provide Appendix F, Material Subcontractor Response Template, for entities proposed to perform value added services, which we did. However, we do not understand the Model Contract definition of Material Subcontract, which we applied in responding to **Section 2.9.5.1.1**, to include value added services. Therefore, we have not provided audited financial statements for entities we proposed to provide value added services in **Section 2.10.2.3**. If LDH would like audited financial statements from these entities, we will provide that information upon request.

2.9.6 Required Forms and Certifications

Each year, Aetna chooses schools in underserved communities to support throughout the school year. In the spring we help to restock the school supplies that many teachers are replacing with their own money for their classroom. Not only do we bring the basics such as crayons, markers, and pencils, but we help to replace other much-needed supplies like copy paper, tissue, hand sanitizers, and cleaning supplies. In 2018, we served Donaldsonville Elementary School, providing essential items to over 300 students.

2.9.6 Required Forms and Certifications

Aetna Better Health of Louisiana is registered as a vendor with the Louisiana Procurement and Contract Network. We understand and comply with all State and federal laws requiring full disclosure of ownership, management, and control of Medicaid managed care organizations.

We provide the following:

- A **Proposal Compliance Matrix (Appendix C)**
- An original **Certification Statement (Appendix D)**
- The **Medicaid Ownership and Disclosure Form (Appendix E)**

2.9.6.1 Appendix C: Proposal Compliance Matrix

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Appendix C: Proposal Compliance Matrix

RFP #3000011953		Proposer:		
RFP Section	**RFP Page(s)**	**Requirement**	**Proposal Section**	**Proposal Page(s)**
2.2.1	9	Table of Contents	2.2.1	Exempt, Pages 1-2
2.2.2	9-10	Cover Letter	2.2.2	Exempt, pages 1-4 (Signed Addenda and Certified Board Resolution account for 8 additional pages.)
Business Proposal				
2.9.1	14-15	Mandatory Qualifications	2.9.1	1 (COA as Attachment A, 1 page.)
2.9.2	15-16	Conflict of Interests	2.9.2	1
2.9.3	16	Moral or Religious Objections	2.9.3	1
2.9.4	16	Material Subcontractors	2.9.4	1
2.9.5	16-17	Financial Condition	2.9.5	Exempt, 1 page. (Financial documents in Attachment B)
2.9.6	17	Required Forms and Certifications:		
2.9.6.1	17	✓ Proposal Compliance Matrix	2.9.6.1	Exempt, Pages 1-3
2.9.6.2	17	✓ Certification Statement	2.9.6.2	Exempt, Appendix D, Pages 1-2
2.9.6.3	17	✓ Medicaid Ownership and Disclosure Form	2.9.6.3	Exempt, Appendix E, electronic-only
Technical Proposal				
2.10.1	18	Executive Summary	2.10.1	Pages 1-5
2.10.2	18	Organizational Experience:		

2.10.2.1	18	✓ Proposal Experience	2.10.2.1	Pages 1-2
2.10.2.2	18-19	✓ Staff Experience and Organizational Structure	2.10.2.2	Pages 1-7 (Page 4 is exempt from section and page limits. Exempt resumes submitted as Attachment C)
2.10.2.3	19	✓ Material Subcontractors	2.10.2.3	Exempt, Pages 1-3 (Material Sub-contractor Response Templates in Attachment F, Pages 1-340.)
2.10.2.4	19	✓ Proposal Reference Contact Information	2.10.2.4	Pages 1-38
2.10.2.5	19-20	✓ NCQA Accreditation	2.10.2.5	Pages 1-2 (Exempt certificate in Attachment D)
2.10.3	20-21	Enrollee Value-Added Benefits	2.10.3	Pages 1-8
2.10.4	21-22	Population Health	2.10.4	Pages 1-12 (Exempt, Optional CHW response included as 2.10.4.5, pages 1-5)
2.10.5	22-23	Care Management	2.10.5	Pages 1-15
2.10.6	23-24	Case Scenarios	Case 1, 2.10.6.1 Case 2, 2.10.6.2 Case 3, 2.10.6.3	Pages 1-5 Pages 1-5 Pages 1-5

2.10.7	24	Provider Network	2.10.7	Exempt. One (1) page indicating location of electronic files.
2.10.8	25	Network Management	2.10.8	Pages 1-15
2.10.9	26-27	Provider Support	2.10.9	Pages 1-14
2.10.10	27-28	Utilization Management	2.10.10	Pages 1-15
2.10.11	28-29	Quality	2.10.11	Pages 1-20 (Exempt CPG Example and Quality Response Template included as Attachment E)
2.10.12	29-30	Value-Based Payment	2.10.12	Pages 1-15
2.10.13	30-31	Claims Management and Systems and Technical Requirements	2.10.13	Pages 1-21 (Pages 6, 7, 13, 14, 15, and 16-21 exempt from page limits)
2.10.14	31-32	Program Integrity	2.10.14	Pages 1-10
2.10.15	32-33	Veteran and Hudson Initiatives Programs Participation	2.10.15	Pages 1-4

2.9.6.2 Appendix D: Certification Statement

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Appendix D: Certification Statement

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Louisiana Medicaid Managed Care Organizations Request for Proposals (RFP), including attachments and appendices.

OFFICIAL CONTACT: The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below:

PROPOSER	Aetna Better Health, Inc. dba Aetna Better Health of Louisiana
VENDOR NUMBER	310173193
DATE	4/18/2019
LDR NUMBER	800629718
OFFICIAL CONTACT NAME	Richard C. Born
EMAIL ADDRESS	BornR@aetna.com*
FAX NUMBER	504-667-4730
PHONE NUMBER	504-667-4580
STREET ADDRESS	2400 Veterans Memorial Boulevard, Suite 200
CITY, STATE, ZIP	Kenner, Louisiana 70062

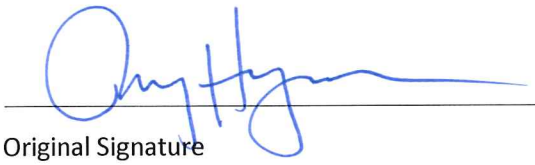
*Best method of document delivery

Proposer certifies that the above information is true and grants permission to the Department to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, Proposer certifies that:

1. The information contained in its response to this RFP is accurate.
2. Proposer complies with each of the mandatory requirements listed in the RFP and will meet or exceed the business and technical requirements specified therein.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's response is valid for at least one hundred and twenty (120) days from the date of Proposer’s signature below.
5. Proposer understands that if selected as the successful Proposer, he/she will have twenty (20) calendar days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.

6. Proposer certifies by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in 2 C.F.R. §200 Subpart F. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov.)
7. Proposer understands that, if selected as a contractor, the Louisiana Department of Revenue must determine that it is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the LDR. Proposer shall comply with R.S. 39:1624(A)(10) by providing its seven-digit LDR account number in order for tax payment compliance status to be verified.
8. Proposer further acknowledges its understanding that issuance of a tax clearance certificate by LDR is a necessary precondition to the approval of any contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to any contract without penalty and proceed with alternate arrangements, should a prospective contractor fail to resolve any identified outstanding tax compliance discrepancies with the LDR within seven (7) days of such notification.
9. Proposer certifies and agrees that the following information is correct: In preparing its response, the Proposer has considered all proposals submitted from qualified, potential subcontractors and suppliers, and has not, in the solicitation, selection, or commercial treatment of any subcontractor or supplier, refused to transact or terminated business activities, or taken other actions intended to limit commercial relations, with a person or entity that is engaging in commercial transactions in Israel or Israeli-controlled territories, with the specific intent to accomplish a boycott or divestment of Israel. Proposer also has not retaliated against any person or other entity for reporting such refusal, termination, or commercially limiting actions. The State reserves the right to reject the response of the proposer if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response.



Original Signature

Randy J. Hyun
Director & President, Aetna Better Health, Inc. dba Aetna Better Health of Louisiana
Chief Executive Officer, Aetna Medicaid

Printed Name

April 18, 2019

Date

2.9.6.3 Appendix E: Medicaid Ownership and Disclosure Form

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Appendix E
Revised 03/2018

Instructions for Louisiana Medicaid Ownership Disclosure Information Entity/Business

This is a multi-page form. Please review the instructions in their entirety before completing the form. ***Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.***

Refer to the web sites listed on the previous pages for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Enter your Provider Name at the top of each page in the space provided.

Section I – Disclosing Entity/Business Provider Information

Louisiana Medicaid Provider Number – Enter your seven (7) digit Medicaid provider number, if known. If this application is for a new Medicaid provider number, leave this field blank.
Taxpayer ID Number – Enter the nine (9) digit Tax ID number for this provider.
National Provider Identifier (NPI) – Enter your ten (10) digit National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov
This enrollment packet is for a – Check the appropriate box from among New Enrollment, Update to Current Enrollment, Re-Validation, Re-Enrollment or Change of Ownership (CHOW). If CHOW, provide the date of the CHOW and the current Louisiana Medicaid Provider number in the spaces provided.
Provider Type – Enter the Louisiana Medicaid Provider Type for this Entity/Business.
Primary Telephone Number(s) of Disclosing Entity/Business - Enter the area code and telephone number(s) at the street address of this Entity/Business.
Doing Business As (DBA) Name – Enter the DBA Name in the space labeled "Doing Business As (DBA) Name." If a license is required, the name entered must match the operating name on the Entity/Business license.
Legal Name of Disclosing Entity/Business – Enter the legal name of the Entity/Business in the space labeled "Legal Name of Entity/Business."
Primary Disclosing Entity/Business Street Address, City, State, Zip - Enter the physical business street address of the Entity/Business requesting enrollment. Enter the city, state and zip code of the physical business street address.
Primary Disclosing Entity/Business Mailing Address/PO Box, City, State, Zip – Enter the mailing address or PO Box of the Entity/Business requesting enrollment. Enter the city, state and zip code of the mailing address.
Additional Post Office Boxes Not Identified Above – Enter any additional Post Office Boxes for the Entity/Business that are stand-alone or not associated with any business location.
Disclosing Entity/Business Telephone Number to Request Medical Records – Enter the area code and telephone number(s) that the Entity/Business uses to answer requests for medical records.
Disclosing Entity/Business Primary Fax Number – Enter the area code and fax number(s) of this Entity/Business.
Email Address of Entity/Business contact person - Enter the email address of the contact person who should receive official LDH notices.
Entity/Business Website – Enter the web address of the Entity/Business website if applicable.

A. **Is there a Corporate Office location for the disclosing Entity/Business?** Check the appropriate box.
DBA Name of Corporate Office – If the Entity/Business does have a corporate office location, enter the DBA Name of that office.
Corporate Office contact information – Enter the street address, mailing address/PO Box, additional PO boxes, phone number, fax number and email address for the corporate office.

B. **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below. Lists are not acceptable.
DBA Name of Additional Location – Enter the DBA name of the additional practice location.
Medicaid Provider # - Enter the Medicaid Provider number of the additional practice, if applicable.
Additional Location contact information – Enter the mailing address/PO Box, street address, additional PO boxes, phone number, fax number and email address for the additional location office. Continue identifying additional locations and the contact information in the spaces provided. If needed, please attach additional sheets if there are more than three additional locations.

C. **Identify how this disclosing Entity/Business is registered with the Internal Revenue Service – Select only 1 of the categories.** Multiple selections may result in a rejection for clarification.
Privately owned or Non-profit Providers Only – Identify the type of Entity/Business as it is registered with the Internal Revenue Service (IRS). Check only one box from among Sole Proprietorship, Partnership/Limited Liability Partnership, Corporation, Limited Liability Corporation (LLC), or Non-profit. Answer any questions associated with the type of Entity/Business in the space(s) provided. Optional: May add comments in the space provided. Continue to Section II.
OR
Louisiana Government Providers Only – Identify the type of Entity/Business if Louisiana government owned. Select only one from among City and/or Parish; Department of Children and Family Services (DCFS), Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Villa, Other LDH agency, Local Education Agency (LEA), Louisiana State University (LSU), or Other State-owned entity. Check the appropriate box and complete the applicable fields.

D. **Is this disclosing Entity/Business publicly traded?** A publicly traded company is one which is traded on the open market, also called publicly held or public company. Check the appropriate box.

E. **Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?** Check the appropriate box. If yes, list all names and Tax IDs in the spaces provided. Attach additional pages if needed.

Section II – Entity/Business Criminal Conviction Disclosure and Additional Information

A. **Has this Entity/Business (since its existence) AND any entity/business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, 1) provide a written statement including the details on all occurrences and 2) attach all official legal documents, including any reinstatements.

Section III – Enrollment In Healthcare Programs

A. **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION IV – PREPARER INFORMATION – INDIVIDUAL COMPLETING DISCLOSURE OF OWNERSHIP INFORMATION

List the full name (including maiden name and hyphenated last name if applicable), social security number, date of birth, and job title. Check one box to identify whether the person completing the form is staff, owner, third party/independent agent, or other. If you check other, please specify by writing the relationship in the space provided. List the Entity/Business address, Entity/Business telephone number, and the Entity/Business email address of the person completing this form. Finally, enter any additional Entity/Business telephone number(s) and Entity/Business email address(es).

SECTION V – OWNERSHIP INFORMATION

Medicaid requires that an Entity/Business fully disclose **ALL** persons and entities that have an ownership interest (either separately or in combination) of 5% or more of this Entity/Business. A separate form, Section V(b), is required for each owner, therefore, please make the necessary copies as a list of owners will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Owners are individuals and/or organizations having direct, indirect, or controlling ownership interest in this disclosing Entity/Business.

- Direct ownership is defined as the possession of stock, equity in capital, or any interest in the profits of this disclosing Entity/Business.
- Indirect ownership is defined as an ownership interest in an Entity/Business that has direct or indirect ownership in this disclosing Entity/Business.
- Controlling interest is defined as having operational direction or management or the ability and authorization:
    - To amend or change the corporate identity.
    - To nominate or name members of the board, directors, or trustees
    - To amend or change the bylaws, constitution, or other operating or management direction
    - To control the sale of any or all of the assets or property upon dissolution of the Entity/Business.
    - To dissolve or transfer this disclosing Entity/Business to new ownership or control.
    - Et cetera.

Owners may also be individuals associated with the Entity/Business:

- Whose personal assets are used to satisfy the Entity/Business creditors.
- Who join together to carry on an Entity/Business and expect to share in the profits and losses of the Entity/Business.
- Who report their share of profits and losses of the Entity/Business on their own personal tax returns.
- Who own corporate stock.
- Who are policy makers.
- Who have veto powers.
- Who have voting power.
- Who have any other responsibilities similar to the ones described above.

Ownership might be implied by titles like the following:

- Founder
- Incorporator
- Member
- Owner
- Shareholder

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION V(a) – INFORMATION ON ALL OWNERS

NEW FORMAT! Please read these directions in detail.

A. **Individuals & Entities/Businesses with Direct Ownership** –List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/ or controlling interest of 5% or greater in the disclosing Entity/Business. Add additional pages if needed.
NOTE: Section V(b) must be completed for each individual listed. Item B and Section V(c) must be completed for each entity/business listed.

B. **Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business –**
First column: List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business in the first column. The disclosing Entity/Business cannot list itself as an owner.
Second column: Name all owners of the entity/business listed in the first column.
Third column: Indicate the percent of ownership each owner has in the entity/business in the first column.
Fourth column: Indicate the percent ownership each owner has in the disclosing Entity/Business. This percent of indirect ownership in the disclosing Entity/Business is determined by multiplying the percentages of ownership in e

ach entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.
Add additional pages if needed.
NOTE: Section V(c) must be completed for each Entity/Business listed and Section V(b) must be completed for each individual listed.

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

An entire Section V(b) (consisting of two pages) must be completed for **each and every individual owner named in Section V(a)**, whether the individual owns a direct or indirect stake in the disclosing Entity/Business. A list of all owners will not be accepted. **Make a copy of the blank form for each owner you report before you fill it out the first time.** For example, if you have five owners, you need to submit five completed Section V(b) forms.

A. **Individual Owner Information** – Enter the First Name, Middle Name, Maiden Name, Last Name and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Title/Job Position within this Entity/Business, the percentage of ownership of the Entity/Business, the Social Security Number (required), date of birth, current mailing address and physical address, telephone number and email address of the owner in the spaces provided.

B. **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?** – Read the question carefully and check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this owner a U.S. citizen?** Check the appropriate box. If no, provide the Alien Verification number.

D. **Does this owner reside outside the State of Louisiana?** – Check the appropriate box. If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the appropriate box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided. Attach additional pages if needed.

E. **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related (e.g. spouse, parent, child, sibling) in the spaces provided. Attach additional pages if needed.

F. **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

G. **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business participating in a Federal/State funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

H. **Has the individual owner named above (ever)** – Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. **Entity/Business Owner Information** – Enter the Entity/Business Name, the DBA Name, the Tax ID Number, the current street address of the primary location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided.

B. **Are there any business locations in addition to the location listed above?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location. Enter the DBA Name of the additional location, the Tax ID Number, the current street address of the additional location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided. Attach additional pages if needed.

C. **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?** Check the appropriate box. If yes, list all names and Tax IDs below. Attach additional pages if needed.

D. **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

E. **Is this Entity/Business and Tax ID listed in the Section I currently enrolled in a Federal/State funded healthcare program?** If yes, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments.

F. **Has this Entity/Business (since its existence) AND any Entity/Business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with, since the inception of those programs, as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, provide a written statement including the details on all occurrences. Attach all official legal documents, including any reinstatements.

SECTION VI – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

A separate VI(b) form is required for each agent or managing employee, therefore, please make the necessary copies as a list of all managing employees and/or agent names will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Managing employee is defined as a general manger, business manager, administrator, director, or other individual who exercises operational or manager control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.

Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider.

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Managing employee/agent
- Officer
- Trustee

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

In the first table, enter the names of each agent, member or officer who is a part of management for the disclosing Entity/Business. In the second table, enter the names of each managing employee for the disclosing Entity/Business. Select the appropriate box to indicate if the individual is also an owner. If so, list their percentage of ownership. Add additional pages if needed.

NOTE: Section VI(b) must be completed for each individual listed unless individual has already been reported in Section V.

SECTION VI(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Make a photocopy of Section VI(b) for each managing employee/agent you report.

A. **AGENT– or – MANAGING EMPLOYEE –** Check a box to specify whether the person is a Managing employee or an Agent. Enter the managing employee/agent's First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable), Title/ Job Position, Social Security Number, Date of Birth, current mailing address, current physical address, telephone number and email address in the spaces provided.

B. **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias? –** Check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this agent or managing employee a U.S. citizen?** Check the appropriate box. If no, provide Alien Verification number.

D. **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related in the spaces provided. Attach additional pages if needed.

E. **Has the agent or managing employee named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

F. **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION VII – AUTHORIZED REPRESENTATIVES

List the individuals who are authorized to sign into legal, binding documents on behalf of this provider, such as direct deposit forms and/or changes to the disclosure of ownership forms. Every person listed here must be either an owner or a managing employee as disclosed in the Disclosure of Ownership forms. Check one box for each person to indicate whether the individual is an owner, a managing employee, or other (specify the title in the space provided).

Printed Name of Authorized Representative – print the name of the authorized representative who can enter into a binding agreement with Louisiana Medicaid.
Title/Position of Authorized Representative – indicate the Authorized Representative's relationship to the entity or business (e.g., owner, administrator, agent, managing employee, billing manager, etc.).
Signature of Authorized Representative – the authorized representative must sign the form. Signatures must be original and in blue ink (stamped signatures and initials are not accepted). Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.
Date of Signature – enter the date this agreement was signed.

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date. Please sign in colored ink (not black).

Reference Material for Louisiana Medicaid Ownership Disclosure Information For an Entity/Business

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address: http://url.ie/ywri

MAPIL Louisiana R.S., Title 46:437.1-14. http://url.ie/yw45

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://url.ie/yw46

Louisiana Update January/February 2009: http://url.ie/yw47

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (Louisiana Register, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at www.lamedicaid.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: http://tinyurl.com/ne58pwb

Social Security Act 1128 a: http://tinyurl.com/3lnj2z9

Provider Name: Aetna Better Health of Louisiana

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION – ENTITY/BUSINESS

Must be completed in its entirety. Refer to Instructions found at www.lamedicaid.com

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number (Leave blank if applying for new number)	2 3 7 7 1 6 7
Taxpayer ID Number	8 0 0 6 2 9 7 1 8
National Provider Identifier (NPI)	1 9 8 2 9 1 9 6 9 2

This enrollment packet is for a
☐ New Enrollment ■ Update to Current Enrollment
☐ Re-Validation ☐ Re-Enrollment

☐ Change of Ownership (CHOW) N/A (Date of CHOW) N/A (Current Medicaid Provider Number)

Provider Type: Health Maintenance Organization

Primary Telephone Number of Disclosing Entity/Business: (855) 242-0802

Doing Business As (DBA) Name: Aetna Better Health of Louisiana	Legal Name of Disclosing Entity/Business: Aetna Better Health, Inc.		
Primary Disclosing Entity/Business Street Address: 2400 Veterans Memorial Blvd., Suite 200	City: Kenner	State: LA	Zip: 70062
Primary Disclosing Entity/Business Mailing Address/PO Box: 2400 Veterans Memorial Blvd., Suite 200	City: Kenner	State: LA	Zip: 70062
Additional Post Office Boxes Not Identified Above: N/A	City: N/A	State: N/A	Zip: N/A
Disclosing Entity/Business Telephone number to request medical records: (855) 242-0802	Disclosing Entity/Business Primary Fax Number: ( ) N/A		
Email Address of Entity/Business contact person: MccurryP@aetna.com	Entity/Business Website (if applicable): https://www.aetnabetterhealth.com/louisiana		

A. ■ **Yes** ☐ **No** **Is there a Corporate Office location separate from the primary location of the disclosing Entity/Business?**

If yes, complete the section below.

DBA Name of Corporate Office: Aetna Inc.

Corporate Office Street Address: 151 Farmington Ave.	City: Hartford	State: CT	Zip: 06156
Corporate Office Mailing Address/PO Box: 151 Farmington Ave.	City: Hartford	State: CT	Zip: 06156
Additional Post Office Boxes Not Identified Above: N/A	City: N/A	State: N/A	Zip: N/A
Corporate Office Phone Number: (860) 273-0123	Corporate Office Fax Number: ( ) N/A		
Corporate Office Email address: LeeE1@aetna.com			

Provider Name: Aetna Better Health of Louisiana

Make a photocopy of this page if more space is needed to list additional locations

B. ☒ Yes ☐ No **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Lists are not acceptable.

1 If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location Aetna Better Health of Louisiana	Medicaid Provider #, if applicable N/A		
Additional Location Street Address 10000 Perkins Rowe, Suite 500	City Baton Rouge	State LA	Zip 70810
Additional Location Mailing Address/PO Box N/A	City N/A	State N/A	Zip N/A
Additional Post Office Boxes Not Identified Above N/A	City N/A	State N/A	Zip N/A
Additional Location Phone Number (855) 242-0802	Additional Location Fax Number ( ) N/A -		
Additional Location Email address N/A			

DBA Name of Additional Location N/A	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location N/A	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

Provider Name: Aetna Better Health of Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service
Select only one (1) – multiple selections may result in a rejection for clarification

Privately Owned or Non-profit Providers Only

☐ **Sole Proprietorship**

☐ **Partnership/Limited Liability Partnership:** How many members are identified with this partnership? _____

☒ **Corporation:** Revenue greater than or equal to $5M annually X Revenue less than $5M annually _____

In the (current) Articles of Incorporation: How many stakeholders/individual owners are identified? 1

How many Board of Director members are identified? 3

How many officers are identified? 11

☐ **Limited Liability Corporation (LLC)**
In the (current) Articles of Organization: How many members are identified? _____

How many managing employees are identified? _____

☐ **Non-profit:** How many members are appointed to the governing board? _____ (Must attach IRS verification showing the non-profit status)

Comments: _____

Louisiana Government Providers Only

☐ **CITY and/or PARISH**

☐ **DCFS**

☐ **LDH**
☐ OBH ☐ OPH
☐ OAAS ☐ OCDD
☐ Villa ☐ Other _____

☐ **LEA (Local Education Agency)**

☐ **LSU**
Hospital - _____

☐ **Other State-owned entity:** _____

D. ☐ **Yes** ☒ **No** **Is this disclosing Entity/Business publicly traded? See instructions.**

E. ☐ **Yes** ☒ **No** **Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name	Tax ID
Name	Tax ID
Name	Tax ID
Name	Tax ID
Name	Tax ID

Provider Name: Aetna Better Health of Louisiana

SECTION II – DISCLOSING ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

A. Has this Entity/Business (since its existence) – AND –

Any Entity/Business affiliated with the same Tax ID number – AND –

Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:

☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
■ Yes ☐ No	Currently have any open or pending healthcare court cases? SEE EXHIBIT 1
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: Aetna Better Health of Louisiana

Make a photocopy of this page if more space is needed to respond to item A below

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. ☒ Yes ☐ No **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, provide the details in the fields below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	Aetna Better Health of Louisiana	80-0629718	LA	Integrated Public Health - 43,143; ACA-52734, SBH-21064

SECTION IV - PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Michelle	Marie	Carter	Carter	-	Gouge

Social Security Number	Date of Birth	Job Title
[redacted]	[redacted]	Counsel

The person completing this form is (please check one):

☒ Staff ☐ Owner ☐ Third Party/Independent Agent ☐ Other (explain) _____

Entity/Business Address	Entity/Business City	Business State	Business Zip
9401 Indian Creek Parkway, Suite 1300	Overland Park	KS	66210

Entity/Business Telephone Number	Entity/Business Email Address
(913) 202-5293	Mmcarter1@aetna.com
Additional Entity/Business Telephone Number(s)	**Additional Entity/Business Email Address(es)**
N/A	N/A

Provider Name: Aetna Better Health of Louisiana

NEW FORMAT! PLEASE REFER TO THE INSTRUCTIONS FOR DETAILED EXPLANTIONS!

Make a photocopy of this page if more space is needed to list owners in items A and B

SECTION V(a) – INFORMATION ON ALL OWNERS

A. Individuals & Entities/Businesses with Direct Ownership

List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/or controlling interest of 5% or greater in the disclosing Entity/Business.

*Fill out Section V(b) for each **Individual**. Fill out both item B and Section V(c) for each **Entity/Business** listed below.*

Individuals or Entities/Businesses with ownership	% of ownership
1. Aetna Health Holdings, LLC	100% (Direct)
2. Aetna Inc.	100% (Indirect)
3. CVS Pharmacy, Inc.	100% (Indirect)
4. CVS Health Corporation	100% (Indirect)
5.	
6.	
7.	
8.	
9.	
10.	

B. Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business

List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business. Identify the owners of that Entity/Business and their % of ownership below.* The disclosing Entity/Business cannot be listed as an owner.

*Fill out Section V(b) for each **Individual** and Section V(c) for each **Entity/Business** listed below.*

Entity/Business/Organization with a direct ownership interest listed in item A	Owners of the Entity/Business identified on the left.	% of ownership in Entity/Business identified on the left	% of ownership in the disclosing Entity/Business
1. Aetna Health Holdings, LLC	a. Aetna Inc.	100%	100%
	b.		
	c.		
	d.		
2. Aetna Inc.	a. CVS Pharmacy, Inc.	100%	0%
	b.		
	c.		
	d.		
3. CVS Pharmacy, Inc.	a. CVS Health Corporation	100%	0%
	b.		
	c.		
	d.		
4. CVS Health Corporation	a. See Exhibit 1		
	b.		
	c.		
	d.		
5.	a.		
	b.		
	c.		
	d.		

*The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.

Provider Name: Aetna Better Health of Louisiana

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

First Name NONE	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Title/Job Position within the disclosing Entity/Business	% ownership	Social Security Number (required) - -	Date of Birth

Healthcare NPI (if applicable)

Street Address	City	State	Zip Code
Mailing Address/PO Box	City	State	Zip Code

Telephone Number - -	Email address

B. ☐ **Yes** ☐ **No** **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☐ **Yes** ☐ **No** **Is this owner a U.S. citizen? If no, provide Alien Verification ____________________**

D. ☐ **Yes** ☐ **No** **Does this owner reside outside the State of Louisiana?**

☐ Yes ☐ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state? If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

E. ☐ **Yes** ☐ **No** **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:

Provider Name: Aetna Better Health of Louisiana

Make a photocopy of this page if more space is needed to respond to items F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Not applicable. Aetna Better Health of Louisiana is a wholly-owned subsidiary of Aetna Health Holdings, LLC

F. ☐ Yes ☐ No **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

G. ☐ Yes ☐ No **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Aetna Better Health of Louisiana

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: Not applicable. Aetna Better Health of Louisiana is a wholly-owned subsidiary of Aetna Health Holdings, LLC

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
H. Has the individual owner named above (ever):	
☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name: N/A	Legal Name of Entity/Business: Aetna Health Holdings, LLC	Tax ID Number (required): 30-012354		
Entity/Business Street Address – Primary Location: 151 Farmington Ave.	City: Hartford	State: CT	Zip: 06156	
Entity/Business Mailing Address/PO Box: 151 Farmington Ave.	City: Hartford	State: CT	Zip: 06156	
Additional Post Office Boxes Not Identified Above: N/A	City:	State:	Zip:	
Telephone Number: (860) 273-0123 -	Fax Number: ( ) N/A -			
Email address of Entity/Business contact person: LeeE1@aetna.com	Entity/Business Website (if applicable): aetna.com			

B. ☐ Yes ■ No **Are there any business locations in addition to the location listed above?**

If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

C. ☐ Yes ■ No **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name		Tax ID	
Name		Tax ID	
Name		Tax ID	

Provider Name: Aetna Better Health of Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Aetna Health Holdings, LLC

D. ☐ Yes ■ No **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**
If yes, complete the section below for each subcontractor. See Exhibit 2

Direction was to provide Aetna Better Health LA subcontractors, not AHH, LLC

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

E. ☐ Yes ■ No **Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Aetna Better Health of Louisiana

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Aetna Health Holdings, LLC

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

F. Has this Entity/Business (since its existence) – AND –

Any Entity/Business affiliated with the same Tax ID number – AND –

Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:

☐ Yes ☑ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☑ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☑ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☑ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☑ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
■ Yes ☐ No	Currently have any open or pending healthcare court cases? SEE EXHIBIT 1
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name: N/A	Legal Name of Entity/Business: Aetna Inc.	Tax ID Number (required): 22-2229683		
Entity/Business Street Address – Primary Location: 151 Farmington Ave.	City: Hartford	State: CT	Zip: 06156	
Entity/Business Mailing Address/PO Box: 151 Farmington Ave.	City: Hartford	State: CT	Zip: 06156	
Additional Post Office Boxes Not Identified Above: N/A	City:	State:	Zip:	
Telephone Number: (860) 27[illegible]-0123 -	Fax Number: ( ) N/A			
Email address of Entity/Business contact person: LeeE1@aetna.com	Entity/Business Website (if applicable): aetna.com			

B. ■ **Yes** ☐ **No** **Are there any business locations in addition to the location listed above?**

172 If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location: See Exhibit 1

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

C. ☐ **Yes** ■ **No** **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name		Tax ID	
Name		Tax ID	
Name		Tax ID	

Provider Name: Aetna Better Health of Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Aetna Inc.

D. ☐ Yes ■ No **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**
If yes, complete the section below for each subcontractor.

Direction is to provide Aetna Better Health LA subcontractors, not Aetna Inc. See Exhibit 2

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

E. ☐ Yes ■ No **Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Aetna Better Health of Louisiana

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Aetna Inc.

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks. F. Has this Entity/Business (since its existence) – AND – Any Entity/Business affiliated with the same Tax ID number – AND – Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
■ Yes ☐ No SEE EXHIBIT 1	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
■ Yes ☐ No	Currently have any open or pending healthcare court cases? SEE EXHIBIT 1
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name: CVS/pharmacy	Legal Name of Entity/Business: CVS Pharmacy, Inc.	Tax ID Number (required): 05-0340626		
Entity/Business Street Address – Primary Location: One CVS Drive	City: Woonsocket	State: RI	Zip: 02895	
Entity/Business Mailing Address/PO Box: One CVS Drive	City: Woonsocket	State: RI	Zip: 02895	
Additional Post Office Boxes Not Identified Above: N/A	City	State	Zip	
Telephone Number: (401) 765-1500 -	Fax Number: ( ) N/A			
Email address of Entity/Business contact person: N/A	Entity/Business Website (if applicable): www.cvshealth.com			

B. ☒ Yes ☐ No **Are there any business locations in addition to the location listed above?**

10k+ If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location: See Exhibit 1

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

C. ☒ Yes ☐ No **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

*Continued on next page

Name	Asset Protection Services	Tax ID	05-0340626
Name	CVS	Tax ID	05-0340626
Name	CVS Distribution Center	Tax ID	05-0340626

*Continued on next page

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

C. ■ Yes ☐ No Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name	CVS Health	Tax ID	05-0340626
Name	CVS Pharmacy	Tax ID	05-0340626
Name	CVS/Pharmacy Central Pharmacy Services	Tax ID	05-0340626
Name	OTC Health Solutions	Tax ID	05-0340626
Name		Tax ID	

Provider Name: Aetna Better Health of Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: CVS Pharmacy, Inc.

D. ☐ Yes ■ No **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**
If yes, complete the section below for each subcontractor.
Please note, we are interpreting this question to refer to business transactions that relate to the MCO consistent with the definition of subcontractor in 42 CFR 455.101.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

E. ☐ Yes ■ No **Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Aetna Better Health of Louisiana

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: CVS Pharmacy, Inc.

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks. **F. Has this Entity/Business (since its existence) – AND –** **Any Entity/Business affiliated with the same Tax ID number – AND –** **Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:**	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
■ Yes ☐ No See Exhibit 1	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
■ Yes ☐ No	Currently have any open or pending healthcare court cases? See Exhibit 1
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name: N/A	Legal Name of Entity/Business: CVS Health Corporation	Tax ID Number (required): 05-0494040		
Entity/Business Street Address – Primary Location: One CVS Drive	City: Woonsocket	State: RI	Zip: 02895	
Entity/Business Mailing Address/PO Box: One CVS Drive	City: Woonsocket	State: RI	Zip: 02895	
Additional Post Office Boxes Not Identified Above: N/A	City	State	Zip	
Telephone Number: (401) 765-1500 -	Fax Number: ( ) N/A			
Email address of Entity/Business contact person: N/A	Entity/Business Website (if applicable): www.cvshealth.com			

B. ☒ Yes ☐ No Are there any business locations in addition to the location listed above?

10k+

If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location: See Exhibit 1

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

C. ☐ Yes ☒ No Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name		Tax ID	
Name		Tax ID	
Name		Tax ID	

Provider Name: Aetna Better Health of Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: CVS Health Corporation

D. ☐ Yes ■ No **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**
If yes, complete the section below for each subcontractor.
Please note, we are interpreting this question to refer to business transactions that relate to the MCO consistent with the definition of subcontractor in 42 CFR 455.101

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

E. ☐ Yes ■ No **Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Aetna Better Health of Louisiana

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: CVS Health Corporation

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks. F. Has this Entity/Business (since its existence) – AND – Any Entity/Business affiliated with the same Tax ID number – AND – Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
■ Yes ☐ No	Currently have any open or pending healthcare court cases? SEE EXHIBIT 1
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: Aetna Better Health of Louisiana

Make a photocopy of this page if more space is needed to list individuals.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1. See Exhibit 1	☐ Yes ■ No	
2.	☐ Yes ■ No	
3.	☐ Yes ■ No	
4.	☐ Yes ■ No	
5.	☐ Yes ■ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing employee(s)	Is this managing employee also an owner?	% ownership
1. See Exhibit 1	☐ Yes ■ No	
2.	☐ Yes ■ No	
3.	☐ Yes ■ No	
4.	☐ Yes ■ No	
5.	☐ Yes ■ No	
6.	☐ Yes ■ No	
7.	☐ Yes ■ No	
8.	☐ Yes ■ No	
9.	☐ Yes ■ No	
10.	☐ Yes ■ No	
11.	☐ Yes ■ No	
12.	☐ Yes ■ No	
13.	☐ Yes ■ No	
14.	☐ Yes ■ No	
15.	☐ Yes ■ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ■ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Randy	Joo Hwan	N/A	Hyun		N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Principal Officer, Director, & President	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
4500 E Cotton Center Blvd	Phoenix	AZ	85040
Physical Address	**City**	**State**	**Zip Code**
4500 E Cotton Center Blvd	Phoenix	AZ	85040

Telephone Number	Email address
(602) 659-1160 -	HyunR@aetna.com

B. ■ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Joo	Hwan	N/A	Hyun		N/A
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Randy J. Hyun

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☑ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☑ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☑ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☑ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☑ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☑ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☑ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ■ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Tracy	Louise	DeWire	Smith		N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President & Treasurer	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
200 Highland Corporate Drive	Cumberland	RI	02864
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
(401) 770-5097 -	Tracy.Smith@CVSHealth.com

B. ■ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Tracy	Louise	DeWire	Smith		N/A
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Tracy L. Smith

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☑ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☑ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☑ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☑ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☑ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☑ No	Currently have any open or pending healthcare court cases?
☐ Yes ☑ No	Been denied malpractice insurance?
☐ Yes ☑ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☑ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Robert	M		Kessler		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President and Secretary	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
4500 E Cotton Center Blvd.	Phoenix	AZ	85040
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 602 659 1141	KesslerR@aetna.com

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Robert M. Kessler

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ■ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Gregory	S		Martino		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
151 Farmington Ave.	Hartford	CT	06156
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 215-510-1286	MartinoG@aetna.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Gregory Martino

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☑ AGENT– or – ☑ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
David	Patrick	N/A	Delaney		N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Director and Chief Financial Officer	0%	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
4500 E Cotton Center Blvd.	Phoenix	AZ	85040
Physical Address	**City**	**State**	**Zip Code**
SAME			

Telephone Number	Email address
602 - 659 - 1643	DelaneyD2@aetna.com

B. ☐ Yes ☑ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☑ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☑ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: David P. Delaney

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☑ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☑ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☑ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☑ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☑ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☑ No	Currently have any open or pending healthcare court cases?
☐ Yes ☑ No	Been denied malpractice insurance?
☐ Yes ☑ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☑ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☒ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Janet	Ruth	Lehrke	Grant		N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Director	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
1285 Fern Ridge Parkway	St. Louis	MO	63141
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 314 444 7226	GrantJ4@aetna.com

B. ☒ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Janet	Ruth	Lehrke	Grant		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Janet R. Grant

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Frank	F.		Chronister	-	N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Director Financial Reporting and Analysis	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
3721 TecPort Drive	Harrisburg	PA	17111
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 717 541 5742	FChronister@aetna.com

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
				-	
				-	

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Frank F. Chronister

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Kevin	J		Casey	-	N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Senior Investment Officer	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
151 Farmington Ave.	Hartford	CT	06156
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 860 273 3708	CaseyKJ@aetna.com

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Kevin J. Casey

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Scott	D		Miller		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Manager - Financial Analysis and Reporting	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
3721 TecPort Drive	Harrisburg	PA	17111
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 717-671-2474	Sdmiller@aetna.com

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Scott D. Miller

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ■ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Edward	C		Lee		N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President and Assistant Secretary	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
151 Farmington Ave.	Hartford	CT	06156
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 860 273 8329	LeeE1@aetna.com

B. ■ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Chung-I			Lee		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Edward C. Lee

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ■ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Melissa	B		Pavlovich	-	N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President Corporate Tax	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
151 Farmington Ave.	Hartford	CT	06156
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 860 273 5244	PavlovichM@aetna.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
				-	
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
				-	

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Melissa B. Pavlovich

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Richard	C		Born		N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President, Medicaid Health Plan	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
2400 Veterans Memorial Blvd	Kenner	LA	70062
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 504 667 4580	BornR@aetna.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Richard C. Born

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Mark	R		Grippi	-	N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Chief Operating Officer	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
2400 Veterans Memorial Blvd	Kenner	LA	70062
Physical Address	City	State	Zip Code
Same			

Telephone Number	Email address
- - 504-667-4490	GrippiM@aetna.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
				-	
				-	

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Mark R. Grippi

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or –☑ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Madelyn	Marie	N/A	Meyn		N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Chief Medical Officer	0%	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
2400 Veterans Memorial Blvd	Kenner	LA	70062
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
504 - 667 - 4541	meynm@aetna.com

B. ☐ Yes ☑ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☑ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☑ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Madelyn M. Meyn

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☑ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☑ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☑ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☑ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☑ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☑ No	Currently have any open or pending healthcare court cases?
☐ Yes ☑ No	Been denied malpractice insurance?
☐ Yes ☑ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☑ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

Provider Name: Aetna Better Health of Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
David	A		Nicosia	-	N/A

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Chief Financial Officer	0	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
2400 Veterans Memorial Blvd	Kenner	LA	70062
Physical Address	**City**	**State**	**Zip Code**
Same			

Telephone Number	Email address
- - 504-577-1392	NicosiaD@aetna.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
				-	
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
				-	

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Aetna Better Health of Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: David A. Nicosia

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ■ **Yes** ☐ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
	SEE EXHIBIT 1			

SECTION VII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO SIGN INTO LEGAL, BINDING DOCUMENTS ON BEHALF OF THIS PROVIDER, SUCH AS DIRECT DEPOSIT FORMS AND/OR CHANGES TO THE DISCLOSURE OF OWNERSHIP FORMS, etc.

Note: Every person listed below must be disclosed in the Disclosure of Ownership forms.

List each person authorized to sign and identify their position in your practice.	
1. See Exhibit 1	☐ Owner ☐ Managing employee ☐ Other _____
2.	☐ Owner ☐ Managing employee ☐ Other _____
3.	☐ Owner ☐ Managing employee ☐ Other _____
4.	☐ Owner ☐ Managing employee ☐ Other _____
5.	☐ Owner ☐ Managing employee ☐ Other _____
6.	☐ Owner ☐ Managing employee ☐ Other _____
7.	☐ Owner ☐ Managing employee ☐ Other _____
8.	☐ Owner ☐ Managing employee ☐ Other _____
9.	☐ Owner ☐ Managing employee ☐ Other _____
10.	☐ Owner ☐ Managing employee ☐ Other _____

Please sign in blue ink (not black)

Randy J. Hyun
Printed Name of Authorized Representative

Signature of Authorized Representative
(sign in blue ink)

President & Chief Executive Officer
Title/Position

4-18-19
Date of Signature

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That the provider has disclosed all necessary information;
2. That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That the provider has reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4. That the provider understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That the provider understands that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That the provider understands that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable Federal or state laws;
7. That the provider understands it is their responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That the provider understands that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That the provider understands if this number is closed due to inaccurate information or inactivity, they will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10. The provider understands that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(b)(1).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(b)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That the provider understands that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, they must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US.
13. The provider understands that it is their responsibility to ensure that all managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
14. The provider understands that it is their responsibility to ensure that it is disclosed on this form if any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
15. The provider understands that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), they are required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
16. The provider understands that they shall report any of the above conditions to the Louisiana Department of Health (LDH). Once enrolled, the provider understands that upon discovery of any of the above conditions, it is their responsibility to report immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
17. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any Federally funded healthcare program, I am required to submit this information and the requested documentation.
18. The provider understands that they are being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." The provider understands that this criminal statute means that if any owners, managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. The provider also understands that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs. The provider also understands that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Randy J. Hyun	
Printed Name of Authorized Representative	Signature of Authorized Representative *(sign in blue ink)*
President & Chief Executive Officer	4-18-19
Title/Position of Authorized Representative	Date of Signature

Aetna Better Health of Louisiana

Louisiana Medicaid Ownership Disclosure Information

EXHIBIT 1

Section II. Aetna Better Health, Inc. d/b/a Aetna Better Health of Louisiana is involved in the following healthcare court cases:

Aetna Better Health of Louisiana is currently involved in only one open or pending health care case. That case, captioned Laguna Commercial Capital, LLC v. Wish Health Services, LLC; Keimyereia Lewis-Jones; Louisiana Healthcare Connections, Inc.; Aetna Better Health, Inc. d/b/a Aetna Better Health of Louisiana; AmeriHealth Caritas Louisiana, Inc.; Community Care Health Plan of Louisiana, Inc. d/b/a Healthy Blue; and UnitedHealthCare of Louisiana, Inc. d/b/a UnitedHealthcare Community, U.S. District Court for the Eastern District of Louisiana, No. 2:19-cv-01522-MVL-KWR, involves a dispute between a provider and their successor-in-interest. Aetna Better Health of Louisiana is named as a defendant for purposes of notification to pay the successor and not the provider.

Section V(a)(B) 4. CVS Health Corporation - CVS Health Corporation is a publicly traded company, listed on the New York Stock Exchange and registered with the Securities Exchange Commission ("SEC"). As a publicly traded company, CVS Health does not track the identity of individual shareholders, but relies on disclosures of beneficial ownership of CVS Health stock which the SEC requires investors to file on Schedules 13D and 13G and related amendments. From time to time, certain institutional investors have filed Schedules 13D and 13G with the SEC, indicating beneficial ownership of 5% or more of CVS Health's common stock. In such filings, the beneficial owner certifies that their shares were acquired in the ordinary course of business and were not acquired for the purpose of changing or influencing the control of CVS Health. Further information on beneficial ownership can be provided upon request.

Section V(c)B – other business locations

Aetna Office Addresses

2300 Yonge Street, Toronto, ON M4P1E4
5F Standard Charter Tower, Shanghai, 31 200120
757 Meng Zi Rd, Huangpu, Shanghai, 200023
No. 50 Liangmaqiao Rd, Beijing, 11 100125
50 Cannon St, London, GT LON EC4V2BE
25 Templar Avenue, Farnborough, HANTS GU146FE
No. 25 Westlands Road, Quarry Bay, 00000
213-B Okhla Indust Ph 3, New Delhi, 110020
Sagar Tech Plaza, Mumbai, 000000
Sentral Senayan 11 W-16, Jakarta, 12 10270
Alexandra House-The Sweepstakes, Dublin, 00000
373 Gangnam-daero seocho-gu, Seoul, 11 100843
330 Lambton Quay, Wellington, 01 6011
112 Robinson Rd 9-01, Singapore, 068902
1277 Mike Crawford Ave, Centurion, 00000
Media One Tower, Plot A008-001, Dubai, 00000
North Twr - Emirates Finl Tower, Dubai, 03 00000

2525 C Street, Anchorage, AK 99503
One Sealaska Plaza, Juneau, AK 99801
4350 E. Cotton Center Blvd., Phoenix, AZ 85040
1830 N. 95th Avenue, Phoenix, AZ 85037
18444 North 25th Ave, Phoenix, AZ 85023
4500 E. Cotton Center Blvd, Phoenix, AZ 85040
4025 E. Cotton Center Blvd, Phoenix, AZ 85040
9801 S. 51st Street, Phoenix, AZ 85044
4750 S 44TH Place, Phoenix, AZ 85040
3535 E. Valencia Rd., Tucson, AZ 85706
4141 N Scottsdale Road, Scottsdale, AZ 85251
8969 West McCartney Road, Casa Grande, AZ 85194
1333/1385 East Shaw Avenue, Fresno, CA 93710
10370/10390 Commerce Ctr Dr, Rancho Cucamonga, CA 91730
515 South Flower Street, Los Angeles, CA 90071
750 Riverpoint Drive, W. Sacramento, CA 95605
2677 North Main Street, Santa Ana, CA 92705
2850 Shadelands Dr, Walnut Creek, CA 94598
10260 Meanley Drive, San Diego, CA 92131
One Sansome Street, San Francisco, CA 94104
21215 Burbank Blvd, Woodland Hills, CA 91367
1500 Wynkoop Street, Denver, CO 80202
4582 S Ulster St, Denver, CO 80237
20 Glover Avenue, Norwalk, CT 06850
29 South Main Street, West Hartford, CT 06107
100 Signature Way, E Granby, CT 06026
151 Farmington Ave Rogers Bldg, Hartford, CT 06156
151 Farmington Ave, C&T Annex, Hartford, CT 06156
151 Farmington Avenue, Atrium Bldg, Hartford, CT 06156
570 Pigeon Hill Rd, Data Center, Windsor, CT 06095
930 Middle St, Data Center, Middletown, CT 06457
252 Chapman Rd., Newark, DE 19702
750 Prides Crossing Ste 200, Newark, DE 19713
789 SW Federal Hwy, Stuart, FL 34994
1340 Concord Terrace, Sunrise, FL 33323
8200 NW 41st St, Doral, FL 33166
9000 Southside Blvd Bld 100, Jacksonville, FL 32256
503 Sunport Lane, Orlando, FL 32809
502 Sunport Lane, Orlando, FL 32809
4630 Woodland Corporate Blvd, Tampa, FL 33614
3611 Queen Palm Drive, Tampa, FL 33619
1820 E Park Ave, Tallahassee, FL 32301
1301 N. Congress Ave., Boynton Beach, FL 33426
1600 SW 80th Terrace, Plantation, FL 33324
1100 Abernathy Rd, NE Bldg 500, Atlanta, GA 30328
1100 Circle 75 Parkway Ste 1400, Atlanta, GA 30339

2000 Riveredge Parkway, Atlanta, GA 30328
3600 Mansell Road, Alpharetta, GA 30022
333 W Wacker Dr, Chicago, IL 60606
550 W Washington Blvd, Chicago, IL 60661
10 S Riverside Plaza, Chicago, IL 60606
2110 Fox Drive, Champaign, IL 61820
4507 N. Sterling Ave., Peoria, IL 61615
One Overlook Point, Lincolnshire, IL 60069
3200 Highland Ave., Downers Grove, IL 60515
3800 Golf Road, Rolling Meadows, IL 60008
111 SE 3rd St, Evansville, IN 47708
3500 Coliseum Blvd East, Ft Wayne, IN 46805
8910 Purdue Rd, Indianapolis, IN 46268
4320 NW 114th St, Urbandale, IA 50322
8535 East 21st St N, Wichita, KS 67206
9401 Indian Creek Parkway, Overland Park, KS 66210
9900 Corporate Campus Dr., Louisville, KY 40223
10000 Perkins Rowe, Bldg G, Ste 500, Baton Rouge, LA 708101527
920 Pierremont Rd, Shreveport, LA 71106
3838 N. Causeway Blvd., Metairie, LA 70002
2400 Veterans Memorial Blvd, Kenner, LA 70062
175 Running Hill Road, South Portland, ME 04106
6720-B Rockledge Drive, Bethesda, MD 20817
13511 Label Lane, Hagerstown, MD 21740
15400 Calhoun Drive, Rockville, MD 20855
509 Progress Dr., Linthicum, MD 21090
53 State St, Boston, MA 02109
77 S. Bedford Street, Burlington, MA 01803
93 Worcester St, Wellesley, MA 02481
2725 Airview Blvd, Kalamazoo, MI 49002
1333 Gratiot Ave, Detroit, MI 48207
3200 Eagle Park Dr NE, Grand Rapids, MI 49525
1044 Eastbury Drive, Lansing, MI 48917
2612 Ashman Street, Midland, MI 48640
2356/2370 Science Parkway, Okemos, MI 48864
28588 Northwestern Highway, Southfield, MI 48034
1405 Xenium Lane North, Plymouth, MN 55441
10991 NW Airworld Drive, Kansas City, MO 64153
4520 South National Ave, Springfield, MO 65810
550 Maryville Centre Drive, St Louis, MO 63141
10802 Farnam Dr, Omaha, NE 68154
15950 W Dodge Road, Omaha, NE 68118
639 Isbell Rd, Reno, NV 89509
1140 Town Center Drive, Las Vegas, NV 89144
475 E Capovilla Ave, Las Vegas, NV 89119
303 Fellowship Road, Mt. Laurel, NJ 08054

100 Willowbrook Road, Freehold, NJ 07728
9 Entin Road, Parsippany, NJ 07054
3 Independence Way, Princeton, NJ 08540
15 Columbia Circle, Albany, NY 12203
1333 Broadway, New York, NY 10018
100 Park Avenue, New York, NY 10017
55 West 125th Street, New York, NY 10027
350 Madison Ave, New York, NY 10017
36 West 25th St, New York, NY 10010
101 Park Ave, New York, NY 10178
100 Park Ave - 27th Fl, New York, NY 10017
88 Froehlich Farms Blvd, Woodbury, NY 11797
300 Corporate Parkway, Amherst, NY 14226
2815 Coliseum Centre Drive, Charlotte, NC 28217
4050 Piedmont Parkway, High Point, NC 27265
2700 X-Ray Drive, Gastonia, NC 28054
2801 Slater Road, Morrisville, NC 27560
1800 East Interstate Avenue, Bismarck, ND 58503
2841 Woodburn Ave, Cincinnati, OH 45206
178 E. State St, Columbus, OH 43215
7400 West Campus Road, New Albany, OH 43054
3015 Glendale Ave, Toledo, OH 43617
3805 Edwards Rd, Cincinnati, OH 45209
4059 Kinross Lakes Parkway, Richfield, OH 44286
3201 Enterprise Parkway, Beachwood, OH 44122
3030 N.W. Expwy Ste 625, Oklahoma City, OK 73112
6120 South Yale Avenue, Tulsa, OK 74136
222 S.W. Columbia Street, Portland, OR 97201
120 E Kensinger Drive, Cranberry, PA 16066
2222 Ewing Road, Moon Township, PA 15108
1425 Union Meeting Road, Blue Bell, PA 19422
3721 TecPort Drive, Harrisburg, PA 17111
1550 Pond Road, Allentown, PA 18104
2000 Market Street, Philadelphia, PA 19103
730 Holiday Dr, Pittsburgh, PA 15220
11 Stanwix Street, Pittsburgh, PA 15222
221 Dawson Rd, Columbia, SC 29224
5350 Poplar Ave, Memphis, TN 38119
1801 West End Avenue, Nashville, TN 37203
800 Crescent Centre Drive, Franklin, TN 37067
2777 Stemmons Freeway, Dallas, TX 75207
135 Oyster Creek, Lake Jackson, TX 77566
Three Sugar Creek Center, Sugar Land, TX 77478
14955 Heathrow Forest Pkwy, Houston, TX 77032
4400 NW Loop 410, San Antonio, TX 78229
3900 Rogers Road, San Antonio, TX 78251

2800 N Dallas Parkway, Plano, TX 75093
9606 N. Mopac Expressway, Austin, TX 78759
4300 Centreway Place, Arlington, TX 76018
257 E 200 S, Salt Lake City, UT 84111
10150 South Centennial Parkway, Sandy, UT 84070
250 W Center St, Provo, UT 84601
630 Peter Jefferson Pkwy, Charlottesville, VA 22911
100 Linden Square Drive, Bristol, VA 24202
6387 Center Dr, Norfolk, VA 23502
9881 Mayland Drive, Richmond, VA 23233
310 1st St SW, Roanoke, VA 24011
1380-1382 Town Square Boulevard NW, Roanoke, VA 24012
2010 Corporate Ridge Road, McLean, VA 22102
14155 Newbrook Drive, Chantilly, VA 20151
600 University St, Seattle, WA 98101
20 F Street, NW, Washington, DC 20001
500 Virginia St East, Charleston, WV 25301

CVS Corporate Office Addresses

444 North 44th Street, Phoenix, AZ, 85008
9501 E Shea Boulevard, Scottsdale, AZ, 85260
555 17th St, Ste 1500, Denver, CO, 80202
1275 Pennsylvania Avenue, NW, Suite 700, Washington, DC, 20004
2211 Sanders Road, Northbrook, IL, 60062
4900 Koger Boulevard #100, Greensboro, NC, 27407
200 Campus Drive, Suite 310, Florham Park, NJ, 07932
29100 Aurora Road, Solon, OH, 44139
100 Scenic View Drive, Cumberland, RI, 02864
200 Highland Corporate Drive, Cumberland, RI, 02864
100 Highland Corporate Drive, Cumberland, RI, 02864
4 Blackstone Valley Place, Lincoln, RI, 02865
11 Blackstone Valley Place, Lincoln, RI, 02865
25 Blackstone Valley Place, Lincoln, RI, 02865
695 George Washington Highway, Lincoln, RI, 02865
935 Douglas Pike, Smithfield, RI, 02917
One CVS Drive, Woonsocket, RI, 02895
1026 Park East Drive, Woonsocket, RI, 02895
475 Park East Drive, Woonsocket, RI, 02895
750 W John Carpenter Freeway, Suite 1200, Irving, TX, 75039
909 E Collins Boulevard, Richardson, TX, 75081

CVS Health Corporation and its subsidiaries (including CVS Pharmacy, Inc.) operate over 10,000 retail pharmacy, LTC pharmacy, mail service pharmacy, specialty pharmacy, PDP, infusion provider and clinical provider locations. Addresses for such additional business locations can be provided upon request.

Section V(c)F

Aetna Inc. responded yes to: *Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory*?

RESPONSE:

On April 21, 2010, the Centers for Medicare & Medicaid Services (CMS) imposed intermediate sanctions on Aetna, which consisted of the suspension of all enrollment and marketing activities with respect to Aetna's Medicare Advantage and Standalone Prescription Drug Plan contracts. The sanctions were a result of Aetna improperly administrating a transition from an open formulary to a closed formulary for its Part D Medicare members. In late May 2011, CMS provided Aetna with a limited waiver to allow existing employer groups to enroll prospective members into an Aetna employer group Medicare Advantage and Standalone Prescription Drug Plan. On June 13, 2011, CMS removed Aetna from Intermediate Sanctions so that Aetna could begin all enrollment and marketing activities; however, CMS excluded Aetna from receiving LIS-auto enrollments. Based on Aetna's progress and performance during the 2012 LIS Readiness Audit, CMS determined that Aetna demonstrated sufficient improvement to merit lifting the LIS auto-enrollment and reassignment exclusion. The exclusion was lifted in September 2012 and Aetna has been eligible for LIS auto-enrollment since that time.

CVS Pharmacy, Inc. responded yes to: *Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?*

RESPONSE:

While there have been no disciplinary actions taken against any healthcare licenses held by CVS Pharmacy Inc. in Louisiana, CVS Pharmacy Inc. holds a number of healthcare licenses and certifications in certain other states. Those licenses and certifications are not currently suspended or terminated by any licensing agency. As with other large pharmacy providers, certain CVS pharmacies and distribution centers operated by CVS Pharmacy, Inc. have citations, correction notices, board orders, or other findings arising from routine inspections, investigations or other examinations by Boards of Pharmacy or other licensing agencies. More detailed information on such findings outside of Louisiana is available upon request.

Aetna Health Holdings, LLC and Aetna Inc., CVS Pharmacy, Inc., CVS Health Corporation responded yes to: *Currently have any open or pending healthcare court cases?*

RESPONSE for Aetna Health Holdings, LLC:

Yes. In the ordinary course of business, Aetna Health Holdings, LLC and its affiliated entities are, or may be, subject to current or pending litigation and other healthcare court cases. Additional reference to material historical legal or administrative actions can be found in Aetna's annual and quarterly reports, available on the company's web site at: www.aetna.com. Ongoing references to Aetna Health Holdings, LLC's legal or administrative actions will be contained in Aetna's annual and quarterly reports or other required filings. More detailed information on such findings is available upon request.

RESPONSE for Aetna Inc.:

Yes. In the ordinary course of business, Aetna Inc. and its affiliated entities are, or may be, subject to current or pending litigation and other healthcare court cases. Additional reference to material historical legal or administrative actions can be found in Aetna Inc.'s annual and quarterly reports, available on the company's web site at: www.aetna.com. Ongoing references to Aetna Inc.'s legal or administrative actions will be contained in

Aetna's annual and quarterly reports or other required filings. More detailed information on such findings is available upon request.

RESPONSE for CVS Pharmacy, Inc.:

Yes. In the ordinary course of business, CVS Health Corporation, CVS Pharmacy, Inc. and their affiliated entities are, or may be, subject to current or pending litigation and other healthcare court cases. Additional reference to material historical legal or administrative actions can be found in CVS Health's annual and quarterly reports, available on the company's web site at: www.cvshealth.com. Ongoing references to CVS Pharmacy's legal or administrative actions will be contained in CVS Health annual and quarterly reports or other required filings. More detailed information on such findings is available upon request.

RESPONSE for CVS Health Corporation:

Yes. In the ordinary course of business, CVS Health Corporation, CVS Pharmacy, Inc. and their affiliated entities are, or may be, subject to current or pending litigation and other healthcare court cases. Additional reference to material historical legal or administrative actions can be found in CVS Health's annual and quarterly reports, available on the company's web site at: www.cvshealth.com. Ongoing references to CVS Health's legal or administrative actions will be contained in CVS Health annual and quarterly reports or other required filings. More detailed information on such findings is available upon request.

SECTION VI(A) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

Name	Agent and/or Managing Employee	Role	Owner?
Randy J. Hyun	Agent, Managing employee	Principal Officer, Director, & President	NO
Tracy L. Smith	Agent	Principal Officer, Vice President, & Treasurer	NO
Robert M. Kessler	Agent	Principal Officer, Vice President, & Secretary	NO
Gregory S. Martino	Agent	Principal Officer & Vice President	NO
David P. Delaney	Agent, Managing employee	Principal Officer, Director, & Chief Financial Officer	NO
Janet R Grant	Agent, Managing employee	Director	NO
Frank F. Chronister	Agent	Principal Officer & Assistant Controller	NO
Kevin J. Casey	Agent	Principal Officer & Senior Investment Officer	NO
Scott Miller	Agent	Principal Officer, Principal Financial Officer, & Controller	NO
Edward C. Lee	Agent	Officer, Vice President, & Assistant Secretary	NO
Melissa B. Pavlovich	Agent	Officer & Vice President	NO
Richard C. Born	Managing employee	Managing Employee – health plan CEO	NO
Mark Grippi	Managing employee	Managing Employee – health plan COO	NO
Madelyn M. Meyn, MD	Managing employee	Managing Employee –	NO

Name	Agent and/or Managing Employee	Role	Owner?
		health plan CMO	
David Nicosia	Managing employee	Managing Employee – health plan CFO	NO

Section VI(b). F. Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded Healthcare program?

Name	Other Entity Name	Position
Randy J. Hyun	Aetna Better Health Inc. (CT)	Director and President
	Aetna Better Health Inc. (GA)	Director and President
	Aetna Better Health Inc. (IL)	Director, Chairman and President
	Aetna Better Health, Inc. (LA)	Director and President
	Aetna Better Health Inc. (NJ)	Director, Chief Executive Officer and President
	Aetna Better Health Inc. (NY)	Director
	Aetna Better Health Inc. (OH)	Director, Chief Executive Officer and President
	Aetna Better Health Inc. (PA)	Director, Chief Executive Officer and President
	Aetna Better Health Inc. (TN)	Director, Chief Executive Officer and President
	Aetna Better Health of California Inc.	Director
	Aetna Better Health of Iowa Inc.	Director, Chief Executive Officer and President
	Aetna Better Health of Kansas Inc.	Director, Chief Executive Officer and President
	Aetna Better Health of Kentucky Insurance Company	Director, Chief Executive Officer and President
	Aetna Better Health of Michigan Inc.	Director, Chief Executive Officer and President
	Aetna Better Health of Missouri LLC	Manager and President
	Aetna Better Health of Nevada Inc.	Director, Chief Executive Officer and President
	Aetna Better Health of North Carolina	Director, Chief Executive Officer and President
	Aetna Better Health of Oklahoma Inc.	Director, Chief Executive Officer and President
	Aetna Better Health of Texas, Inc.	Director, Chief Executive Officer and President
	Aetna Better Health of Washington, Inc.	Director, Chief Executive Officer and President
	Aetna Florida Inc.	Director, Chief Executive Officer and President
	Aetna Health Inc. (PA)	Director
	Aetna Medicaid Administrators LLC	President
	Coventry Health Care of West Virginia, Inc.	Director, President and Chief Executive Officer
	Delaware Physicians Care,	Director, Chairman and President

Name	Other Entity Name	Position
	Incorporated	
	Schaller Anderson Medical Administrators, Incorporated	Director, Chairman and President
Tracy L. Smith	Aetna Better Health Inc. (CT)	Vice President and Treasurer
	Aetna Better Health Inc. (GA)	Vice President and Treasurer
	Aetna Better Health Inc. (IL)	Vice President and Treasurer
	Aetna Better Health, Inc. (LA)	Vice President and Treasurer
	Aetna Better Health Inc. (NJ)	Vice President and Treasurer
	Aetna Better Health Inc. (NY)	Vice President and Treasurer
	Aetna Better Health Inc. (OH)	Vice President and Treasurer
	Aetna Better Health Inc. (PA)	Vice President and Treasurer
	Aetna Better Health Inc. (TN)	Vice President and Treasurer
	Aetna Better Health of California Inc.	Vice President and Treasurer
	Aetna Better Health of Iowa Inc.	Vice President and Treasurer
	Aetna Better Health of Kansas Inc.	Vice President and Treasurer
	Aetna Better Health of Kentucky Insurance Company	Vice President and Treasurer
	Aetna Better Health of Michigan Inc.	Vice President and Treasurer
	Aetna Better Health of Missouri LLC	Vice President and Treasurer
	Aetna Better Health of Nevada Inc.	Vice President and Treasurer
	Aetna Better Health of North Carolina	Vice President and Treasurer
	Aetna Better Health of Oklahoma Inc.	Vice President and Treasurer
	Aetna Better Health of Texas, Inc.	Vice President and Treasurer
	Aetna Better Health of Washington, Inc.	Vice President and Treasurer
	Aetna Florida Inc.	Vice President and Treasurer
	Aetna Health Inc. (PA)	Vice President and Treasurer
	Aetna Health Inc. (TX)	Vice President and Treasurer
	Aetna Health of Iowa Inc.	Vice President and Treasurer
	Aetna Medicaid Administrators LLC	Vice President and Treasurer
	Coventry Health Care of Florida, Inc.	Vice President and Treasurer
	Coventry Health Care of Nebraska, Inc.	Vice President and Treasurer
	Coventry Health Care of Virginia, Inc.	Vice President and Treasurer
	Coventry Health Care of West Virginia, Inc.	Vice President and Treasurer
	Delaware Physicians Care, Incorporated	Vice President and Treasurer
	Schaller Anderson Medical Administrators, Incorporated	Vice President and Treasurer
Robert M. Kessler	Aetna Better Health Inc. (CT)	Secretary
	Aetna Better Health Inc. (GA)	Vice President and Secretary
	Aetna Better Health Inc. (IL)	Secretary
	Aetna Better Health, Inc. (LA)	Vice President and Secretary
	Aetna Better Health Inc. (NJ)	Vice President and Secretary
	Aetna Better Health Inc. (NY)	Vice President and Secretary

Name	Other Entity Name	Position
	Aetna Better Health Inc. (OH)	Vice President and Secretary
	Aetna Better Health Inc. (PA)	Vice President and Secretary
	Aetna Better Health Inc. (TN)	Vice President and Secretary
	Aetna Better Health of California Inc.	Vice President and Secretary
	Aetna Better Health of Iowa Inc.	Vice President and Secretary
	Aetna Better Health of Kansas Inc.	Vice President and Secretary
	Aetna Better Health of Kentucky Insurance Company	Vice President and Secretary
	Aetna Better Health of Michigan Inc.	Vice President and Secretary
	Aetna Better Health of Missouri LLC	Vice President and Secretary
	Aetna Better Health of Nevada Inc.	Vice President and Secretary
	Aetna Better Health of North Carolina	Vice President and Secretary
	Aetna Better Health of Oklahoma Inc.	Vice President and Secretary
	Aetna Better Health of Texas, Inc.	Vice President and Secretary
	Aetna Better Health of Washington, Inc.	Vice President and Secretary
	Aetna Florida Inc.	Vice President and Secretary
	Aetna Medicaid Administrators LLC	Secretary
	Coventry Health Care of West Virginia, Inc.	Vice President and Secretary
	Delaware Physicians Care, Incorporated	Secretary
	Schaller Anderson Medical Administrators, Incorporated	Secretary
Gregory S. Martino	Aetna Better Health Inc. (CT)	Vice President
	Aetna Better Health Inc. (GA)	Vice President
	Aetna Better Health, Inc. (LA)	Vice President
	Aetna Better Health Inc. (NJ)	Vice President
	Aetna Better Health Inc. (PA)	Vice President
	Aetna Better Health of Texas, Inc.	Vice President
	Aetna Health Inc. (PA)	Director and Vice President
	Aetna Health Inc. (TX)	Director and Vice President
David P. Delaney	Aetna Better Health Inc. (CT)	Director and Chief Financial Officer
	Aetna Better Health Inc. (GA)	Director and Chief Financial Officer
	Aetna Better Health Inc. (IL)	Director and Chief Financial Officer
	Aetna Better Health, Inc. (LA)	Director and Chief Financial Officer
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	Aetna Better Health of Iowa Inc.	Director and Chief Financial Officer
	Aetna Better Health of Kansas Inc.	Director and Chief Financial Officer
	Aetna Better Health of Kentucky Insurance Company	Director and Chief Financial Officer
	Aetna Better Health of Michigan Inc.	Director and Chief Financial Officer

Name	Other Entity Name	Position
	Aetna Better Health of Missouri LLC	Manager and Chief Financial Officer
	Aetna Better Health of Nevada Inc.	Director and Chief Financial Officer
	Aetna Better Health of North Carolina	Director and Chief Financial Officer
	Aetna Better Health of Oklahoma Inc.	Director and Chief Financial Officer
	Aetna Better Health of Texas, Inc.	Director and Chief Financial Officer
	Aetna Better Health of Washington, Inc.	Director and Chief Financial Officer
	Aetna Florida Inc.	Director and Chief Financial Officer
	Aetna Medicaid Administrators LLC	Chief Financial Officer
	Coventry Health Care of West Virginia, Inc.	Director and Chief Financial Officer
	Delaware Physicians Care, Incorporated	Director, Treasurer and Chief Financial Officer
	Schaller Anderson Medical Administrators, Incorporated	Director, Treasurer and Chief Financial Officer
Janet R. Grant	Aetna Better Health Inc. (IL)	Director
	Aetna Better Health, Inc. (LA)	Director
	Aetna Better Health Inc. (OH)	Director
	Aetna Better Health Inc. (TN)	Director
	Aetna Better Health of Iowa Inc.	Director
	Aetna Better Health of Kansas Inc.	Director
	Aetna Better Health of Michigan Inc.	Director
	Aetna Better Health of Missouri LLC	Manager
	Aetna Better Health of Oklahoma Inc.	Director
	Aetna Better Health of Texas, Inc.	Director
Frank F. Chronister	Aetna Better Health Inc. (CT)	Assistant Controller
	Aetna Better Health Inc. (GA)	Assistant Controller
	Aetna Better Health Inc. (IL)	Assistant Controller
	Aetna Better Health, Inc. (LA)	Assistant Controller
	Aetna Better Health of Iowa Inc.	Assistant Controller
	Aetna Better Health of Kansas Inc.	Assistant Controller
	Aetna Better Health of Kentucky Insurance Company	Assistant Controller
	Aetna Better Health of Michigan Inc.	Corporate Controller
	Aetna Better Health of Missouri LLC	Corporate Controller
	Aetna Better Health of Nevada Inc.	Assistant Controller
	Aetna Better Health of Oklahoma Inc.	Assistant Controller
	Aetna Better Health of Washington, Inc.	Controller
	Aetna Health of Iowa Inc.	Corporate Controller
	Coventry Health Care of West Virginia, Inc.	Corporate Controller
Kevin J. Casey	Aetna Better Health Inc. (CT)	Senior Investment Officer
	Aetna Better Health Inc. (GA)	Senior Investment Officer
	Aetna Better Health Inc. (IL)	Senior Investment Officer
	Aetna Better Health, Inc. (LA)	Senior Investment Officer

Name	Other Entity Name	Position
	Aetna Better Health Inc. (NJ)	Senior Investment Officer
	Aetna Better Health Inc. (NY)	Senior Investment Officer
	Aetna Better Health Inc. (OH)	Senior Investment Officer
	Aetna Better Health Inc. (PA)	Senior Investment Officer
	Aetna Better Health Inc. (TN)	Senior Investment Officer
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	Aetna Better Health of Kansas Inc.	Senior Investment Officer
	Aetna Better Health of Kentucky Insurance Company	Senior Investment Officer
	Aetna Better Health of Michigan Inc.	Senior Investment Officer
	Aetna Better Health of Missouri LLC	Senior Investment Officer
	Aetna Better Health of Nevada Inc.	Senior Investment Officer
	Aetna Better Health of North Carolina	Senior Investment Officer
	Aetna Better Health of Oklahoma Inc.	Senior Investment Officer
	Aetna Better Health of Texas, Inc.	Senior Investment Officer
	Aetna Better Health of Washington, Inc.	Senior Investment Officer
	Aetna Florida Inc.	Senior Investment Officer
	Aetna Health Inc. (PA)	Senior Investment Officer
	Aetna Health Inc. (TX)	Senior Investment Officer
	Aetna Health of Iowa Inc.	Senior Investment Officer
	Coventry Health Care of Florida, Inc.	Senior Investment Officer
	Coventry Health Care of Nebraska, Inc.	Senior Investment Officer
	Coventry Health Care of Virginia, Inc.	Senior Investment Officer
	Coventry Health Care of West Virginia, Inc.	Senior Investment Officer
	Delaware Physicians Care, Incorporated	Senior Investment Officer
Scott Miller	Aetna Better Health Inc. (IL)	Principal Financial Officer and Controller
	Aetna Better Health, Inc. (LA)	Principal Financial Officer and Controller
	Aetna Better Health of Kentucky Insurance Company	Principal Financial Officer and Controller
	Aetna Better Health of Nevada Inc.	Principal Financial Officer and Controller
	Coventry Health Care of Nebraska, Inc.	Corporate Controller
Edward C. Lee	Aetna Better Health Inc. (CT)	Vice President and Assistant Secretary
	Aetna Better Health Inc. (GA)	Vice President and Assistant Secretary

Name	Other Entity Name	Position
	Aetna Better Health Inc. (IL)	Vice President and Assistant Secretary
	Aetna Better Health, Inc. (LA)	Vice President and Assistant Secretary
	Aetna Better Health Inc. (NJ)	Vice President and Assistant Secretary
	Aetna Better Health Inc. (NY)	Vice President and Assistant Secretary
	Aetna Better Health Inc. (OH)	Vice President and Assistant Secretary
	Aetna Better Health Inc. (PA)	Vice President and Assistant Secretary
	Aetna Better Health Inc. (TN)	Assistant Secretary
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	Aetna Better Health of Kansas Inc.	Vice President and Assistant Secretary
	Aetna Better Health of Kentucky Insurance Company	Vice President and Assistant Secretary
	Aetna Better Health of Michigan Inc.	Vice President and Assistant Secretary
	Aetna Better Health of Missouri LLC	Vice President and Assistant Secretary
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	Aetna Better Health of Texas, Inc.	Vice President and Assistant Secretary
	Aetna Better Health of Washington, Inc.	Vice President and Assistant Secretary
	Aetna Florida Inc.	Vice President and Assistant Secretary
	Aetna Health Inc. (PA)	Vice President and Secretary
	Aetna Health Inc. (TX)	Vice President and Secretary
	Aetna Health of Iowa Inc.	Vice President and Secretary
	Aetna Medicaid Administrators LLC	Vice President and Assistant Secretary
	Coventry Health Care of Florida, Inc.	Vice President and Secretary
	Coventry Health Care of Nebraska, Inc.	Vice President and Secretary
	Coventry Health Care of Virginia, Inc.	Vice President and Secretary
	Coventry Health Care of West Virginia, Inc.	Vice President and Assistant Secretary

Name	Other Entity Name	Position
	Delaware Physicians Care, Incorporated	Vice President and Assistant Secretary
	Schaller Anderson Medical Administrators, Incorporated	Vice President and Assistant Secretary
Melissa B. Pavlovich	Aetna Better Health Inc. (CT)	Vice President
	Aetna Better Health Inc. (GA)	Vice President
	Aetna Better Health Inc. (IL)	Vice President and Assistant Secretary
	Aetna Better Health, Inc. (LA)	Vice President
	Aetna Better Health Inc. (NJ)	Vice President
	Aetna Better Health Inc. (NY)	Vice President
	Aetna Better Health Inc. (OH)	Vice President
	Aetna Better Health Inc. (PA)	Vice President
	Aetna Better Health Inc. (TN)	Vice President
	Aetna Better Health of California Inc.	Vice President
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	Aetna Better Health of Kansas Inc.	Vice President
	Aetna Better Health of Kentucky Insurance Company	Vice President
	Aetna Better Health of Michigan Inc.	Vice President
	Aetna Better Health of Missouri LLC	Vice President
	Aetna Better Health of Nevada Inc.	Vice President
	Aetna Better Health of North Carolina	Vice President
	Aetna Better Health of Oklahoma Inc.	Vice President
	Aetna Better Health of Texas, Inc.	Vice President
	Aetna Better Health of Washington, Inc.	Vice President
	Aetna Florida Inc.	Vice President
	Aetna Health Inc. (PA)	Assistant Secretary
	Aetna Health Inc. (TX)	Vice President
	Aetna Health of Iowa Inc.	Vice President
	Aetna Medicaid Administrators LLC	Vice President and Assistant Secretary
	Coventry Health Care of Florida, Inc.	Vice President
	Coventry Health Care of Nebraska, Inc.	Vice President
	Coventry Health Care of Virginia, Inc.	Vice President
	Coventry Health Care of West Virginia, Inc.	Vice President and Assistant Secretary
	Delaware Physicians Care, Incorporated	Vice President and Assistant Secretary
	Schaller Anderson Medical Administrators, Incorporated	Vice President and Assistant Secretary
Richard C. Born	Aetna Better Health, Inc. (LA)	Chief Executive Officer – Managing Employee
Mark Grippi	Aetna Better Health, Inc. (LA)	Chief Operating Officer – Managing

Name	Other Entity Name	Position
		Employee
Madelyn M. Meyn, MD	Aetna Better Health, Inc. (LA)	Chief Medical Officer – Managing Employee
David Nicosia	Aetna Better Health, Inc. (LA)	Chief Financial Officer – Managing Employee

SECTION VII –REPRESENTATIVES AUTHORIZED TO SIGN ON BEHALF OF AETNA BETTER HEALTH OF LOUISIANA

List each person authorized to sign and identify their position in your practice		
1	Randy J. Hyun	Principal Officer, Director, & President
2	Tracy L. Smith	Principal Officer, Vice President & Treasurer
3	Robert M. Kessler	Principal Officer, Vice President & Secretary
4	Gregory S. Martino	Principal Officer, Vice President
5	David P. Delaney	Principal Officer, Director & Chief Financial Officer
6	Janet R Grant	Director
7	Frank F. Chronister	Principal Officer, Assistant Controller
8	Kevin J. Casey	Principal Officer, Senior Investment Officer
9	Scott Miller	Principal Officer, Principal Financial Officer & Controller
10	Edward C. Lee	Officer, Vice President & Assistant Secretary
11	Melissa B. Pavolvich	Officer, Vice President
12	Marc A. Parr	Officer, Assistant Treasurer
13	Michael M. Sinisgalli	Officer, Assistant Treasurer
14	Diane E. Steponaitis	Officer, Assistant Treasurer
15	Michelle Carter-Gouge	Officer, Assistant Secretary
16	WendyAnn M. Cianci	Officer, Assistant Secretary
17	Sandra M. Coombes	Officer, Assistant Secretary
18	Sherelle R. Hill	Officer, Assistant Secretary
19	Theresa M. Hurd	Officer, Assistant Secretary
20	Cynthia A. Montano	Officer, Assistant Secretary
21	David P. Poetto	Officer, Assistant Secretary
22	Timothy J. Roach	Officer, Assistant Secretary
23	Melissa K. Ronski	Officer, Assistant Secretary
24	James P. Wolf	Officer, Assistant Secretary

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Exhibit 2
Aetna Better Health of Louisiana*
Calendar Year 2018
Subcontracts paid greater than $25,000

Subcontractor	Address	City	State	Zip	Phone #	2018 Spend
Aetna Medicaid Administrators	4500 E. Cotton Center Blvd	Phoenix	AZ	85040	1-866-800-6398	[redacted]
Logisticare	1275 Peachtree Street NE, 6th Floor	Atlanta	GA	30309	800-486-7647	[redacted]
Block/Superior Vision	939 Elkridge Landing Road, Suite 200	Linthicum	MD	21090	443-451-1056	[redacted]
Dentaquest	465 Medford Street	Boston	MA	21229	1-800-417-7140	[redacted]
CVS Caremark	PO Box 848001	Dallas	TX	75284	972-612-8163	[redacted]
Evicore/Medsolutions	730 Cool Springs Blvd., Ste 800	Franklin	TN	37067	615-468-4396	[redacted]
Navarro/OTC	One CVS Drive (Mail code 2280)	Woonsocket	RI	02895	401-770-8261	[redacted]
Change Healthcare	12016 Collections Center Dr.	Chicago	IL	60693	1-800-804-7430	[redacted]

**Direction provided by LDH is to provide Aetna Better Health of Louisiana's subcontractors rather than those of any its owners.*

2.10 Technical Proposal Requirements

Louisiana's breast cancer mortality rate is statistically significantly higher than the rest of the country. Aetna has promised to bring solutions to our communities and members by providing resources including access to screenings and treatment, meeting our members where they live, work, and worship. Through grant funding, the Louisiana Breast & Cervical Health Program will extend its mobile screenings units to underinsured, lower-income women in Louisiana.

2.10.1 Executive Summary

Pancreatic cancer was the 10th-most commonly diagnosed cancer in Louisiana. Aetna's support of the Purple Stride Louisiana Walk in 2018 was an opportunity to show our commitment to helping with the fight of chronic illness and disease in our communities.

2.10.1 Executive Summary

A Greater Shared Vision and System of Support

In late 2018, Aetna Inc. was acquired by CVS Health Corporation (CVS Health), the nation's premier health innovations company. CVS Health's goal is helping people on their path to better health and well-being, and it mirrors our own goals. For example, CVS Health's pioneering approach to total health is illustrated by its bold move to no longer sell tobacco products in its retail stores, and through such commitments, the strengths of our individual organizations are surpassed only by the strength we have as a unified company. Therefore, moving forward, Aetna Inc. will be able to advance and achieve better health and better care at a lower cost, take advantage of more real-time data and proactive population health care strategies, and tap into broad national networks and unique provider relationships. It also means a potential innovative expansion of our CVS MinuteClinic access in certain regions in Louisiana.

> *"There is absolutely no partnership between most of the MCOs and the providers, and it is tearing apart practices in rural communities. Aetna Better Health has been an exception to this by using a systematic approach to provider relations."*
>
> **—Alec Jeansonne, CEO**
> **Collective Healthcare Solutions**

As part of this CVS Health family, Aetna Better Health of Louisiana (Aetna) will bring these strengths to all our Medicaid enrollees, the Louisiana Department of Health (LDH), our providers, and our stakeholders and community-based agencies. Currently serving more than 120,000 enrollees, we are well prepared to ramp up services and benefits to include the total 375,000-plus anticipated enrollees through this new contract. We are committed to being transparent with our operations and programs while growing and improving our Medicaid managed care delivery system. Grounded in the Triple Aim, we strive to improve the health of populations (better health), enhance the experience of care of enrollees (better care), and effectively manage Louisiana's Medicaid per capita care costs (lower costs). CVS Health and Aetna are community-based and locally focused on enabling a more effective holistic treatment approach for every enrollee and better use of Louisiana's finite Medicaid dollars. **Together, we will continue to listen, to learn, and to take action to improve the lives of those we serve.**

Effective Solutions to LDH's Goals and Objectives

As an organization and as Louisianans serving Louisianans, **we remain passionate and inspired as we pledge to maintain our organizational mission to work with LDH while supporting its contract goals** and offering effective solutions to the following:

- Advancing evidence-based practices, high-value care, and service excellence
- Supporting innovation and continuous quality improvement
- Ensuring enrollees have ready access to care
- Improving enrollee health and decreasing fragmentation
- Increasing integration across providers and care settings
- Utilizing a population health approach that maximizes enrollee health and well-being
- Reducing complexity and administrative burden
- Aligning financial incentives
- Improving care quality through data and collaboration
- Minimizing wasteful spending, abuse, and fraud

> *"Aetna is a leader in closing the access gap and helping Louisiana reduce barriers to mental and substance use treatment."*
>
> **—Charles Edwards, CEO**
> **One TeleMed**

Our Overarching Differentiators Offer Something Extra

Louisiana exudes a ***lagniappe* culture.** It is part of us, our traditions, and the places in which we live. Aetna strives to reciprocate that something extra through what we believe are differentiators that only we can offer. Our differentiators include the following programs and successes.

Broad Collaboration on Value-based Payments

Eighty-five percent of our contracted PCPs serve seventy-six percent of the enrollees contracted under a value-based payment arrangement.

We have an extensive value-based payment arrangements program in support of the Triple Aim. The "2017 Healthy Louisiana Value-based Report" showed our value-based payment (VBP) spend at 34 percent of provider payments compared to the statewide Medicaid health plan weighted average of just 16 percent. Not resting on past accomplishments, **in 2018 Aetna further increased the percent of provider payments tied to VBP to 51 percent**. Currently, 76 percent of Aetna enrollees in Louisiana are served by a value-based primary care provider (PCP) and 85 percent of Aetna PCPs are participating in a VBP program. In addition, our value-based providers have lowered the total cost of care for their population. In 2017, our Louisiana shared-savings VBP arrangements provider partners, representing 15 percent of the total plan's enrollment, experienced an overall 33 percent lower per member per month (PMPM) cost of care than the overall health plan's enrollment. These same provider partners' high-risk enrollees, representing 22 percent of the total plan's high-risk enrollees, experienced a 12 percent lower PMPM cost of care than the overall health plan's high-risk enrollees.

Quality—Better Care, Better Health, Lower Cost

Our substantial improvement trajectory surpassed all other plans within Louisiana on the Healthcare Effectiveness Data and Information Set (HEDIS), State performance, Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Child with Chronic Condition (CCC) CAHPS survey measures, including meeting the 75th percentile for the following:

- Antidepressant medication management acute phase
- Antidepressant medication management continuation phase
- Chlamydia screening in women aged 16 to 24 years
- Adult CAHPS Survey: how well doctors communicate
- CCC CAHPS Survey: how well doctors communicate and rating of personal doctor

We were the number one-ranked health plan in Louisiana for 2018 HEDIS measures for the following:

- Well-child visits in the first 15 months of life
- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with upper respiratory infection
- Diabetes screening for people with schizophrenia or bipolar disorder

Provider Network

Aetna far exceeds the State's provider network access standards for adult PCPs in rural and urban parishes. The current standard is 90 percent, and to date we have 98 percent coverage across Louisiana. Additionally, 90 percent of our PCP network has open and accessible panels for new enrollees. **Our 2019 year-to-date provider post-call survey satisfaction rate is 94.7 percent. Additionally, 9 out of 10 provider calls are resolved at first contact.** In addition, Aetna has contracts with over 23,000 providers, which includes over 5,000 primary care providers, 18,000 specialty physicians, 4,900 behavioral health specialists, and 251 behavioral health and physical health hospitals across the state. Our network for the Medicaid program also includes 100% of the federally qualified health centers and rural health clinics across Louisiana.

Population Health Programs Maximize Enrollee Health

Our new breast cancer community health worker program is a population health intervention that addresses the identified disparity for African-American women. Our community health workers (CHWs) collaborate with the Louisiana Breast and Cervical Health Program to provide breast screening education and linkages to resources for screenings. They work closely with community- and faith-based organizations, such as Louisiana Baptists and Congregational Health Services, to bring prevention, education, and linkages to screenings for enrollees and the population at-large in the communities where they reside. Our CHWs serve as an integral member of the enrollee's multi-disciplinary care team (MDCT) and work to address enrollees' individual needs, such as access to transportation and access to preventive and early intervention activities. We also are developing the capability to measure other outcomes, including self-management and lifestyle changes.

Addressing High Emergency Department Utilization through Diversion Coordinators

We employ emergency department (ED) coordinators who work under the umbrella of our Care Management team. These coordinators establish relationships with hospital staff throughout the state, engage enrollees with high ED utilization, and provide outreach to at-risk enrollees. They also attend collaborative provider meetings, discuss the needs of the enrollees that need extra support during Aetna integrated rounds, and engage enrollees through face-to-face and telephonic outreach.

Aetna successfully controls appropriate ED and inpatient utilization year-over-year. We have achieved the following in 2018 vs. 2017:

- 4.98% decrease in ED visits/1000
- 4.3% decrease in PMPM for inpatient admissions
- 7.1% decrease in physical health admissions/1000
- 11.1% decrease in behavioral health admissions/1000
- 10.5% decrease in physical health readmissions/100
- 36.2% decrease in behavioral health readmissions/1000

Integrative Care Coordinates Behavioral Health and Physical Health Needs

Individualized care planning focuses on coordination and integration between physical and behavioral health services provided in the enrollee's community. When an enrollee receives services requiring a plan of care from LDH, such as home- and community-based services or services through the Office of Public Health, case managers collaborate and coordinate among the agencies. Enrollees with behavioral health needs may also receive referral to telepsychiatry as needed; coordination with an Assertive Community Treatment (ACT) team prior to discharge from an inpatient facility, if eligible for ACT services; and biweekly rounds that address enrollees with high utilization rates. We also ensure connection to specialized substance use disorder treatment. Since its launch in 2017, Aetna's Enterprise Wide Opioid Taskforce has supported the advancement of Aetna's clinical strategy to combat the opioid overdose crisis. Fueled by cross-functional collaborations and insights, Aetna's opioid initiatives have yielded meaningful results. In the first year since announcing our five-year enterprise goals, **we have seen a nearly 30 percent increase in the rate of medication-assisted treatment or other evidence-based treatments used by enrollees with opioid use disorder, among other significant improvements**.

Adoption of Elli to Meet New Enrollees' Needs

As one of the first adopters of Elli in Louisiana, we recognize the value it will bring to our plan and to LDH. We will gain access to four years of claims data collected from fee-for-service Medicaid and Medicaid managed care organizations across the state. The data will be available to us on day one of an individual's enrollment. The data provides additional risk stratification that we will consider in concert with our predictive modeling risk stratification results. We will leverage Elli, in particular, when we enroll an individual with previous Medicaid history, enabling us to immediately engage the enrollee in appropriate tier of care management and streamline the Health Needs Assessment process.

Fraud, Waste, and Abuse Savings, Recoveries, and Tools

To maintain strict oversight on fraud, waste, and abuse (FWA) to protect the State's Medicaid dollars and to aid in FWA savings and recoveries, we use verified, time-tested policies and procedures to outline all the steps we take from fraud, waste, and abuse identification to pre- and post-recovery efforts. This safeguards us, our providers, and our subcontractors, and it helps us proactively manage and analyze prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud to the State. **Total FWA/program integrity savings for 2018 were $26,237,246.** Also, **Healthcare Fraud Shield** is our new lead-generation tool for 2019—**a platform that comes equipped with approximately 600 business rules and algorithms based on the latest fraud schemes** maintained and updated quarterly to identify FWA. Healthcare Fraud Shield assigns a risk score for each provider or enrollee and uses application screens to show all leads/billing activity for follow-up. Healthcare Fraud Shield contains provider, enrollee, and alert dashboards that show the top potential FWA providers/enrollees, top scoring specialties, score analysis, and top changes in provider risk scores.

Proactively Addressing High Utilization

We proactively address challenges associated with high utilization and increasing medical trends. For example, our focus on high-risk pregnancy and babies admitted to a neonatal intensive care unit (NICU) is essential as prevention and early intervention can dramatically reduce the number of children exposed to trauma. In alignment with LDH, we coordinate a systematic approach to decreasing health risks and costs associated with babies admitted to the NICU. Our approach, which includes intensive care management, discharge navigation, collaboration with system partners, and a targeted enrollee education campaign, has resulted in increased health outcomes and cost savings—**we saved $3,386,923 in 2017, a 19 percent increase from 2016**. In addition, we reduced the average length of stay in the NICU from 18.4 days in 2017 to 13.2 days in 2018, and bed days/1000 from 78.1 in 2017 to 67.7 in 2018.

Engaging Enrollees in Managed Care

We value and support an enrollee's choice in how they engage with us and have specifically designed our care management model—an enhanced, regionally based multi-disciplinary care team model—to better engage enrollees and families in care management services and improve health outcomes. We organize Care Management teams that are local to the enrollees they support, promoting improved specialty knowledge of services and providers in the area. We cross-train our behavioral health and physical health case managers to act as a single point of contact for the enrollee, and to work with other enrollees of the MDCT.

Successful Engagement Efforts

In 2018, we achieved the following:

- A 94% success rate with enrollee engagement in care management services for Quarter 4
- Increased field visits by 35%
- Increased volume of outreach by 65.5% from 2016 to 2018

Access to Crucial Residential Treatment

To increase access to crucial services, we do not require prior authorization for the lower intensity level of residential substance use treatment or Multisystemic Therapy, though we track and trend for potential over-utilization. We authorize services that are not part of the Medicaid benefit structure to ensure continuity of care, treatment at the appropriate level, and better health outcomes for our enrollees. In particular, the low intensity level of care is crucial to supporting an enrollee's recovery in the community and their ability to be self-sufficient; it provides a bridge between higher-cost, more intensive care, and community living. Enrollees also receive support with employment and housing at this level of care, which are significant social determinants of health in a person's recovery from substance abuse.

Enrollee Phone App to Aid in Claims Notification

We are in the process of creating our claims notification phone app. We will be providing claim notifications and other pop-up information in our enrollee mobile application to catch inappropriate claim

billing after payment. This will allow the enrollee to either confirm or deny that the claim was theirs. We will provide easy-to-follow instructions when a member believes the claim was fraudulently submitted.

MinuteClinic Access

We are prepared, upon award and in collaboration with the State, to expand MinuteClinic access in at least one existing CVS store and as many as three existing CVS stores. We will assess the regions of the state where there are a high number of potentially preventable emergency room visits, feasibility of Clinic placement and overall timing, and staging for the new clinic(s).

Highly Experienced Key Personnel and Local Leadership

We are a highly experienced, dedicated, and successful team with extensive local, program-specific knowledge. Our chief executive officer, Rick Born, has 30 years of health care experience (with the last three years spent leading Aetna Better Health of Louisiana). He has full profit and loss accountability with direct leadership of operations, medical management, behavioral health, quality, compliance, program integrity, and community development. **Mr. Born has created cost-effective, efficient operations and strong external relationships, and has managed membership growth of over 25 percent.** Other key staff highlights include the following:

- Our chief operating officer oversees all operational health plan functions, including enrollee services, information technology, provider contracting, provider servicing, and grievances and appeals
- Our chief financial officer successfully manages our financial operations and LDH reporting
- Our chief medical officer (having most recently served as our medical director) has **implemented Aetna NICU/obstetrics/gynecology best practices and fully integrated daily rounds with behavioral health and physical health**
- Our behavioral health medical director is certified in both psychiatry and addiction medicine and oversees the integration of our behavioral health and physical health programs

Conclusion

Aetna Better Health of Louisiana understands LDH's vision for the contract and is committed to achieving the vision through improving the health of populations (better health), enhancing the experience of care of enrollees (better care), and effectively managing Medicaid care costs (lower costs). Enrollees and their families are at the center of everything we do and are an extension of who we are as a health plan. We are well positioned for continued success through our relationship with LDH and look forward to an uninterrupted partnership serving our neighbors and friends—together we will continue to listen, to learn, and to take action. **We work for the community and will be from the community.**

2.10.2 Organizational Experience

Aetna believes in building communities where all children are healthy and ready to learn. Our support of Kingsley House allows the organization to provide more early childhood education, preparing youth to succeed at all levels of school.

2.10.2.1 Proposer Experience

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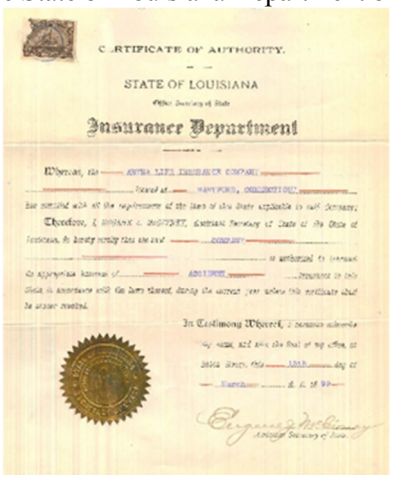
2.10.2.1 Proposer Experience

Aetna Better Health of Louisiana has been **a true partner to the State since 2015**. We are committed to being transparent in our operations and programs while expanding our Medicaid managed care delivery system to improve the health of populations (better health), enhance the experience of care of enrollees (better care), and effectively manage Medicaid per capita care costs (lower costs). We focus on administrative simplification for our providers while improving access for enrollees. For example, we engage with providers to create additional reimbursement through value-based payment (VBP) arrangements, as evidenced by having 51 percent of our provider payments and 76 percent of our enrollment tied to one. In addition, continuing our tradition of continual growth, innovation, and increasing access to care, we are prepared, upon award and in collaboration with the State, to **expand MinuteClinic access in at least one existing CVS store and as many as three existing CVS stores**. We will assess the regions of the state where there are a high number of potentially preventable emergency room visits, feasibility of Clinic placement and overall timing, and staging for the new clinic(s).

Organizational History and Experience (2.10.2.1.1): For over 160 years, Aetna has been a mainstay in the lives of Americans, serving a comprehensive array of insurance needs. Aetna is proud of its deep roots and longstanding history of service in Louisiana dating to 1899—two years before the birth of Louis Armstrong—when affiliate Aetna Life Insurance Company was granted a license from the State of Louisiana Department of Insurance, as depicted in **Figure 2.10.2.1-1.** Being one of the first insurance companies in the nation to offer health insurance gives Aetna unparalleled experience and the time-tested ability to adapt to complex changes. A recent example of this is our merger with CVS Health Corporation (CVS Health). This strategic partnership exponentially expands our ability to effect positive change in local communities and across the health care system. Like CVS Health, Aetna is community-based and locally focused, engaging enrollees with the care they need when and where they need it. By bringing together the experience and expertise of Aetna and CVS Health, we are building a uniquely powerful platform that will open a new front door to health care, reshape the enrollee experience, and lead to healthier communities.


CERTIFICATE OF AUTHORITY.

STATE OF LOUISIANA

Insurance Department

Figure 2.10.2.1-1: 1899 COA
Aetna Life Insurance Company began serving Louisianans over 120 years ago.

The Aetna Medicaid organization currently serves nearly 2 million Medicaid enrollees through our administration of Medicaid managed care plans in 16 states, 11 of which with overall enrollment in the past 12 months roughly equal to or greater than that [1] of Louisiana (1.4M): Arizona (1.7M)[2], California (11.8M), Florida (4.2M), Illinois (2.8M), Kansas, Kentucky, Maryland, Michigan (2.3M), New Jersey (1.7M), New York (6.5M), Ohio (2.6M), Pennsylvania (2.9M), Texas (4.3M), Virginia, and West Virginia. The Aetna organization has over 30 years of experience delivering innovative, quality, and efficient services to complex Medicaid populations, far exceeding the preferred qualification of 7 years of experience (RFP **Section 2.10.2.1.2.1** and **Section 2.10.2.1.2.2**). In addition, our Florida, Virginia, and Kansas plans were recently awarded new contracts that expand our Medicaid footprint. **Table 2.10.2.1-1** depicts the volume of Medicaid managed care enrollment in Louisiana compared to other Aetna footprint states.

[1] December 2018 Medicaid & CHIP Enrollment Data Highlights: accessed March 25, 2019; https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.
[2] Aetna's contract engagement in Arizona is through an administrative services contract (ASC) to provide administrative services to an unaffiliated health plan that holds risk-bearing contracts with applicable agencies. Our Texas experience includes both an ASC and risk-bearing contracts that an affiliated health plan holds directly with the State agency.

The Aetna organization is honored and privileged to currently provide Louisianans integrated, managed care for over 250,000 Louisiana Medicaid, Medicare, Medicare Part D, and commercial enrollees. Through the years, we have been proud to provide a variety of insurance products for Louisianans as part of our commitment to quality, ready access, and innovation to maximize enrollee health, reduce health disparities to advance health equity for all enrollees, and address social determinants of health within a flexible, value-based approach. Our VBP arrangements with many of the largest systems in Louisiana, such as Willis-Knighton Health System and Baton Rouge General, supports innovation and reduces costs while improving enrollees' access to quality care. **We work for the community and will be from the community.** Our key personnel are all based in Louisiana and currently serve approximately 120,000 Medicaid enrollees. Our staff is 100 percent dedicated to the local plan and to the people of the State of Louisiana, a commitment that will continue into the new contract.

Aetna's mission is to build a healthier world by assisting enrollees on their path to better health, better care, and lower costs, and Medicaid managed care is an integral part of that mission. We demonstrate this through collaboration with key stakeholders as we work to achieve the following organizational goals:

- **Be local:** We engage our enrollees with the care they need where they need it. Our locally based care managers have achieved a 51 percent increase in enrollees engaged in care management.
- **Make it simple:** We collaborate with key stakeholders to offer administrative simplification solutions, one example being bringing the managed care organizations together to simplify the treatment record review process.
- **Improve health:** We help people achieve better health at a lower cost by aligning financial incentives and building shared capacity to improve quality through data and collaboration.
- **Lead the change:** We challenge the status quo with new technologies, value-based payment models, and collaborations.
- **Attract and inspire:** We unlock the power of our people to transform health care. Our staff has the freedom to develop initiatives and innovations to achieve LDH's goals.
- **Optimize performance and service:** We ensure our people, processes, and technology enables our strategy. Using verified, time-tested methods, we achieved over $26 million in total Louisiana program integrity savings in 2018.

Table 2.10.2.1-1: Volume of Medicaid Managed Care Enrollment

State	# of Years	Aggregate Enrollment[3]
Arizona	17	416,337[4]
Texas	>13	275,774[5]
Kentucky	8	224,908
Pennsylvania	26	218,670
Louisiana	**4**	**119,494**
West Virginia	23	119,125
Kansas	<1	107,621
Florida	26	102,046
Virginia	23	93,408
New Jersey	4	51,438
Michigan	15	45,032
Ohio	5	25,015
Maryland	16	15,384
California	1	11,061
Illinois	8	7,247
New York	7	6,948

Aetna is and has been part of the fabric of the Healthy Louisiana program for the past four years, daily demonstrating our commitment to enrollees, providers, and LDH. We are deeply invested in Louisiana's local communities and will continue working to improve the lives and health of Louisianans upon award.

[3] Membership is as of December 31, 2018, for all states except Kansas, which began operations in January 2019.
[4] In Arizona, an Aetna-affiliated entity performs administrative functions for an unaffiliated health plan, Mercy Care, and is not the risk-bearing entity holding the contracts between the State agency and Mercy Care.
[5] The Texas membership number includes membership for our affiliate, Aetna Better Health of Texas (88,109), and for Parkland Community Health Plan (187,665), an unaffiliated health plan for which an Aetna-affiliated entity performs administrative functions but is not the risk-bearing entity holding the contract with the State agency.

2.10.2.2 Staff Experience and Organizational Structure

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2.10.2.2 Staff Experience and Organizational Structure

Aetna understands, acknowledges, and will comply with all of the requirements of the **RFP** and the **Model Contract**.

Aetna Better Health of Louisiana's Key Personnel and Required Staff (2.10.2.2)

Our experienced personnel support LDH's goal of achieving the Triple Aim—better health, better care, and lower costs—by providing support services for the traditional benefits and services in addition to social determinants of health. We have a clearly defined staffing model designed to fulfill all of LDH's requirements and to adjust to LDH's changing needs. Our staffing plan is a continuous, integrated, and scalable model. It is built on the principle of Louisianans serving Louisianans, managed by local health plan leaders to ensure quality staffing for a growing enrollment or any new contract requirements.

Aetna Better Health of Louisiana's minimum wage is $16 an hour.

The cornerstone of our staffing plan is highly experienced leadership with extensive local, program-specific knowledge. With 30 years of health care experience, the last three of which leading Aetna Better Health of Louisiana, Chief Executive Officer Rick Born plays a key role in identifying and hiring key personnel. He is supported by Aetna's highly experienced, qualified, talented leadership team and our Implementation Talent Acquisition team. To support the growth envisioned in this contract, we are committed to attracting additional professional staff with significant managed care experience with Medicaid populations. Mr. Born and his leadership team will seek local candidates who are experienced and familiar with the local Medicaid health care delivery system and culture in Louisiana and have all the Louisiana licensures and certifications required by law and the Model Contract.

Our key personnel are all based in Louisiana and they currently serve approximately 120,000 enrollees. Our staff is 100 percent dedicated to the local plan and to the State of Louisiana, a commitment that will continue into the new contract. Initially, our staffing plan assumes a total enrollment of approximately 375,000 enrollees. Under this scenario, by the contract start date, we expect to have 421 **staff members** to support that enrollment. Based on the national Aetna Medicaid organization's experience managing programs of similar scope and scale across 16 states, it is our practice to hire and train additional staff, refine processes, provide backup resources, and institute other changes to meet States' requirements should there be an unexpected increase or decrease in volume.

Aetna Better Health of Louisiana anticipates hiring approximately 250 additional local staff.

Process for Identifying Key Personnel

To identify key personnel, Aetna uses proven methodologies. We recruit local Louisiana health care experts who know Louisiana Medicaid whenever possible and hire experienced professionals who meet our qualifications and requirements. We use hiring tools and techniques that define the position by the knowledge, education, skills, and competencies candidates should possess. Our hiring process includes the following steps:

1. Capitalizing on our extensive relationships throughout Louisiana
2. Using local and national talent acquisition staff
3. Using detailed job descriptions to define and communicate our job expectations, required knowledge, skills, and competencies and to assist us further in the targeted selection of qualified candidates
4. Posting of position availability on both internal and external job sites
5. Reviewing candidate applications by our hiring team
6. Conducting interviews of candidates by our Human Resources team and plan leadership
7. Seeking approval from LDH for key position hires

Once hired, new employees participate in a structured orientation both to Aetna and to the Heathy Louisiana program.

Diversity

We are keenly aware of the value that geographic, racial, and cultural diversity brings to our business. Our reputation as an employer of choice enables us to attract the best-qualified candidates and it has earned us recognition from a variety of organizations including the United States Business Leadership Network and the American Association of People with Disabilities. We were included for the 11th time since 2001 on DiversityInc's annual list of the Top 50 Companies for Diversity.

Aetna is a Recognized Employer of Choice

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

Individuals Appointed to Key Personnel/Leadership Roles (2.10.2.2.1/ 2.10.2.2.2.1)

Aetna's key personnel steer our health plan and actively engage and collaborate with enrollees, program stakeholders, subcontractors, LDH, legislators, and providers across the state. We have built a team that seamlessly supports administrative simplification. The following positions are identified as key personnel by LDH, are located within Louisiana, and are dedicated 100 percent to our local plan and its enrollees. For each of the key personnel listed in **Table 2.10.2.2-1,** we have included their name, role, and a brief description of their responsibilities within our governance and operating structure. Their resumes are located at the end of this section.

Functional Operations/Material Subcontractors Organizational Chart (2.10.2.2.2.2)

Figure 2.10.2.2-1 illustrates our functional operating structure; our key teams that oversee the long-term goals and objectives and day-to-day activities under our current contract. Our material subcontractors listed include CaremarkPCS Health, L.L.C., DentaQuest USA Insurance Company, Inc.; LogistiCare Solutions, LLC; and Superior Vision Benefit Management, Inc. All of these subcontractors will report into our operations function except for CaremarkPCS Health, L.L.C., which will report into our pharmacy function.

Key Team Roles, Full-time Equivalents (2.10.2.2.2.3 and 2.10.2.2.2.4)

Table 2.10.2.2-2 illustrates our key teams, their roles, activities, communication with leadership, major qualifications, competencies, and lead highlights, in addition to briefly describing the team's role, operating activities for which it is accountable, and how it reports to and informs decisions by leadership. All committees listed report into our **Quality Management Oversight Committee/Quality Assessment Performance Improvement Committee (QAPI),** which is chaired by our chief medical officer with cross-functional organizational representation and involvement from providers and LDH. The committee provides executive oversight of the QAPI program and makes recommendations to the board of directors about QM and performance improvement activities.

Table 2.10.2.2-1: Aetna Key Personnel that Support the Health Plan

Key Personnel	Role	Brief Description : Governance Function and Operating Structure
Rick Born, MBA, CMCE	Chief Executive Officer (CEO)	• Leads and manages the entire plan with full profit and loss accountability; has direct leadership of the chief operating, financial, and medical officers; medical management, quality, contract compliance, program integrity, business continuity planning and emergency coordinator, and community development; responsibilities include managing and developing these nine direct reports; serves as the primary contact for LDH regarding all issues; and coordinates with other additional staff required on a daily basis to fulfill the requirements of the contract • This position reports directly to the board of directors.
Mark Grippi	Chief Operating Officer (COO)	• Oversees all health plan operations and is accountable for functions and results as well as day-to-day operations of multiple levels of staff and multiple functions within the health plan; maintains direct leadership of enrollee services, provider physical and behavioral services, provider claims education, information technology, grievance system, and reporting and oversight of shared services of claims and encounters, and enrollment; is the primary point of contact if the CEO is unavailable to meet with LDH or other stakeholders; additionally, offers extensive experience in LTSS and value-based payments • This position reports to the CEO.
Madelyn Meyn, MD (interim)	Chief Medical Officer (CMO)	• Develops, implements, and oversees clinical policies and procedures, including, but not limited to, service authorization, grievance and appeal review, discharge planning, and utilization management; coordinates with the behavioral health (BH) medical director to integrate the administration and management of behavioral and physical health services; leads the QAPI Committee, including QM/UM Committee • This position reports to the CEO.
[redacted]	[redacted]	• Shares the management of BH services with the behavioral health coordinator; leads all major clinical and quality management components of the BH services for Aetna Better Health of Louisiana; coordinates with the medical director to integrate the administration and management of BH and physical health services • This position reports to the CMO, who reports to the CEO.
David Nicosia, MBA	Chief Financial Officer (CFO)	• Manages the day-to-day financial staff to meet the performance requirements of our current contract; responsible for financial results and reporting and serves as the primary point of contact for all health plan financial issues • This position reports to the CEO.
[redacted]	[redacted]	• Works with health plan leadership and multidisciplinary clinical and operational teams to develop strategies for innovative and quality-focused pharmacy (medical) services; collaborates with medical management teams on plan performance measures; leads pharmacy quality and performance improvement programs in accordance with State Medicaid contract, federal requirements, and plan accreditation standards; assists with policy reviews; acts as a liaison to the State of Louisiana Department of Health Pharmacy team to ensure Aetna meets contractual requirements; and guides the implementation of laws and amendments pertaining to pharmacy • This position reports to the CMO, which reports to the CEO.
[redacted]	[redacted]	• Maintains a highly effective plan compliance program including all policy tracking processes while chairing both the Plan Compliance Committee and the Policy and Procedure Committee; facilitates the External Quality Reviews and serves as a critical resource to all operational areas • This position reports to the CEO.

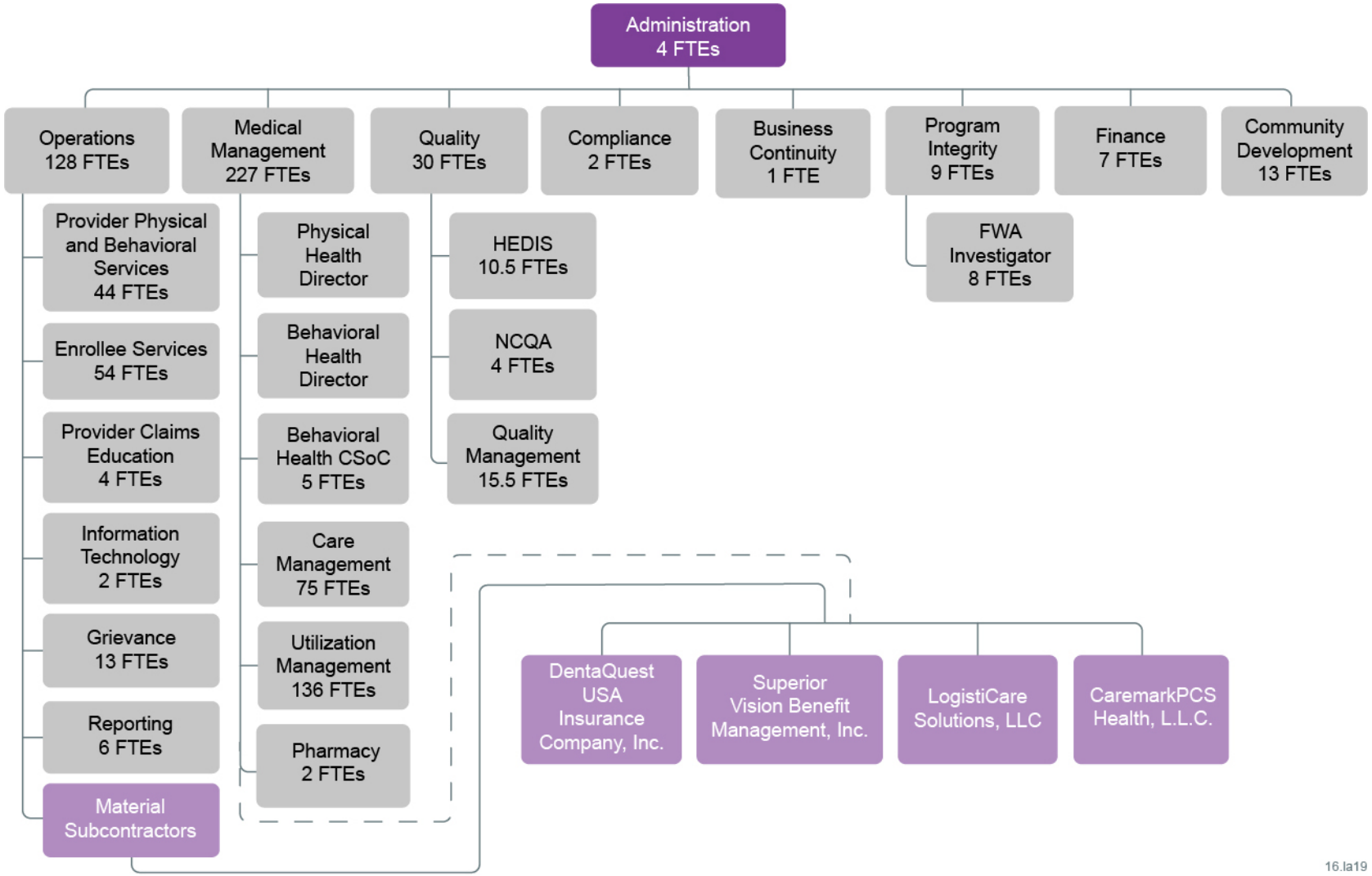

Figure 2.10.2.2-1: Aetna Key Teams Organizational Chart

This chart highlights each functional team and material subcontractors and their reporting flow into administration.

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Table 2.10.2.2-2: Key Teams Roles, Activities, Reporting Structure, FTEs, and Communication Flow

Key Team/FTEs	Role and Qualifications	Operating Activities, Reporting Structure, Communication, Team Lead Description
Administration **FTEs: 4**	• **Role**: serves as the main contact for LDH, State agencies, other stakeholders, community partners, enrollees and their families, providers, and the community; is responsible for building and sustaining the long-term relationships with our stakeholders that help us understand and meet the needs and expectations of our customers. • **Major qualifications:** extensive leadership experience, profit and loss accountability, and mastery in finance, compliance, and creating/executing strategy	• **Operating activities**: oversees the leadership team, LDH contract management, cross-functional teams; develops/maintains a strong business strategy to provide revenue growth and increased profitability through strategic plans, financial analysis, contract negotiation, and process improvement with full profit and loss accountability • **Reporting structure**: administration reports to Aetna Medicaid • **Communication with leadership**: includes updating the board of directors through meetings and written communications on plan issues, growth, financial status, and all functional areas concerning key teams and State and stakeholder relationships • **Team lead description:** extensive experience in profit and loss accountability, leading operational teams, achieving growth goals, contract negations
Operations **FTEs: 128**	• **Role**: manages the ongoing operations of multiple levels of staff and multiple functions and departments across the Aetna Better Health organization to meet LDH's program performance requirements and Aetna Better Health operating standards; is accountable to the CEO for operational and financial results and serves as the primary point of contact with LDH for operational issues. • **Major qualifications:** experience with health care management operations including claims, information technology, enrollee and provider services including network management and provider contracting, and call centers, Medicaid/government programs; cross-functional team implementation	• **Operating activities**: encompasses the administration of business practices to create efficiency and value for Aetna, LDH, and our local stakeholders; ensures continuous improvement through National Committee for Quality Assurance principles such as the Plan-Do-Study-Act model which informs how we communicate and operate; oversees provider physical and behavioral services, enrollee services, provider claims education, encounter, information technology, grievance system, reporting, and shared services key teams • **Reporting structure**: the COO leads the operations functions and reports to administration • **Communication with leadership**: operations leaders meet daily/weekly with the CEO on the oversight/daily functions on the teams listed previously under operating activities; also conducts weekly meetings with all direct reports and other key staff • **Team lead description:** experience in health plan operations, leading operational teams, State reporting requirements, implementing workflows
Medical Management **FTEs: 227**	• **Role**: responsible for prior authorization, care management (integrated physical and behavioral health services), population health, community health workers, health equity, disease management, and CSoC (children's system of care) BH services; develops and implements programs to improve enrollee health through strategies that include enrollee risk stratification and assembling enrollee cohorts using predictive modeling • **Major qualifications**: experience with health care delivery systems/managed care, medical management operations, and utilization review and management practices, processes, and procedures, cultural sensitivity	• **Operating activities**: ensures the quality of relevant care while promoting appropriate use of medical services and plan resources; maintains utilization decisions affecting the enrollee health care in a fair, impartial, consistent manner; includes oversight and day-to-day contact with care management, utilization management, and behavioral health • **Reporting structure**: the CMO leads medical management and reports to administration • **Communication with leadership**: medical management leaders meet daily/weekly with CEO/other leadership and presents monthly updates to the Quality Management/Utilization Management Committee (QM/UM); also holds weekly meetings with all direct reports and other key functional staff • **Team lead description:** experience leading/applying all aspects of the medical interpretation of clinical policies and procedures, administering BH services and physical health services
Quality	• **Role**: monitors our health care delivery system and	• **Operating activities**: oversees the evaluation of all services provided and the results achieved as

Key Team/FTEs	Role and Qualifications	Operating Activities, Reporting Structure, Communication, Team Lead Description
FTEs: 30	verifies that we provide health care services that improve the health status/health outcomes of our enrollees; integrates interdepartmental monitoring processes and activities; focuses on improving the enrollee's biological, psychological, and social well-being, with an emphasis on quality of care and the non-clinical aspects of all services; incorporates continuous quality improvement concept; responsible for QAPI program • **Major qualifications:** experience with health plan delivery system/quality initiatives and process improvement; policy tracking processes; monitoring processes and activities	compared with accepted standards; and focuses on quality assurance and various attributes of health care, such as cost, place, accessibility, treatment, benefits, enrollee health, and social determinants • **Reporting structure**: reports to administration • **Communication with leadership**: quality leaders meet daily/weekly with CEO/other leadership and present monthly updates to the QM/UM Committee; holds weekly meetings with all direct reports and other key functional staff on issues/resolutions/innovations • **Team lead description:** experience integrating interdepartmental monitoring processes and activities focusing on enrollees' BH/physical well-being through quality and continuous improvement goals
Compliance **FTEs: 2**	• **Role**: responsible for overall compliance with the contract; reaches across the organization to encourage high business standards to advance enrollee, State/LDH, plan objectives and to benefit all customers, and to safeguard Aetna's reputation • **Major qualifications**: experience with health plan compliance program; policy tracking processes; knowledge of operational areas, proactively addressing and coordinating with government agencies	• **Operating activities**: establishes policies, processes, and procedures to maintain compliance excellence; maintains strategies that support proactive monitoring and tracking systems designed to prevent, detect, and correct conduct that violates the low or Aetna's value system; focuses include staffing and governance, effective training and education, risk identification and monitoring, and procedures for prompt reporting • **Reporting structure**: reports to the contract compliance officer who reports to administration • **Communication with leadership**: compliance leaders meet daily/weekly with CEO/other leadership and presents monthly updates to the Compliance Committee • **Team lead description**: experience supporting operations/cross-functional teams; monitors budgets/performance metrics; and focuses on compliance related to claims management, provider services, grievance and appeals, Special Investigations Unit, and long-term care
Pharmacy **FTEs: 2**	• **Role**: works with clinical and operational teams to develop strategies for innovative and quality focused pharmacy (medical) services while collaborating with medical management teams on plan performance measures; leads pharmacy quality and performance improvement programs in accordance with State Medicaid contract, federal requirements, and plan accreditation standards; acts as a liaison to LDH of Louisiana Department of Health Pharmacy team to ensure Aetna meets contractual requirements • **Major qualifications**: health care pharmacy utilization, formularies/prior authorization requirements, compliance with State and federal utilization, quality, and risk management regulations	• **Operating activities**: partners with LDH team to ensure Aetna meets contractual requirements and laws and amendments pertaining to pharmacy; develops/maintains internal drug utilization review (DUR) compliance; analyzes/validates reports; directs prescription benefit drug coverage consistent with State requirements; reviews/manages drug utilization practices and trends, and works on interdisciplinary teams to ensure clinically appropriate and fiscally responsible pharmacy services are delivered to improve enrollee health • **Reporting structure**: reports to medical management, which reports to the CMO, which reports to administration • **Communication with leadership**: pharmacy lead meets daily/weekly with CEO/other leadership; holds weekly meetings with all direct reports and other key functional staff on issues/pharmacy initiatives • **Major qualifications**: experience in health care system pharmacy utilization, formularies/prior authorization requirements, compliance with State and federal utilization, quality, and risk management regulations • **Team lead description:** directs prescription benefit drug coverage consistent with State requirements, reviews/monitors the plan's pharmacy goals, maintains internal processes for compliance and LDH DUR program

Key Team/FTEs	Role and Qualifications	Operating Activities, Reporting Structure, Communication, Team Lead Description
Program Integrity FTEs: 9	• **Role:** manages targeted collection and analysis of utilization data to identify potential fraud, waste, abuse (FWA) including enrollee/provider data management, service authorization, and claims administration to improve our program resources (including the home- and community-based services waiver) • **Major qualifications:** health care fraud detection, prevention, and investigation; leadership role, direct experience working in a relevant federal agency, knowledge of both criminal and civic laws related to the prosecution of suspected health care fraud	• **Operating activities**: accountable for ensuring the integrity of all payments made for health care enrollee services; focuses on fiscal responsibility to LDH to help ensure the thoughtful use of financial and other resources, through a coordinated process of education, reviews, audits, and appropriate corrective action plans • **Reporting structure**: reports to the program integrity officer who reports to administration • **Communication with leadership**: program integrity leaders meet daily/weekly with CEO/other leadership; holds weekly meetings with all direct reports and other key functional staff on issues/resolutions/innovations • **Team lead description:** experience monitoring potential fraud and abuse through data mining for enrollees, providers, and subcontractors; leading fraud investigators
Finance FTEs: 7	• **Role**: responsible for accounting systems and finance operations including financial reporting and audit activities; manages budgeting and forecasting cycles and general ledger accounting system, verifying that we meet all financial performance goals and reporting requirements • **Major qualifications**: financial management including strategic/business planning, accounting, and financial analysis, extensive experience in health care, managed care insurance, or financial services, competitor knowledge	• **Operating activities**: oversees operational, financial, and budgetary goals, the budget, and general ledger accounting system, and annual external audit of financial statements; confirms all contractual financial performance and reporting requirements and submits timely encounters; manages decision-making affecting financial reporting/accounting policy, on a Generally Accepted Accounting Principles (GAAP) and statutory basis; evaluates the accounting and reporting aspects (GAAP and statutory) of key business strategies; and collaborates with the corporate controller to execute short- and long-range strategic plans • **Reporting structure**: reports to the CFO, who reports to administration • **Communication with leadership**: finance leaders meet daily/weekly with CEO • **Team lead description:** experience preparing corporate/departmental financial statements/budgets/analyses and value-based contracting analyses
Business Continuity FTE: 1	• **Role**: manages plans for how we will continue serving our enrollees during natural disasters or other wide-spread service interruptions; emergency planning includes anticipating and thinking through our response to possible challenges; coordinates the health care continuity disaster response needs, recovery, and business functions in the event a disaster, power outage, or other scenario causing a significant disruption in service delivery or business operations • **Major qualifications:** prior role in managed health care facilities/emergency management; developing/implementing security awareness training programs, knowledge of business processes, systems development methodologies	• **Operating activities**: maintains the emergency management plan as part of business contingency plans, and validation methodology, providing recovery from unforeseen disruption to facilities, technology systems, or applications; maintains infrastructure/business processes for enrollee emergency contact/special health care data comprisable in an emergency; maintains plan for data backup and restoration, offsite storage of vital business/customer data (e.g., enrollee medical records), systems recovery through remote backup site, continuity of telephone operations, plan rehearsal, and testing results • **Reporting structure**: reports to administration • **Communication with leadership**: business continuity leaders meet daily/weekly with CEO/other leadership; holds weekly meetings with all direct reports and other key functional staff on issues/resolutions/innovations • **Team lead description:** experience coordinating continuity disaster response plans and implementing the various responses needed including natural disasters, power outages, and other service disruptions for enrollees and protecting their health care information

2.10.2.3 Material Subcontractors

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2.10.2.3 Material Subcontractors

Aetna has a proven record of improving outcomes for our Louisiana enrollees by providing appropriate, coordinated care and services in a financially responsible manner. Aetna's commitment to providing the best and most comprehensive integrated care for enrollees sometimes involves delegating certain services or functions to other organizations that are expert specialists in their disciplines. In this event, we enter into a formal agreement assigning material subcontractors the authority to perform specialized functions or services on Aetna's behalf.

Material Subcontractors

Aetna undertakes subcontracts only when it adds value for our enrollees. We use well-qualified, experienced subcontractors to provide services in support of our Healthy Louisiana program—subcontractors with unique expertise and proven records of accomplishment relative to improving outcomes for our enrollees by providing appropriate, coordinated care and services in a financially responsible manner. Where we utilize a material subcontractor to provide services related to the delivery or payment of managed care organization covered services or a value-added benefit such as dental service, we provide a completed **Material Subcontractor Response Template**, including an executed or draft **Material Subcontractor Agreement**, in **Appendix F**.

All of our proposed material subcontractors have an established relationship with Aetna and currently demonstrate sustained quality performance serving Healthy Louisiana enrollees.

CaremarkPCS Health, L.L.C. (CaremarkPCS), an affiliated subcontractor, performs pharmacy benefit management (PBM) services which may include, but are not limited to, pharmacy claims adjudication with sophisticated and technologically advanced real-time systems; retail, mail order, and specialty pharmacy network management with robust audit and fraud investigation capabilities; and real-time and retrospective safety monitoring programs that identify members at risk for adverse outcomes. CaremarkPCS has provided PBM services since 1969 and has served Medicaid enrollees since 1988. Currently, CaremarkPCS works with 33 Medicaid health plans across the country representing over 21 million covered lives. CaremarkPCS' pharmacy help desk is available 24 hours a day, 7 days a week to assist our pharmacies in supporting our enrollees so they can obtain the medications they need for better health.

DentaQuest USA Insurance Company, Inc. (DentaQuest) administers Aetna's value-added adult dental services benefit because we know that good oral health can lead to improving enrollee health. Dental benefit administration is not one of Aetna's core competencies, so we leverage DentaQuest's expertise in this area to provide the best possible service to our enrollees. Because DentaQuest performs statewide fee-for-service children's dental services, subcontracting with them to administer the value-added adult dental services benefit helps to reduce complexity and administrative burden for providers and enrollees by offering a seamless transition from child to adult dental care.

LogistiCare Solutions, LLC provides non-emergency medical transportation services.

Superior Vision Benefit Management, Inc. performs comprehensive vision benefit management, including provider network, claims, and enrollee services. These activities will include provider contracting, credentialing, and relations; claims processing and payment; enrollee services support; continuous quality improvement program activities; and program reporting.

Subcontractor Oversight Activities

Prior to contracting with a material subcontractor, Aetna evaluates the prospective material subcontractor's ability to perform the activities to be subcontracted. We perform a pre-delegation review

audit to determine staff qualifications, clinical and administrative capabilities, integration capabilities, data transfer capabilities, operational readiness, and alignment with the Healthy Louisiana scope of work. Our quality management program includes formal, multilayered processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract. All aspects of the contract are evaluated through our Compliance Committee to ensure compliance with contractual requirements.

Aetna performs ongoing monitoring of subcontractor performance. We meet with material subcontractors on a periodic basis, depending on the subcontractor, and perform a comprehensive review annually in which we measure performance efforts that address past concerns identified by LDH. If any deficiencies or areas for improvement are identified, we require the material subcontractor to take corrective action. Aetna provides LDH with a copy of the annual review and any corrective action plans developed as a result.

National Oversight

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

Local Oversight

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

In accordance with Aetna's culture of compliance, all team members understand they play a role in subcontractor oversight. Team members from Network Management, Provider Services, Operations, and Quality are trained to report subcontractor-related concerns to management. For example, our service coordinators are the front line in identifying potential problems or issues related to vendors and subcontractors. If an interaction with an enrollee related to subcontractor performance raises a red flag or suggests there is a problem, the service coordinator will escalate the issue to management. Issues can often be resolved without further escalation once they are referred to the appropriate department for remediation.

Financial Oversight

Aetna maintains financial oversight by assessing each material subcontractor's financial condition to determine its ability to maintain financial solvency. As part of our financial due diligence, we perform a financial review of all delegated entities at least annually to provide oversight of the contractor's

continuing compliance with and ability to meet Aetna standards. Our Finance team reviews audited and unaudited financial statements such as the subcontractor's balance sheet, income statement, statements of cash flow, and interim reports. The Finance team will provide an assessment of the results of operation, liquidity of current assets, and sufficiency of cash to pay claims payable and financial reserves. This detailed review assists us in determining the risk exposure to Aetna and provides a basis for calculating a letter of credit or insolvency reserve, if needed. The Finance team will make recommendations regarding increasing the frequency of additional reviews. Finally, the financial report is distributed to the various oversight committees.

Poor audit results, increases in enrollee complaints, indications that downstream providers are not being paid, news reports about a subcontractor's financial instability, or alerts from LDH can trigger heightened financial monitoring and oversight activities. We will implement a corrective action plan (CAP) to help the subcontractor become compliant. We will require improvement and resolution on a short timeline—typically 30 or 60 days. The DOC, Compliance department, and Joint Operating Committee will review financial results. If the CAP is not successful and the subcontractor's financial stability remains poor, or if we continue to receive complaints, we may terminate the contract based upon contractual provisions.

2.10.2.3 Appendix F: Material Subcontractor Response Template

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Appendix F: Material Subcontractor Response Template

CaremarkPCS Health, L.L.C.

DentaQuest USA Insurance Company, Inc.

LogistiCare Solutions, LLC

Superior Vision Benefit Management, Inc.

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CaremarkPCS Health, L.L.C.

Appendix F

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Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
Aetna Better Health, Inc. d/b/a Aetna Better Health of Louisiana (Aetna Better Health of Louisiana)
Material subcontractor name:
CaremarkPCS Health, L.L.C. (CaremarkPCS)
Description of the Proposer's role and material subcontractor's role:
Aetna Better Health of Louisiana will contract directly with the Louisiana Department of Health to deliver the services as outlined in RFP #3000011953. CaremarkPCS, an affiliated subcontractor, performs pharmacy benefit management services which may include but are not limited to pharmacy claims adjudication with sophisticated and technologically advanced real-time systems; retail, mail order and specialty pharmacy network management with robust audit and fraud investigation capabilities; and, real time and retrospective safety monitoring programs that identify members at risk for adverse outcomes.
Explanation of why the Proposer plans to subcontract this service and/or function:
Our commitment to providing the best and most comprehensive integrated care for enrollees sometimes involves delegating certain services or functions to other organizations who are expert specialists in their disciplines. In this event, material subcontractors enter into a formal agreement giving them the authority to perform specialized functions or services on our behalf. Aetna Better Health of Louisiana utilizes the services of CaremarkPCS because it is a trusted provider of PBM services, having served as the Aetna Medicaid organization's pharmacy material subcontractor since 2010. CVS Health Corporation (CVS Health), Aetna Better Health of Louisiana's ultimate parent, is Utilization Review Accreditation Commission-accredited in PBM, drug therapy management, mail service pharmacy, specialty pharmacy, and health call center; and National Committee for Quality Assurance-accredited in utilization management, case management, and disease management.

A description of the material subcontractor's organizational experience:

CaremarkPCS has provided PBM services since 1969 and has served Medicaid enrollees since 1988. Currently, CaremarkPCS works with 33 Medicaid health plans across the country representing over 21 million covered lives; CaremarkPCS's pharmacy help desk is available 24 hours a day, 7 days a week to assist their pharmacies in supporting enrollees so they can obtain the medications they need for better health.

CaremarkPCS: The PBM and mail service pharmacy segment of CVS Health provides a full range of PBM services. Pharmaceutical Card System (PCS), a predecessor of Caremark, was founded in 1969 in Scottsdale, Arizona, effectively launching the pharmacy benefit management industry.

CVS Specialty: The specialty pharmacy business of CVS Health (part of the PBM segment) includes our specialty pharmacy services for patients who require treatment for rare or complex conditions. CVS Health pioneered hemophilia home care and began supplying specialty medications in 1978, via predecessor Baxter Health Care Corporation.

MinuteClinic: The retail medical clinic business of CVS Health (part of the retail segment) is the leading retail medical clinic provider in the United States. The first QuickMedx centers (the predecessor to MinuteClinic) opened in the Minneapolis-St. Paul area in May 2000 as a more affordable alternative to emergency rooms and urgent care centers.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

Ongoing PBM oversight and collaboration between Aetna Better Health of Louisiana's pharmacy director, Aetna Medicaid Pharmacy Management, CVS Health Corporation, and the Department ensures that PBM services are administered by CaremarkPCS in the best interest of Healthy Louisiana enrollees; and in the amount, duration, and scope of benefits as defined in the contract and all applicable NCQA, URAC and other State and federal law regulatory requirements and standards. Additionally, Aetna Better Health of Louisiana draws on the experiences of affiliate plans regarding oversight of CaremarkPCS, and we can adjust our monitoring approach to address any performance problems identified in other states that may be applicable to Louisiana.

Prior to the effective date of new programs, the pharmacy director will confirm that all delegated pharmacy services are prepared for implementation in compliance with contractual and regulatory requirements. The pharmacy director and the chief medical officer (CMO), in collaboration with the National Medicaid Pharmacy Management department, will monitor the pharmacy services performed by CaremarkPCS through weekly operational meetings to review performance metrics including, but not limited to the following: paid and non-paid claims processing; DUR edits and program activities; encounter submission acceptance rates; pharmacy network performance and GeoAccess® reports; and pharmacy help desk activities.

As part of Aetna's Quality Management Committee structure, we will continue utilizing the Aetna Better Health of Louisiana Delegation Oversight Committee (DOC) chaired by the CMO. DOC members include the pharmacy director, compliance officer, and representation from all areas of the health plan including Operations, Medical Management, Care Management, and Quality Management. The DOC will meet on a quarterly basis to assess and evaluate key performance metrics, including, but not

limited to the following: cost performance and trends, prospective and retrospective drug utilization review (DUR) programs and impacts; specialty drug utilization and strategies; pharmacy network and pharmacy help desk service levels; and clinical pharmacy programs outcomes. When appropriate, CaremarkPCS representatives such as the strategic account executive, strategic account director, clinical advisor, specialty account executive, or analytic consultant will attend DOC meetings to discuss key initiatives that support innovation and a culture of continuous quality improvement in Louisiana.

Other processes Aetna Better Health of Louisiana will implement to monitor and evaluate the performance of CaremarkPCS to ensure that all contract requirements are met and to determine the return on investment include:

• **Third-Party Audits**: CaremarkPCS will undergo an annual third-party audit (the SAS-70) to evaluate controls relevant to the processing of claim and drug rebate transactions and to confirm that these controls are in place and operating effectively. The audit testing includes aspects of the information security, physical security, access to data files and programs, and development of and modification to information systems. Additionally, under the direction of the Aetna Medicaid Pharmacy Management department, a third-party vendor is contracted to complete an annual audit on functions delegated to CaremarkPCS that will evaluate the operational effectiveness of controls relevant to benefit and formulary setup, claims processing, and network pricing. The resulting annual reports for these audits will be provided to the Aetna National Medicaid Pharmacy Director, Aetna Better Health of Louisiana Pharmacy Director, and our Medical Director/CMO for review and next steps, which may include, but are not limited to, presentation at the DOC.

• **Encounter Submissions Edits:** Aetna Better Health of Louisiana's Encounter Management System will use edits and checkpoints to validate CaremarkPCS' pharmacy encounters for accuracy, completeness, and member eligibility. Encounters identified with errors will be returned to CaremarkPCS for correction. Aetna Medicaid Pharmacy Management, on behalf of Aetna Better Health of Louisiana, will submit encounters that pass our edits and controls to the State, as required by the contract. In 2018, the acceptance rate was 98.81 percent.

• **Reporting:** Aetna Better Health of Louisiana will require CaremarkPCS to meet all reporting requirements for its functional responsibilities listed in the contract, within the timeframes specified.

- **Quarterly Reports:** A set of important reports used in managing pharmacy services and providing PBM oversight is CaremarkPCS' comprehensive quarterly Rx Insights Costs and Trends Detail Report found within the Delegated Oversight quarterly report package. Information and metrics found within the quarterly report package include, but are not limited, to the following: claims statistics; key drug utilization and cost trends; top drugs and therapy classes; pharmacy audit statistics; point-of-service edits; and encounter statistics.
- **Daily, Weekly, and Monthly Reports:** Reports include CaremarkPCS performance reports for claims/encounter timeliness, completeness, and accuracy; reports on Pharmacy Help Desk activities; and other reports pertaining to performance such as complaint statistics, fraud reports, claims dashboard, and encounter aging.

If issues of non-compliance or emerging risks are identified, Aetna Better Health of Louisiana will take immediate action to correct the problem. Determined by the nature of the problem, remediation may include training, more frequent monitoring, corrective action plans, sanctions, notices to cure, or subcontractor termination. The pharmacy director will monitor corrective action plans and report

progress on them to the DOC and the Quality Management Oversight Committee for tracking to completion.

Our return on investment is not measured in terms of a mathematical calculation that yields a percent return, but rather in terms of our enrollees' access to the medical services and care they need to live healthier, more independent lives. The services that CaremarkPCS provides will allow Aetna Better Health of Louisiana to administer pharmacy services on a scale that we would not be able to achieve otherwise. Our robust quality management program helps to ensure that our Healthy Louisiana enrollees are receiving the highest quality care and services as they seek to achieve their health goals. This in turn enables Aetna Better Health of Louisiana to support the State in its objective to build a Medicaid managed care delivery system that improves the health of populations, enhances the experience of care for individuals, and effectively manages Medicaid per capita care costs.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	RCA-EXHIBIT A Page 14 of 17 § 6.3
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	AMENDMENT TO PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT (Louisiana Medicaid) Page 1
3	Specify the effective dates of the subcontract agreement.	AMENDMENT TO PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT (Louisiana Medicaid) Page 1
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	RCA-EXHIBIT A Page 14 of 17 §6.6
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	RCA-EXHIBIT A Page 14 of 17 §6.4
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	RCA-EXHIBIT A Page 14 of 17 §6.4
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	RCA-EXHIBIT A Page 12 of 17 §4.15
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	RCA-EXHIBIT A Page 16 of 17 §7.1
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	RCA-EXHIBIT A Page 1 of 17 PARAGRAPH 3
10	Identify the population covered by the subcontract.	RCA-EXHIBIT A Page 3 of 17

		DEFINITION OF MEMBER
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	RCA-EXHIBIT A Page 14 of 17 §6.3
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	RCA-EXHIBIT A Page 3 of 17 §2.1
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	RCA-EXHIBIT A Page 4 of 17 § 2.3
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	RCA-EXHIBIT A Page 1 DEF EMERGENCY SERVICES Page 5 of 17 § 2.8
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. §493.1 and 493.3, and any other federal requirements.	RCA-EXHIBIT A Page 5 of 17 §2.9
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	RCA-EXHIBIT A Page 10 of 17 § 4.6
17	Include record retention requirements as specified in the contract between LDH and the MCO.	RCA-EXHIBIT A Page 10 of 17 §4.9

18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	RCA-EXHIBIT A Page 11 of 17 §4.10
19	INTENTIONALLY LEFT BLANK	
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	RCA-EXHIBIT A Page 11 of 17 §4.11
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	RCA-EXHIBIT A Page 11 of 17 §4.11
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	RCA-EXHIBIT A Page 11 of 17 §4.11
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	RCA-EXHIBIT A Page 12 of 17 §4.16
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	RCA-EXHIBIT A Page 11 of 17 §4.12
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	RCA-EXHIBIT A Page 11 of 17 §4.13
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	AMENDMENT TO PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT (Louisiana Medicaid)

		Louisiana Operating Term Addendum To Schedule P Page 6-15
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	RCA-EXHIBIT A Page 7 of 17 § 3.3
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	RCA-EXHIBIT A Page 7 of 17 §3.3
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	RCA-EXHIBIT A Page 8 of 17 §3.7
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	RCA-EXHIBIT A Page 8 of 17 §3.6
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	RCA-EXHIBIT A Page 14 of 17 § 6.8
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	RCA-EXHIBIT A Page 3 & 6 of 17 §2.1 & 2.13
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	RCA-EXHIBIT A Page 9 of 17 §4.1
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	RCA-EXHIBIT A Page 14 of 17 §6.4

35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	RCA-EXHIBIT A Page 14 of 17 § 6.1
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	RCA-EXHIBIT A Page 15 of 17 §6.9
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	RCA-EXHIBIT A Page 9 of 17 § 4.2
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	RCA-EXHIBIT A Page 12 of 17 §4.14
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	RCA-EXHIBIT A Page 12 of 17 § 4.17
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	RCA-EXHIBIT A Page 15 of 17 §6.11
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	RCA-EXHIBIT A Page 12 of 17 §4.19
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	RCA-EXHIBIT A Page 4 of 17 § 2.4

43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	RCA-EXHIBIT A Page 15 of 17 § 6.12
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non- compliance with an information, records or data request.	RCA-EXHIBIT A Page 4 of 17 §2.5(d)

CaremarkPCS Health, L.L.C.
Amendment to Pharmacy Benefit Management Subcontract Agreement
(Louisiana Medicaid)

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CaremarkPCS Health, L.L.C.
RCA-Exhibit A

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DentaQuest USA Insurance Company, Inc.

Appendix F

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Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
Aetna Better Health, Inc. d/b/a Aetna Better Health of Louisiana (Aetna Better Health of Louisiana)
Material subcontractor name:
DentaQuest USA Insurance Company, Inc.
Description of the Proposer's role and material subcontractor's role:
Aetna Better Health of Louisiana will contract directly with the Louisiana Department of Health to deliver the services as outlined in RFP #3000011953. DentaQuest's role is to administer our value-added adult dental services benefit, as well as the early and periodic screening, diagnostic, and treatment (EPSDT) dental benefit for children.
Explanation of why the Proposer plans to subcontract this service and/or function:
The Aetna Medicaid organization's commitment to providing the best and most comprehensive integrated care for enrollees sometimes involves delegating certain services or functions to other organizations who are expert specialists in their disciplines. In this event, material subcontractors enter into formal agreements giving them the authority to perform specialized functions or services on a health plan's behalf. We know that good oral health can lead to improving enrollee health. Aetna Better Health of Louisiana utilizes the services of DentaQuest because, as DentaQuest performs statewide fee-for-service children's dental services, subcontracting with them to administer the value-added adult dental services benefit helps to reduce complexity and administrative burden for providers and enrollees by offering a seamless transition from child to adult dental care.
A description of the material subcontractor's organizational experience:
Founded as a state-specific dental entity in 1966, DentaQuest since has expanded into the leading dental administrator in government programs with its focus on improving oral health through innovative solutions. DentaQuest is the largest administrator of government-sponsored dental and vision programs in the nation, with more than two decades of in-depth experience in the Medicaid/CHIP, Medicare Advantage, dual-eligible, and health exchange segments. As a dental benefits administrator, DentaQuest serves approximately 24 million members nationwide. Today, DentaQuest is the largest dental benefits administrator in the Medicaid space with more than 20 million members in Medicaid/CHIP programs in 30 states. DentaQuest USA Insurance Company, Inc. is a wholly-owned, indirect subsidiary of Dental Service of Massachusetts, Inc. (DSM), and a Massachusetts nonprofit dental service corporation. DSM is wholly-controlled by Catalyst Institute, Inc., a Massachusetts charitable corporation. DSM has insured and administered commercial dental benefits programs in Massachusetts since the 1960s. In 2001, DSM established a DentaQuest subsidiary through which it develops dental benefits businesses in other states. Today, the subsidiaries of DentaQuest Group, Inc. are engaged in the business of administering dental benefits programs for commercial group and individual markets, managed care organizations

that participate in government programs (Medicaid, CHIP and Medicare Advantage), and state agencies responsible for Medicaid and CHIP programs throughout the country. DentaQuest, LLC is the entity responsible for providing all administrative and managerial services to the DentaQuest enterprise.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

Although Aetna Better Health of Louisiana may delegate the authority to perform functions in support of the Healthy Louisiana program, we do not delegate accountability for the quality of care or services the contractor provides. Our Quality Assurance and Performance Improvement (QAPI) program has a comprehensive set of policies and procedures to manage the delegation of responsibility for any delegated program function. We understand all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight, with selecting subcontractors, and with ongoing monitoring of subcontractor performance. By leveraging this experience, we ensure the successful completion of all delegated functions under the Healthy Louisiana program.

The processes Aetna Better Health of Louisiana will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment include:

- Monitoring and evaluating delegated functions through semiannual reports
- Conducting pre-assessments prior to delegation, with annual desk audits or web conference reviews conducted with a random sampling of files thereafter
- Confirming that delegated functions/services are carried out consistently and in compliance with both Aetna's and other applicable accredited standards (i.e., NCQA and others as indicated) and the mutually agreed-upon delegation agreement
- Performing an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards
- Monitoring ongoing corrective actions to address identified deficiencies, promote progress, and take necessary action, if improvements do not occur
- Reviewing the delegated organization's program that oversees the delegated functions and its quality program to verify it is in alignment with Aetna's quality improvement processes
- Monitoring the subcontractor downstream provider agreements to ensure they comply with the regulatory requirements of the State contract

The Medical Management, Quality Management, Provider Services, and if applicable, Care Management, and Utilization Management departments are responsible for implementing the oversight process and maintaining monitoring activities, including monitoring the delegate's provisions to safeguard members' protected health information, as applicable.

Delegation oversight activities are formally monitored as a component of the QAPI program. Audit reports of delegated activities and CAPs, if applicable, are submitted to the appropriate oversight committee (e.g., QM/UM Committee, Delegation Subcommittee, National Vendor Delegate Oversight Committee) for review and approval and then to the Quality Management Oversight Committee. Should deficiencies be identified, we work with the delegated organization to set priorities and develop a corrective action plan (CAP). We retain the right to revoke the delegation agreement for

non-compliance or if CAPs are not sustained.

Our return on investment is not measured in terms of a mathematical calculation that yields a percent return, but rather in terms of our enrollees' access to the medical services and care they need to live healthier, more independent lives. Quality service to its members is at the root of DentaQuest's mission and history, which spans more than half a century. The services that DentaQuest provides will allow Aetna Better Health of Louisiana to administer dental services on a scale that we would not be able to achieve otherwise. Our robust quality management program helps to ensure that our Healthy Louisiana enrollees are receiving the highest quality care and services as they seek to achieve their health goals. This in turn enables Aetna Better Health of Louisiana to support the State in its objective to build a Medicaid managed care delivery system that improves the health of populations, enhances the experience of care for individuals, and effectively manages Medicaid per capita care costs.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14 Section 6.3
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Dentaquest LA Eff 020115 Executed Base Agreement Page 21
3	Specify the effective dates of the subcontract agreement.	Dentaquest LA Eff 020115 Executed Base Agreement Page 2, First paragraph
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.6
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.4
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.4
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.15
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 16, Section 7.1
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 1, Paragraph 3

		Page 15, Section 6.10
10	Identify the population covered by the subcontract.	Dentaquest LA Eff 020115 Executed Base Agreement Page 3, Section 1.11 Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 6, Section 2.17
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.3
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 3-4, Section 2.1
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.3
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 5, Section 2.8
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. §493.1 and 493.3, and any other federal requirements.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 5, Section 2.9
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9-10, Section 4.6 Page 10-11, Section 4.9
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 10-11 Section 4.9

18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11 Section 4.10
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20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.3 Page 11, Section 4.11
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11, Section 4.11
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11, Section 4.11
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.16
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11, Section 4.12
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11-12, Section 4.13

26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Dentaquest LA Eff 020115 Executed Base Agreement Page 8, Section 4.1 Exhibit 1, Services and Compensation Schedule Page 23-24 Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.2
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.3
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.3
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 8, Section 3.7
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 8, Section 3.6
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14-15, Section 6.8
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 3, Section 2.1 Page 6, Section 2.13

33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.1
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.1 Page 14, Section 6.4
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.1
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 15, Section 6.9
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.2
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.14
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.17
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 15, Section 6.11
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.4 Page 12, Section 4.19

42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.4
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 15, Section 6.12
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non- compliance with an information, records or data request.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.5(d)

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DentaQuest USA Insurance Company, Inc.
Executed Base Agreement

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DentaQuest USA Insurance Company, Inc.
Appendix A Louisiana Medicaid Regulatory Compliance Addendum

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LogistiCare Solutions, LLC

Appendix F

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Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
Aetna Better Health, Inc. d/b/a Aetna Better Health of Louisiana (Aetna Better Health of Louisiana)
Material subcontractor name:
LogistiCare Solutions, LLC (LogistiCare)
Description of the Proposer's role and material subcontractor's role:
Aetna Better Health of Louisiana will contract directly with the Louisiana Department of Health to deliver the services as outlined in RFP #3000011953. The role of LogistiCare is to provide non-emergency medical transportation services.
Explanation of why the Proposer plans to subcontract this service and/or function:
Our commitment to providing the best and most comprehensive integrated care for enrollees sometimes involves delegating certain services or functions to other organizations who are expert specialists in their disciplines. In this event, material subcontractors enter into a formal agreement giving them the authority to perform specialized functions or services on our behalf. Aetna Better Health of Louisiana utilizes the services of LogistiCare because it is a trusted provider of non-emergency transportation services for our enrollees.
A description of the material subcontractor's organizational experience:
LogistiCare is a wholly owned subsidiary of The Providence Service Corporation (NASDAQ: PRSC) and is the nation's largest provider of non-emergency medical transportation programs for state governments and managed care organizations. LogistiCare was founded in 1986 when it began developing data and technology solutions for ambulance vehicles. Seeing the challenges customers faced in controlling program costs as well as coordinating and monitoring transportation, in 1991 LogistiCare broadened its scope to include NEMT consulting and by 1996, NEMT became the company's primary focus. Since first working in Georgia and Connecticut more than 20 years ago, LogistiCare has grown its business significantly – delivering quality service to nearly 24 million eligible consumers nationwide and maintaining a contract retention rate of 97.5 percent. LogistiCare manages more than 230 customized NEMT programs in 49 states and the District of Columbia. In 2018, LogistiCare provided nearly 65 million trips across the United States.
The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
Although Aetna Better Health of Louisiana may delegate the authority to perform functions in support of the Healthy Louisiana program, we do not delegate accountability for the quality of care or services the contractor provides. Our Quality Assurance and Performance Improvement (QAPI) program has a comprehensive set of policies and procedures to manage the delegation of responsibility for any delegated program function. We understand all processes required for effective oversight of

subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight, with selecting subcontractors, and with ongoing monitoring of subcontractor performance. By leveraging this experience, we ensure the successful completion of all delegated functions under the Healthy Louisiana program.

The processes Aetna Better Health of Louisiana will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment include:

- Monitoring and evaluating delegated functions through semiannual reports
- Conducting pre-assessments prior to delegation, with annual desk audits or web conference reviews conducted with a random sampling of files thereafter
- Confirming that delegated functions/services are carried out consistently and in compliance with both Aetna's and other applicable accredited standards (i.e., NCQA and others as indicated) and the mutually agreed-upon delegation agreement
- Performing an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards
- Monitoring ongoing corrective actions to address identified deficiencies, promote progress, and take necessary action, if improvements do not occur
- Reviewing the delegated organization's program that oversees the delegated functions and its quality program to verify it is in alignment with Aetna's quality improvement processes
- Monitoring the subcontractor downstream provider agreements to ensure they comply with the regulatory requirements of the State contract

The Medical Management, Quality Management, Provider Services, and if applicable, Care Management, and Utilization Management departments are responsible for implementing the oversight process and maintaining monitoring activities, including monitoring the delegate's provisions to safeguard members' protected health information, as applicable. Delegation oversight activities are formally monitored as a component of the QAPI program. Audit reports of delegated activities and CAPs, if applicable, are submitted to the appropriate oversight committee (e.g., QM/UM Committee, Delegation Subcommittee, National Vendor Delegate Oversight Committee) for review and approval and then to the Quality Management Oversight Committee. Should deficiencies be identified, Aetna works with the delegated organization to set priorities and develop a corrective action plan (CAP). We retain the right to revoke the delegation agreement for non-compliance or if CAPs are not sustained.

Our return on investment is not measured in terms of a mathematical calculation that yields a percent return, but rather in terms of our enrollees' access to the medical services and care they need to live healthier, more independent lives. The services that LogistiCare provides will allow Aetna Better Health of Louisiana to administer non-emergency transportation services on a scale that we would not be able to achieve otherwise, thereby increasing enrollees' access to care. Our robust quality management program helps to ensure that our Healthy Louisiana enrollees are receiving the highest quality care and services as they seek to achieve their health goals. This in turn enables Aetna Better Health of Louisiana to support the State in its objective to build a Medicaid managed care delivery system that improves the health of populations, enhances the experience of care for individuals, and effectively manages Medicaid per capita care costs.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14 Section 6.3
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Base Agreement Page 21 Signature Page
3	Specify the effective dates of the subcontract agreement.	Base Agreement Page 2 1st Paragraph; Line 2
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.6
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.4
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.4
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.15
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 16, Section 7.1
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 1, Paragraph 3

		Page 15, Section 6.10
10	Identify the population covered by the subcontract.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 6, Section 2.17
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.3
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 3-4, Section 2.1
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.3
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 5, Section 2.8
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. §493.1 and 493.3, and any other federal requirements.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 5, Section 2.9
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9-10, Section 4.6 Page 10-11, Section 4.9
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 10-11 Section 4.9

18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11 Section 4.10
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20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.3 Page 11, Section 4.11
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11, Section 4.11
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11, Section 4.11
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.16
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11, Section 4.12
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11-12, Section 4.13

26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Base Agreement Services and Compensation Schedule; Page 23 Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.2
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.3
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.3
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 8,Section 3.7
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 8, Section 3.6
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14-15, Section 6.8
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 3, Section 2.1 Page 6, Section 2.13
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.1

34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.1 Page 14, Section 6.4
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.1
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 15, Section 6.9
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.2
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.14
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.17
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 15, Section 6.11
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.4 Page 12, Section 4.19
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.4

43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 15, Section 6.12
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non- compliance with an information, records or data request.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.5(d)

LogistiCare Solutions, LLC
Executed Base Agreement

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LogistiCare Solutions, LLC
Appendix A Louisiana Medicaid Regulatory Compliance Addendum

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Superior Vision Benefit Management, Inc.

Appendix F

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Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
Aetna Better Health, Inc. d/b/a Aetna Better Health of Louisiana (Aetna Better Health of Louisiana)
Material subcontractor name:
Superior Vision Benefit Management, Inc. (Superior Vision)
Description of the Proposer's role and material subcontractor's role:
Aetna Better Health of Louisiana will contract directly with the Louisiana Department of Health to deliver the services as outlined in RFP #3000011953. The role of Superior Vision is to perform comprehensive vision management services, including all aspects of service delivery and the administrative support services to support vision benefits. These activities will include provider contracting, credentialing, and relations; claims processing and payment; member services support; continuous quality improvement program activities; and program reporting.
Explanation of why the Proposer plans to subcontract this service and/or function:
Our commitment to providing the best and most comprehensive integrated care for enrollees sometimes involves delegating certain services or functions to other organizations who are expert specialists in their disciplines. In this event, material subcontractors enter into formal agreements giving them the authority to perform specialized functions or services on our behalf. Aetna Better Health of Louisiana utilizes the services of Superior Vision because it has more than 25 years' experience managing vision benefits on behalf of both health plans (with an emphasis on government programs) and commercial group business. In Louisiana, Superior Vision has administered vision services for the Louisiana Medicaid and CHIP programs since inception in 2012. Currently, they provide comprehensive routine vision and medical eye care services to more than 300,000 Louisiana Medicaid and CHIP members.
A description of the material subcontractor's organizational experience:
In 1990, Block Vision began providing high-quality eye care and administrative services, with a focus on serving health plan clients. In December 2014, Block Vision merged with Superior Vision, a leading provider of vision plan coverage to commercial groups on a nationwide basis. This merger positioned the combined company as a national leader in both health plan and commercial vision benefits services. On December 1, 2017, Superior Vision's ownership completed its acquisition of Davis Vision, which had been previously announced on August 9, 2017. This new partnership leverages the expertise and services of each company and provides a larger suite of benefit offerings along with the broadest access in the industry to quality vision care. Together with affiliates, the combined companies currently manage vision benefits on behalf of over 33 million members nationwide. Since 1994, Superior Vision has delivered a full-spectrum of vision care services on behalf of government-sponsored health plans. Today, in partnership with 79 health plans, they administer a continuum of vision services ranging from routine to medical/surgical to more than 13 million

Medicaid, CHIP, and Medicare Advantage members. Superior Vision is the largest administrator of vision benefits for government-sponsored health plans in the nation.

This experience has led to the development of services designed to meet the unique needs of their clients and members including:

- Ensuring appropriate accommodations for members with special needs
- Delivering services in a culturally-competent manner
- Providing data management and program reporting, including compliance with applicable state-required and/or federally required performance standards and reporting templates
- Offering a comprehensive quality management program that complies with NCQA and applicable state and federal standards
- Monitoring and acting on fraud, waste and abuse as appropriate
- Delivering disease management and member outreach initiatives
- Providing customized account management with a focus on personalized customer service
- Managing services across the eye care spectrum, including a robust medical eye-care management program that:
    - o Allows members to receive uninterrupted care from a single provider when a medical eye condition is detected during a routine eye exam
    - o Benefits clients through lower program costs and the elimination of "leakage" between the routine vision and medical eye care delivery systems

Superior Vision's long-term experience managing services on behalf of Medicaid, CHIP, and Medicare Advantage programs makes them uniquely qualified to deliver outstanding service to the Louisiana Department of Health and to Healthy Louisiana enrollees.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

Although Aetna Better Health of Louisiana may delegate the authority to perform functions in support of the Healthy Louisiana program, we do not delegate accountability for the quality of care or services the contractor provides. Our Quality Assurance and Performance Improvement (QAPI) program has a comprehensive set of policies and procedures to manage the delegation of responsibility for any delegated program function. We understand all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight, with selecting subcontractors, and with ongoing monitoring of subcontractor performance. By leveraging this experience, we ensure the successful completion of all delegated functions under the Healthy Louisiana program.

The processes Aetna Better Health of Louisiana will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment include:

- Monitoring and evaluating delegated functions through semiannual reports
- Conducting pre-assessments prior to delegation, with annual desk audits or web conference reviews conducted with a random sampling of files thereafter
- Confirming that delegated functions/services are carried out consistently and in compliance with both Aetna's and other applicable accredited standards (i.e., NCQA and others as indicated) and the mutually agreed-upon delegation agreement

- Performing an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards
- Monitoring ongoing corrective actions to address identified deficiencies, promote progress, and take necessary action, if improvements do not occur
- Reviewing the delegated organization's program that oversees the delegated functions and its quality program to verify it is in alignment with Aetna's quality improvement processes
- Monitoring the subcontractor downstream provider agreements to ensure they comply with the regulatory requirements of the State contract

The Medical Management, Quality Management, Provider Services, and if applicable, Care Management, and Utilization Management departments are responsible for implementing the oversight process and maintaining monitoring activities, including monitoring the delegate's provisions to safeguard members' protected health information, as applicable.

Delegation oversight activities are formally monitored as a component of the QAPI program. Audit reports of delegated activities and CAPs, if applicable, are submitted to the appropriate oversight committee (e.g., QM/UM Committee, Delegation Subcommittee, National Vendor Delegate Oversight Committee) for review and approval and then to the Quality Management Oversight Committee. Should deficiencies be identified, we work with the delegated organization to set priorities and develop a corrective action plan (CAP). We retain the right to revoke the delegation agreement for non-compliance or if CAPs are not sustained.

Our return on investment is not measured in terms of a mathematical calculation that yields a percent return, but rather in terms of our enrollees' access to the medical services and care they need to live healthier, more independent lives. The services that Superior Vision provides will allow Aetna Better Health of Louisiana to administer vision services on a scale that we would not be able to achieve otherwise. Our robust quality management program helps to ensure that our Healthy Louisiana enrollees are receiving the highest quality care and services as they seek to achieve their health goals. This in turn enables Aetna Better Health of Louisiana to support the State in its objective to build a Medicaid managed care delivery system that improves the health of populations, enhances the experience of care for individuals, and effectively manages Medicaid per capita care costs.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14 Section 6.3
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Superior Vision LA Effective 020115 Executed Agreement Agreement Page 21
3	Specify the effective dates of the subcontract agreement.	Superior Vision LA Effective 020115 Executed Agreement Page 1, First Paragraph
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.6
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.4
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.4
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.15
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 16, Section 7.1
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum

		Page 1, Paragraph 3 Page 15, Section 6.10
10	Identify the population covered by the subcontract.	Superior Vision LA Effective 020115 Executed Agreement Page 3, Section 1.13 Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 6, Section 2.17
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.3
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 3-4, Section 2.1
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.3
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 5, Section 2.8
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. §493.1 and 493.3, and any other federal requirements.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 5, Section 2.9
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9-10, Section 4.6 Page 10-11, Section 4.9
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 10-11 Section 4.9

18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 11 Section 4.10
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20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.3 Page 11, Section 4.11
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26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Superior Vision LA Effective 020115 Executed Agreement Page 23 Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.2
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.3
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.3
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33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.1

34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.1 Page 14, Section 6.4
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 14, Section 6.1
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37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 9, Section 4.2
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.14
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 12, Section 4.17
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 15, Section 6.11
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 7, Section 3.4 Page 12, Section 4.19
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.4

43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 15, Section 6.12
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non- compliance with an information, records or data request.	Appendix A Louisiana Medicaid Regulatory Compliance Addendum Page 4, Section 2.5(d)

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Superior Vision Benefit Management, Inc.
Executed Base Agreement

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Superior Vision Benefit Management, Inc.
Appendix A Louisiana Medicaid Regulatory Compliance Addendum

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2.10.2.4 Proposal Reference Contact Information

Louisiana | Transforming Health Care | **Aetna**

2.10.2.4 Proposer Reference Contact Information

Aetna Better Health of Louisiana's vision for our relationship with LDH is to serve as a dependable, transparent, and trusted partner in creating solutions to key public health issues—collaborating with stakeholders to design effective policy and achieve the Healthy Louisiana program goals, especially the requirements of the contract.

From time to time, an Aetna organization health plan may miss a contractual requirement and receive a notice of action, an important indicator of an opportunity for improvement. Our multidisciplinary approach to identifying, remediating, and monitoring compliance issues is companywide. We perform root-cause analysis and employ the Plan-Do-Study-Act method to address the underlying issues that lead to a notice of action. Results and recommendations are reported to Aetna organization leadership and translated into improved policies and procedures. Aetna is committed to a culture of continuous quality improvement. **We listen. We learn. We take action.**

As illustrated in **Table 2.10.2.4-1,** Aetna currently manages a number of managed care programs with diverse membership in sixteen states, all of which are included on the following pages. **None of the contracts listed have been subject to a compliance action terminating a contract for poor or non-performance.**

Table 2.10.2.4-1: Aetna's Aggregate Enrollment and Population Experience by State

State	Aggregate Enrollment	CHIP	TANF	ABD/ SSI[1]	ACA[2] Exp.	BH Carve-In[3]	Duals	LTSS[4]	Children in Foster Care	IDD[5]
Arizona	416,337[6]	X	X	X	X	X	X	X	X	X
California	11,061	X	X	X	X	X	X	X		
Florida	102,046	X	X	X		X	X	X		X
Illinois	7,247		X	X	X	X	X	X		X
Kansas	107,621	X	X	X		X	X	X	X	X
Kentucky	224,908	X	X	X	X	X	X		X	
Louisiana	119,494	X	X	X	X	X	X		X	
Maryland	15,384	X	X	X	X				X	
Michigan	45,032	X	X	X	X		X	X	X	X
New Jersey	51,438	X	X	X	X	X	X	X	X	X

[1] Aged, Blind, and Disabled/Supplemental Security Income
[2] Affordable Care Act
[3] Behavioral Health Carve-in
[4] Long-term Services and Supports
[5] Intellectual or Developmental Disability
[6] In Arizona, an Aetna-affiliated entity performs administrative functions for an unaffiliated health plan, Mercy Care, and is not the risk-bearing entity holding the contracts with the State agency.

State	Aggregate Enrollment	CHIP	TANF	ABD/ SSI[1]	ACA[2] Exp.	BH Carve-In[3]	Duals	LTSS[4]	Children in Foster Care	IDD[5]
New York	6,948			X			X	X		
Ohio	25,015			X		X	X	X		
Pennsylvania	218,670	X	X	X	X				X	
Texas	275,774[7]	X	X	X		X	X	X		X
Virginia	93,408	X	X	X		X	X	X	X	X
West Virginia	119,125		X	X	X	X				

In accordance with **RFP Section 2.10.2.4.1**, **Table 2.10.2.4-2** and **Table 2.10.2.4-3** provide the contact information (name, title, phone number, and email) for the lead state program manager in each state, including Louisiana, for which Aetna's Medicaid organization has managed a Medicaid managed care contract for comparable services within the past three (3) years. **Table 2.10.2.4-2** provides reference contact information for Aetna Better Health of Louisiana and affiliated Medicaid health plans, and **2.10.2.4-3** provides reference contact information for Medicaid health plans not affiliated with Aetna Better Health of Louisiana but managed by Aetna. In accordance with **RFP Section 2.10.2.4.2**, each such reference includes a brief description of the types and numbers of individuals served, Aetna's key responsibilities in connection with each state contract, and any compliance actions taken by the State or municipalities during the entire term of its contract, including, but not limited to, corrective action plans and monetary penalties[8].

Aetna Better Health of Louisiana and Other Affiliated Medicaid Health Plans

The Medicaid health plans listed in **Table 2.10.2.4-2** include Aetna Better Health of Louisiana and its affiliates that have held at-risk Medicaid managed care contracts for comparable services within the past three years. The health plans within this table have or had direct contractual relationships with the State agencies in their respective states. We list our Louisiana contracts first, followed by contracts listed alphabetically by state. We provide the membership numbers for the last month for which we have publicly available information (December 2018) unless otherwise indicated.

[7] The Texas membership number includes membership for our affiliate, Aetna Better Health of Texas (88,109), and for Parkland Community Health Plan (187,665), an unaffiliated health plan for which an Aetna-affiliated entity performs administrative functions but is not the risk-bearing entity holding the contract with the State agency.

[8] For active contracts, compliance actions are provided for the entire term of the current contract through April 8, 2019, and not for the entire period of the applicable health plan's tenure in each state. For contracts that are no longer active, we provided compliance actions for the last active contract term and not for the entire period of the health plan's tenure in each state. If LDH seeks additional information, we will provide it upon request.

Table 2.10.2.4-2: Proposer Reference Contact Information—Aetna Better Health of Louisiana and Affiliated Medicaid Health Plans

Health Plan Name	**Aetna Better Health, Inc. dba Aetna Better Health of Louisiana**		
Client Name	**Louisiana Department of Health and Hospitals**		
Lead State Program Manager Contact Information	**Name**	Stacy J. Guidry	
	Title	Section Chief – Medicaid Program Operations and Compliance	
	Phone Number	337-857-6115	
	Email	stacy.guidry@la.gov	
Populations Served	Healthy Louisiana—Medicaid and Children's Health Insurance Program (CHIP)—Temporary Assistance for Needy Families (TANF), CHIP, Aged, Blind, and Disabled (ABD), Affordable Care Act (ACA)	**Number of Individuals Served**	119,494
		Health Plan Tenure in the State	February 2015 – Present
Key Responsibilities	Aetna Better Health of Louisiana provides managed care services for CHIP, TANF, pregnant women, breast and cervical cancer program, ABD (including Supplemental Security Income [SSI], extended Medicaid programs, Medicaid purchase plan program, provisional Medicaid program, and over 65 and not disabled), continued Medicaid program, TB-infected individual program, ACA, specialized behavioral health, and voluntary opt-in populations as defined in 2.4.2 of the Model Contract. Covered services include but are not limited to medical, behavioral health, pharmacy, vision, dental, and non-emergency medical transportation (NEMT), including non-emergency ambulance transportation. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (02/01/2015 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
04/16/2019	Improper payments made to behavioral health service providers not complying with state law	Notice of Action	N/A	Closed
04/02/2019	Failure to meet prompt pay standards	Sanction	$105,000	Paid
02/25/2019	Failure to meet prompt pay performance standards	Sanction	$15,000	Paid
02/15/2019	Failed to validate provider directory data to ensure accurate data is on file for all contracted providers	Sanction	$50,000	Under appeal
12/04/2018	Failure to meet established benchmarks for quality improvement – performance measure outcomes	Sanction	$500,000	Paid
10/19/2018	Failed to conduct a member satisfaction survey for the specialized behavioral health population using the LDH-established methodology and survey template	Notice of Non-Compliance (NONC)	N/A	LDH will verify use of appropriate template with the 2019 surveys
06/25/2018	Provider directory accuracy does not reach 90%	NONC	$50,000	Paid

Health Plan Name	Aetna Better Health, Inc. dba Aetna Better Health of Louisiana			
06/01/2018	Claims reprocessing	Notice of Action	N/A	Closed
05/17/2018	HCPCS code update	Notice of Action	N/A	Closed
12/21/2017	Modernization project	Notice of Action	N/A	Closed
12/19/2017	Reporting – financial report timeliness	Sanction	$16,000	Paid
11/21/2017	Provider directory	NONC	N/A	Closed
10/25/2017	Regulatory reporting	NONC	$182,000	Paid
07/21/2017	Regulatory reporting	Sanction	$44,000	Paid
05/16/2017	Untimely processing of grievances	NONC	N/A	Closed
03/10/2017	Claims processing accuracy – RX rate changes	NONC	N/A	Closed
02/22/2017	Contract requirements – daily incremental TPL	NONC	N/A	Closed
01/18/2017	BH reports	NONC	N/A	Ongoing
09/20/2016	Failure to meet financial reporting requirements	Notice of Action	N/A	Closed
09/29/2016	Failure to pay interest	Notice of Action	N/A	Closed
07/19/2016	Reporting – encounter data	Notice of Monetary Penalty	$570,000	Paid
07/18/2016	Lack of TPL carrier code on EOPs	Notice of Action	N/A	Closed

Health Plan Name	Aetna Better Health, Inc. dba Aetna Better Health of Louisiana	
Client Name	**Louisiana Department of Health and Hospitals**	
Lead State Program Manager Contact Information	**Name**	Stacy J. Guidry
	Title	Section Chief – Medicaid Program Operations and Compliance
	Phone Number	337-857-6115
	Email	stacy.guidry@la.gov
Client Name	**Centers for Medicare & Medicaid Services**	
CMS Contact	**Name**	Donald Marik

Health Plan Name	Aetna Better Health, Inc. dba Aetna Better Health of Louisiana		
Information	Title	Health Insurance Specialist, CMS Account Manager/Aetna	
	Phone Number	303-844-2646	
	Email	Donald.Marik@cms.hhs.gov	
Populations Served	Medicare Advantage Dual-Eligible Special Needs Plan (D-SNP)—Duals	Number of Individuals Served	143[9]
		Health Plan Tenure in the State	January 1, 2019 - Present
Key Responsibilities	Aetna Better Health of Louisiana offers Medicare Advantage D-SNP services for dually eligible members. Covered services include abdominal aortic aneurysm screening, ambulance, annual wellness, bone mass measurement, breast cancer screening, cardiac rehabilitation, cardiovascular disease testing, cervical and vaginal cancer screening, chiropractic services, colorectal cancer screening, dental, hearing, depression screening, diabetes screening/training/supplies, DME, emergency care, personal emergency response/medical alert system, pharmacy/RX, home health care, hospice, immunizations, inpatient hospital care, inpatient mental health care, meal benefit, medical nutritional therapy, obesity screening and therapy, outpatient services (lab/X-ray/surgical supplies), outpatient rehab services, outpatient substance abuse services, outpatient surgery, physician services, podiatry, prostate cancer screening, prosthetic devices, pulmonary rehab, alcohol misuse screening and counseling, lung cancer screening, std screening, services to treat kidney disease, skilled nursing facility care, smoking and tobacco cessation, supervised exercise therapy, transportation services, urgent care, and vision care. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Current Contract Term (01/01/2019 – Present)			
None			

Health Plan Name	Aetna Better Health of California Inc.		
Client Name	California Department of Health Care Services (DHCS), Medi-Cal Managed Care Division		
Lead State Program Manager Contact Information	Name	Stephanie Issertel	
	Title	Contract Manager, Central Operations Unit	
	Phone Number	916-633-0193	
	Email	Stephanie.Issertel@dhcs.ca.gov	
Populations Served	Medi-Cal Managed Care Contract—ABD/SSI, CHIP, Long Term Services and Supports (LTSS), TANF	Number of Individuals Served	11,061
		Health Plan Tenure in the State	January 2018 – Present

[9] Membership as of January 1, 2019

Health Plan Name	Aetna Better Health of California Inc.
Key Responsibilities	Aetna Better Health of California Inc. provides managed care services for Medicaid and CHIP populations, including seniors and persons with disabilities, pregnant women, infants, children, children/youth with special health care needs, low-income adults, children in foster care, individuals receiving SSI, and individuals receiving LTSS. Covered services include medical, BH, pharmacy, vision, and dental. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.

Compliance Actions During the Current Contract Term (01/01/2018 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
07/09/2018	Annual network certification submission and identified deficiencies	CAP	N/A	Closed
06/05/2018	Delegation oversight - DHCS has required Aetna Better Health of California Inc. (ABH-CA) and other Medi-Cal managed health care plans (MCPs) to implement CAPs to address discrepancies and fraudulent activities by a Management Services Organization that was sub-delegated by ABH-CA and other MCPs for claims and utilization management functions.	CAP	N/A	Open

Health Plan Name	Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida		
Client Name	Florida Healthy Kids Corporation		
Lead State Program Manager Contact Information	Name	Lindsay Lichti	
	Title	Health and Dental Plan Contract Manager	
	Phone Number	850-224-5437	
	Email	lichtil@healthykids.org	
Populations Served	Florida Healthy Kids – CHIP	Number of Individuals Served	49,820
		Health Plan Tenure in the State	1993 – Present
Key Responsibilities	Aetna Better Health of Florida provides managed care services for the Florida Healthy Kids CHIP population for children ages 0 to 18. Covered services include medical, BH, pharmacy, vision, dental, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (10/01/2015 – Present)

None

Health Plan Name	Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida	
Client Name	Florida Department of Children and Families—Southern Region	
Lead State Program Manager Contact Information	Name	Debra Scott-Clark
	Title	Government Operations Consultant III
	Phone Number	850-412-4026
	Email	Debra.Scott-Clark@ahca.myflorida.com

Health Plan Name	Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida		
Populations Served	Statewide Medicaid Managed Care—Managed Medical Assistance—Medicaid only—TANF, ABD, LTSS, dually eligible individuals	**Number of Individuals Served**	52,226
		Health Plan Tenure in the State	January 2014 – Present
Key Responsibilities	Aetna Better Health of Florida provides managed care services for TANF, ABD, LTSS, and dually eligible individuals, including pregnant women, infants, children, low-income families and adults, individuals receiving SSI, and LTSS individuals. Covered services include medical, BH, home- and community-based services (HCBS)/LTSS, pharmacy, vision, dental, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (12/01/2018 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
2/25/2019	Timely report violations in the access, use and disclosure of PHI	Sanction	$4,000	Paid
02/18/2019	Encounter data submission requirements regarding timeliness	Sanction	$2,000	Paid

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Illinois		
Client Name	**Illinois Department of Healthcare and Family Services**		
Lead State Program Manager Contact Information	**Name**	Laura Phelan	
	Title	Contract Monitor, Bureau of Managed Care, Division of Medical Programs	
	Phone Number	312-793-1587	
	Email	Laura.Phelan@illinois.gov	
Populations Served	Family Health Plan – Affordable Care Act Contract – TANF, ACA	**Number of Individuals Served**	189,113
		Health Plan Tenure in the State	August 2014 – December 2017[10]
Key Responsibilities	Aetna Better Health of Illinois provided managed care services for the TANF and ACA populations, including pregnant women, infants, children, children/youth with special health care needs, low-income adults, and individuals on SSI. Covered services included medical, BH, HCBS/LTSS, pharmacy, vision, dental, and NEMT. Key responsibilities included physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Final Contract Term (07/11/2014 – 12/31/2017)

[10] With runout responsibilities to continue through December 31, 2019

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Illinois			
Date of Action	**Category**	**Compliance Action Type**	**Monetary Sanction (if applicable)**	**Final Disposition**
10/17/2017	Reporting – encounter data	Sanction	$50,000	Paid
05/16/2017	Failure to provide covered services	Sanction	$28,733	Paid
04/27/2016	Quality of care; health risk assessments issue	CAP	N/A	Closed
03/22/2016	Non-Compliance of Telephone Access Standards	CAP	N/A	Closed
05/12/2015	Failure to provide waiver services	Sanction	$25,000	Paid

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Illinois		
Client Name	**Illinois Department of Healthcare and Family Services**		
Lead State Program Manager Contact Information	**Name**	Laura Phelan	
	Title	Contract Monitor, Bureau of Managed Care, Division of Medical Programs	
	Phone Number	312-793-1587	
	Email	Laura.Phelan@illinois.gov	
Populations Served	Integrated Care Plan Contract—ABD, LTSS	**Number of Individuals Served**	28,565
		Health Plan Tenure in the State	April 2011 – December 2017[11]
Key Responsibilities	Aetna Better Health of Illinois provided managed care services for the ABD and LTSS populations, low-income adults, and individuals on SSI. Covered services included medical, BH, HCBS/LTSS, pharmacy, vision, dental, and NEMT. Key responsibilities included physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Final Contract Term (04/27/2011 – 12/31/2017)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
05/04/2018	Grievance and appeals timeliness & accuracy	CAP	N/A	Closed

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Illinois	
Client Name	**Illinois Department of Healthcare and Family Services**	
Lead State Program Manager Contact Information	**Name**	Laura Phelan
	Title	Contract Monitor, Bureau of Managed Care, Division of Medical Programs

[11] With runout responsibilities to continue through December 31, 2019

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Illinois		
	Phone Number	312-793-1587	
	Email	Laura.Phelan@illinois.gov	
Populations Served	Managed Long-Term Services and Supports Program—LTSS	**Number of Individuals Served**	7,221
		Health Plan Tenure in the State	July 2016 – December 2017[12]
Key Responsibilities	Aetna Better Health of Illinois provided managed care services for the managed LTSS and dually eligible population, including individuals aged 65 and older and adults with disabilities requiring long-term care. Covered services included medical, BH, HCBS/LTSS, pharmacy, vision, dental, and NEMT. Key responsibilities included physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Final Contract Term (06/17/2016 – 12/31/2017)			
None			

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Illinois Premier Plan		
Client Name	**Illinois Department of Healthcare and Family Services**		
Lead State Program Manager Contact Information	**Name**	Laura Phelan	
	Title	Contract Monitor, Bureau of Managed Care, Division of Medical Programs	
	Phone Number	312-793-1587	
	Email	Laura.Phelan@illinois.gov	
Client Name	**Centers for Medicare & Medicaid Services**		
CMS Contact Information	**Name**	Chad Johnson	
	Title	Health Insurance Specialist, CMS Customer Relations Branch	
	Phone Number	312-353-1269	
	Email	Benjamin.Johnson@cms.hhs.gov	
Populations Served	Medicare-Medicaid Alignment Initiative—Duals	**Number of Individuals Served**	7,247
		Health Plan Tenure in the State	November 2013 – Present
Key Responsibilities	Aetna Better Health of Illinois provides managed care services for individuals dually eligible for Medicare and Medicaid. Covered services include medical, BH, HCBS/LTSS, pharmacy, vision, dental, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Current Contract Term (01/01/2018 – Present)			

[12] With runout responsibilities to continue through December 31, 2019

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Illinois Premier Plan			
Date of Action	**Category**	**Compliance Action Type**	**Monetary Sanction (if applicable)**	**Final Disposition**
10/18/2018	2018 Accuracy and Accessibility Study – Interpreter Availability Measure	NONC	N/A	Closed

Health Plan Name	Aetna Better Health of Kansas Inc.		
Client Name	**Kansas Department of Health and Environment Division of Health Care Finance**		
Lead State Program Manager Contact Information	**Name**	Shirley Norris	
	Title	Senior Manager, MCO Operations	
	Phone Number	785-296-4767	
	Email	Shirley.Norris@ks.gov	
Populations Served	KanCare 2.0—ABD/SSI, CHIP, Intellectual and Developmental Disabilities (I/DD), LTSS, Serious Mental Illness (SMI), TANF	**Number of Individuals Served**	107,621[13]
		Health Plan Tenure in the State	January 2019 - Present
Key Responsibilities	Aetna Better Health of Kansas Inc. provides managed care services for Medicaid and CHIP populations, including seniors and persons with disabilities, pregnant women, infants, children, children/youth with special health care needs, low-income adults, individuals receiving SSI, and individuals receiving LTSS. Dually eligible, children in foster care, and children with special health care needs populations can voluntarily enroll in the program. Covered services include medical, BH, pharmacy, dental, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Current Contract Term (01/01/2019 – Present)			
None			

Health Plan Name	Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky		
Client Name	**Kentucky Cabinet for Health and Family Services**		
Lead State Program Manager Contact Information	**Name**	Catherine York	
	Title	Deputy General Counsel, Office of the Secretary	
	Phone Number	502-564-7905 x 3422	
	Email	Catherine.York@Ky.gov	
Populations Served	Kentucky Medicaid and KCHIP—TANF, CHIP, ABD, ACA, Dually Eligible Individuals, Foster Care	**Number of Individuals Served**	224,908
		Health Plan Tenure in the State	July 2011 – Present

[13] Aetna Better Health of Kansas began operations on January 1, 2019. The number of individuals served is as of January 31, 2019.

Health Plan Name	Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky
Key Responsibilities	Aetna Better Health of Kentucky provides managed care services for the TANF, CHIP, ABD, ACA, and dually eligible populations, including pregnant women, infants, children, children/youth with special health care needs, low-income adults, children in foster care, individuals receiving SSI, ACA individuals, and dually eligible enrollees. Covered services include medical, BH, pharmacy, vision, and dental. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.

Compliance Actions During the Current Contract Term (11/01/2011 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
04/02/2019	Issue with subcontractor out of compliance with contract	CAP	N/A	Open
03/15/2019	Reporting – encounter data	Sanction	$308,272	Paid
03/06/2019	Issue with subcontractor out of compliance with contract	NONC	N/A	Open
02/15/2019	Reporting – encounter data	Sanction	$309,936	Paid
01/18/2019	Reporting – encounter data	Sanction	$317,383	Paid
01/15/2019	Duplicate pharmacy encounters	NONC	N/A	
12/21/2018	Reporting – encounter data	Sanction	$359,577	Paid
11/16/2018	Reporting – encounter data	Sanction	$295,822	Paid
10/30/2018	Issue with subcontractor out of compliance with contract	CAP	N/A	
10/26/2018	Identified encounters that are out of compliance with coding guidelines	CAP	N/A	
10/20/2018	Reporting – encounter data	Sanction	$574,889	Paid
09/14/2018	Reporting – encounter data	Sanction	$395,405	Paid
09/13/2018	Issue with subcontractor out of compliance with contract	CAP	N/A	Open
08/18/2018	Reporting – encounter data	Sanction	$326,900	Paid
07/25/2018	Reporting – encounter data	Sanction	$15,840	Paid
06/21/2018	Withhold forfeiture due to legacy issues	Withhold Forfeiture	$246,253	Paid
06/15/2018	Reporting – encounter data	Sanction	$369,905	Paid
05/18/2018	Reporting – other data	Sanction	$419,408	Paid
04/20/2018	Reporting – encounter data	Sanction	$307,342	Paid
03/27/2018	Contractual requirements not met	Sanction	$5,000	Paid
03/16/2018	Reporting – encounter data	Sanction	$333,699	Paid
02/16/2018	Reporting – encounter data	Sanction	$462,165	Paid
01/18/2018	Reporting – encounter data	Sanction	$372,948	Paid
01/24/2018	Contractual requirements not met	CAP	N/A	Closed
12/20/2017	Contractual requirements not met	CAP	N/A	Closed
12/19/2017	Contractual requirements not met	CAP	N/A	Closed
12/18/2017	Reporting – encounter data	Sanction	$408,703	Paid
11/17/2017	Reporting – encounter data	Sanction	$370,928	Paid
10/20/2017	Reporting – encounter data	Sanction	$373,469	Paid
09/28/2017	Claims processing timeliness	NONC	N/A	Closed

Health Plan Name	Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky			
09/19/2017	Claims processing accuracy	Sanction	$15,000	Paid
09/19/2017	Claims processing accuracy	Sanction	$25,000	Paid
09/19/2017	Claims processing accuracy	Sanction	$25,000	Paid
09/18/2017	Reporting – encounter data	Sanction	$361,928	Paid
09/14/2017	Credentialing	NONC	N/A	Closed
09/13/2017	Fee schedule changes	NONC	N/A	Closed
08/18/2017	Claims processing accuracy	CAP	N/A	Closed
08/18/2017	Claims processing accuracy	CAP	N/A	Closed
08/17/2017	Reporting – other data	CAP	N/A	Closed
08/16/2017	Reporting – encounter data	Sanction	$360,217	Paid
08/14/2017	Claims processing timeliness	CAP	N/A	Closed
08/10/2017	Untimely response to regulator	Sanction	$1,000	Paid
08/09/2017	Claims processing timeliness	CAP	N/A	Closed
07/26/2017	Contract requirements	Sanction	$10,000	Paid
07/26/2017	Claims processing accuracy	CAP	N/A	Closed
07/24/2017	Fee schedule changes	NONC	N/A	Closed
07/24/2017	Credentialing	CAP	N/A	Closed
07/21/2017	Reporting – encounter data	Sanction	$359,095	Paid
07/17/2017	Claims processing accuracy	CAP	N/A	Closed
06/27/2017	Audit/review	Sanction	$25,000	Paid
06/23/2017	Reporting – encounter data	Sanction	$375,080	Paid
06/08/2017	Claims processing accuracy	CAP	N/A	Closed
06/08/2017	Claims processing timeliness	CAP	N/A	Closed
05/24/2017	Fee schedule changes	CAP	N/A	Closed
05/18/2017	Reporting – encounter data	Sanction	$359,813	Paid
05/09/2017	Call center report	NONC	N/A	Closed
04/17/2017	Reporting – encounter data	Sanction	$359,594	Paid
03/16/2017	Claims processing accuracy	CAP	N/A	Closed
03/15/2017	Reporting – encounter data	Sanction	$399,264	Paid
03/13/2017	Contract requirements	NONC	N/A	Closed
03/09/2017	Claims processing timeliness	CAP	N/A	Closed
02/17/2017	Reporting – encounter data	Sanction	$366,816	Paid
02/16/2017	Claims processing timeliness	CAP	N/A	Closed
02/08/2017	Claims processing accuracy	CAP	N/A	Closed
01/24/2017	Other	CAP	N/A	Closed
01/17/2017	Reporting – encounter data	Sanction	$450,174	Paid
12/12/2016	Claims processing accuracy	Letter of Concern	N/A	Closed
12/01/2016	Reporting – encounter data	Sanction	$450,175	Paid
11/22/2016	Claims processing accuracy	CAP	N/A	Closed
11/22/2016	Claims processing accuracy	CAP	N/A	Open
11/16/2016	Claims processing accuracy	CAP	N/A	Closed
11/09/2016	Claims processing timeliness	CAP	N/A	Closed
11/07/2016	Provider charged for ER triage claims	CAP	N/A	Closed
11/07/2016	Claims processing accuracy	CAP	N/A	Closed
11/03/2016	Reporting – encounter data	Letter of Concern	N/A	Closed

Health Plan Name	Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky			
11/03/2016	Reporting – encounter data	Sanction	$363,762	Paid
10/25/2016	Subcontractor mistakenly terminated a provider	CAP	N/A	Closed
10/25/2016	Reporting – encounter data	Sanction	$272,624	Paid
10/21/2016	Claims processing timeliness	Letter of Concern/CAP	N/A	Closed
10/21/2016	Claims processing timeliness	CAP	N/A	Conditional acceptance of CAP
10/19/2016	Provider complaint regarding lack of responsiveness to inquiries by the plan	Letter of Concern	N/A	Closed
10/13/2016	Response to inquiry dated July 14, 2016 regarding provider payment suspension process.	Letter of Concern	N/A	Open
10/11/2016	Lack of submission of information required for SFY 2016.	CAP	N/A	Closed
10/10/2016	Behavioral health providers not enrolled timely	CAP	N/A	Closed
10/10/2016	Plan failed to collect change of ownership information from pharmacy provider	Letter of Concern	N/A	Closed
09/29/2016	Complaint to DMS regarding lack of responsiveness by the plan	Letter of Concern	N/A	Closed
09/29/2016	Reporting – encounter data	Sanction	$78,928	Paid
09/28/2016	Claims processing accuracy	CAP	N/A	Closed
09/23/2016	Claims processing timeliness	CAP	N/A	Closed
09/23/2016	Claims processing accuracy	CAP	N/A	Closed
09/23/2016	Plan did not meet contract requirements for credentialing timeliness	CAP	N/A	Closed
09/23/2016	Claims processing accuracy	CAP	N/A	Closed
09/23/2016	Report submitted containing insufficient information	Letter of concern	N/A	Closed
09/23/2016	Plan did not state which SIU provider site visit were announced vs unannounced	Letter of Concern	N/A	Closed
09/23/2016	Technical issue with TPL file submission	Letter of Concern	N/A	Closed
09/12/2016	Claims processing accuracy	CAP	N/A	Closed
09/08/2016	Claims processing accuracy	Letter of concern	N/A	Closed
09/01/2016	Claims processing accuracy	Withhold and Forfeiture/CAP	$141,839	Closed
09/01/2016	Failure to cooperate under Section 28.0, Provider Services (lack of response to provider inquiries)	Withhold and Forfeiture	$280,000	Closed
08/29/2016	Claims processing accuracy	CAP	N/A	Closed
08/29/2016	Claims processing accuracy	CAP	N/A	Closed
08/29/2016	Claims processing timeliness	CAP	N/A	Closed

Health Plan Name	Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky			
08/29/2016	Failure by plan staff to follow protocol for coordination between two state agencies	Letter of Concern	N/A	Closed
08/29/2016	Reporting – encounter data	Sanction	$26,381	Paid.
08/25/2016	Claims processing accuracy	CAP	N/A	Closed
08/25/2016	Provider system issues related to system migration	CAP	N/A	Closed
08/10/2016	Untimely response to state inquiry	CAP	N/A	Closed
07/28/2016	Reporting – encounter data	CAP	N/A	Closed
07/28/2016	Reporting – encounter data	CAP	N/A	Closed
07/28/2016	Reporting – encounter data	CAP	N/A	Closed
07/28/2016	Reporting – encounter data	Sanction	$229,250	Paid
07/26/2016	TPL file technical issues	CAP	N/A	Closed
07/20/2016	Reporting – encounter data	Letter of Concern	N/A	Closed
07/15/2016	Lack of ability to specifically identify SIU investigations originating from service verifications letters	Letter of Concern	N/A	Closed
07/15/2016	Concern related to low SIU staff to case load ratio	Letter of Concern	N/A	Closed
07/15/2016	Plan provided incomplete response to state inquiry	Letter of Concern	N/A	Closed
07/15/2016	Plan response to DMS inquiry regarding TPL failed to specify timeframes in the Plan's processes.	Letter of Concern	N/A	Open pending validation
07/08/2016	Plan provided incomplete information for program integrity audit	CAP	N/A	Closed
06/29/2016	Lack of dermatologists	CAP	N/A	Closed
06/29/2016	Untimely response to state inquiry	CAP	N/A	Closed
06/29/2016	Reporting – encounter data	Sanction	N/A	Closed
06/14/2016	Reporting – encounter data	CAP	N/A	Closed
06/09/2016	Result of IPRO audit; dental access and availability standards not met	CAP	N/A	Closed
06/07/2016	Reporting – encounter data	CAP	N/A	Closed
05/31/2016	Reporting – encounter data	Sanction	$225,670	Paid
05/31/2016	Unsecure email sent from subcontractor to state	Letter of Concern	N/A	Closed
05/26/2016	Claims processing timeliness	CAP	N/A	Closed
05/26/2016	Claims processing accuracy	CAP	N/A	Closed
05/10/2016	Lack of dermatologists	Letter of Concern	N/A	Closed
05/09/2016	Untimely resolution to void a claim from provider/DMS	CAP	N/A	Closed
04/04/2016	Reporting – encounter data	Sanction	$144,250	Paid
04/04/2016	Untimely response to grievance and appeals	CAP	N/A	Closed
03/31/2016	Incomplete reporting - monitoring for subcontractors delegated vendor audit dates not listed in report	Letter of Concern	N/A	Closed
03/30/2016	Claims processing Accuracy	CAP	N/A	Closed

Health Plan Name	Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky			
03/30/2016	Claims processing Accuracy	CAP	N/A	Closed
03/25/2016	Lack of sufficient training of provider relations staff	CAP	N/A	Closed
03/23/2016	Call center report- 1 out of 1,843 calls received a busy signal to the Behavioral Health Services Hotline	Letter of Concern	N/A	Closed
03/18/2016	Claims processing accuracy	Letter of Concern	N/A	Closed
03/18/2016	TPL file was not submitted timely	CAP	N/A	Closed
03/07/2016	Claims processing timeliness	Letter of Concern	N/A	Closed
03/04/2016	Reporting – encounter data	Sanction	$131,385	Paid
03/04/2016	Claims processing accuracy	Letter of Concern	N/A	Closed
02/29/2016	Provider Network file errors due to migration	Letter of Concern	N/A	Closed
02/29/2016	Vendors Provider Manual required updating	CAP	N/A	Closed
02/29/2016 04/08/2013	Claims processing accuracy	CAP	N/A	Closed
02/29/2016	Claims processing accuracy	CAP	N/A	Closed
02/22/2016	Reporting – encounter data	CAP	N/A	Closed
02/22/2016	Reporting – encounter data	CAP	N/A	Closed
02/18/2016	Untimely responses to providers, DMS, and DOI	CAP	$283,000	Closed
02/18/2016	Provider Network file errors due to migration	CAP	$283,000	Closed
02/16/2016	Claims processing accuracy	Letter of Concern	N/A	Closed
02/12/2016	Action plan requested to address migration issue where member eligibility files were not complete	CAP	N/A	Closed
02/12/2016	Action plan requested to address migration issue where foster care population was affected by incomplete member eligibility files	CAP	$567,000 Withhold	Closed
02/02/2016	Reporting – encounter data	Sanction	$134,135	Paid
01/28/2016	Claims processing accuracy	Letter of Concern	N/A	Closed
01/26/2016	Non-compliance with Program Integrity contract requirements assessed in EQRO review	CAP	$560,000 Withhold	Closed
01/26/2016	Claims processing accuracy	Letter of Concern	N/A	Closed
01/19/2016	Reporting – encounter data	CAP	N/A	Closed
01/19/2016	Network deficiency	CAP	N/A	Closed
01/16/2016	Action plan requested to ensure members are not forwarded to DMS to update TPL information	CAP	N/A	Closed
01/14/2016	Subcontractor provider network file errors	CAP	N/A	Closed

Health Plan Name	Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky			
01/11/2016	Audit/review	Audit/Review	N/A	Closed
01/01/2016	Reporting – encounter data	Sanction	$122,320	Paid
12/01/2015	Reporting – encounter data	Sanction	$188,900	Paid
07/14/2015	Clarification requested of a report not received timely	CAP	N/A	Closed
06/10/2015	Reporting – encounter data	CAP	N/A	Closed
05/11/2015	Member received correspondence with "Domestic Violence" written on the envelope	Letter of Concern	N/A	Closed
05/6/2015	Subcontractor report did not reflect all subcontractors	Letter of Concern	N/A	Closed
	Reporting – encounter data	CAP	N/A	Closed
05/4/2015	Grievance and Appeals report did not include requests for disenrollment for cause	Letter of Concern	N/A	Closed
04/17/2015	Failure to meet pre-determined goals of demonstrable or sustained improvement of PIP	CAP	N/A	Closed
03/24/2015	Network deficiency	CAP	N/A	Closed
03/09/2015	Audit/Review	Audit/Review	N/A	Closed
11/03/2014	Audit/Review	Audit/Review	N/A	Closed
03/14/2014	Claims processing timeliness	CAP	N/A	Closed
10/15/2013	Claims processing timeliness	Sanction	$5,000	Closed
04/08/2013	Audit/Review	Audit/Review	N/A	Closed

Health Plan Name	**Aetna Health Inc. dba Aetna Better Health of Maryland**		
Client Name	**Maryland Department of Health and Mental Hygiene HealthChoice**		
Lead State Program Manager Contact Information	**Name**	Susan Tucker	
	Title	Executive Director	
	Phone Number	410-767-1430	
	Email	Susan.Tucker@Maryland.gov	
Populations Served	HealthChoice – TANF, CHIP	**Number of Individuals Served**	15,384
		Health Plan Tenure in the State	November 2017 – Present
Key Responsibilities	Aetna Better Health of Maryland provides managed care services for the TANF and CHIP populations, including pregnant women, infants, children, and children/youth with special health care needs, low-income adults, and individuals receiving SSI effective January 1, 2018. Covered services include medical, BH, pharmacy, and vision, as well as adult dental and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (01/01/2019 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition

Health Plan Name	Aetna Health Inc. dba Aetna Better Health of Maryland
None	

Health Plan Name	Aetna Better Health of Michigan Inc.		
Client Name	**Michigan Department of Health and Human Services**		
Lead State Program Manager Contact Information	**Name**	M. Cooley	
	Title	Contract Manager, Integrated Care Division, Medical Services Administration	
	Phone Number	517-335-6603	
	Email	CooleyM2@michigan.gov	
Client Name	**Centers for Medicare & Medicaid Services**		
CMS Contact Information	**Name**	Kimberly Honey	
	Title	CMS Regional Office Account Manager	
	Phone Number	312-886-7903	
	Email	Kimberly.Honey1@cms.hhs.gov	
Populations Served	Demonstration to Integrate Care for Persons Eligible for Medicare and Medicaid (MMP) – Duals	**Number of Individuals Served**	7,047
		Health Plan Tenure in the State	October 2014 – Present
Key Responsibilities	Aetna Better Health of Michigan Inc. provides managed care services for individuals dually eligible for Medicare and Medicaid. Covered services include medical, BH, HCBS/LTSS, pharmacy, vision, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Current Contract Term (01/01/2018 – Present)			
None			

Health Plan Name	Aetna Better Health of Michigan Inc.		
Client Name	**Michigan Department of Health and Human Services**		
Lead State Program Manager Contact Information	**Name**	Darryl Bragg	
	Title	Medicaid Contract Manager, Managed Care Plan Division	
	Phone Number	517-284-1164	
	Email	braggd@michigan.gov	
Populations Served	Michigan Medicaid-only Plan – TANF, ABD, ACA, CHIP[14]	**Number of Individuals Served**	37,985
		Health Plan Tenure in the State	October 2004 – Present

[14] The Healthy Michigan Plan (MIChild—CHIP) program was integrated into this contract on January 1, 2016.

Health Plan Name	Aetna Better Health of Michigan Inc.
Key Responsibilities	Aetna Better Health of Michigan Inc. provides a full scope of managed care services, including physical health (PH) and BH services, operations, medical management, and ancillary support functions (legal, actuarial, and financial management). In 2016, we began providing managed care services for the CHIP population, including children aged 0 to 18 years. Covered services include medical, pharmacy, vision, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.

Compliance Actions During the Current Contract Term (10/01/2018 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
02/25/2019	Program Integrity Report	CAP	N/A	Open
11/28/2018	Program Integrity Report	CAP	N/A	Closed
10/02/2018	August 2018 contract compliance review	CAP	N/A	Closed

Health Plan Name	Aetna Better Health of Missouri LLC		
Client Name	Missouri Department of Social Services, Missouri HealthNet Division		
Lead State Program Manager Contact Information	Name	Bobby Jo Garber	
	Title	Managed Care Director	
	Phone Number	573-526-4274	
	Email	bobbi.j.garber@dss.mo.gov	
Populations Served	Missouri HealthNet Managed Care – TANF and CHIP	Number of Individuals Served	273,905[15]
		Health Plan Tenure in the State	1995 – April 2017
Key Responsibilities	Aetna Better Health of Missouri LLC provided a full scope of managed care services, including PH and BH services, operations, medical management, and ancillary support functions (legal, actuarial, and financial management) to TANF and CHIP populations. Key responsibilities included physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Final Contract Term (07/01-2015 – 04/30/2017)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
01/06/2017	Credentialing	Sanction	$80,000	Paid
11/10/2016	Failure to meet contractual credentialing timeframes.	Sanction	$35,000	Paid
07/10/2016	Failure to meet staff requirements for case management supervisor for behavioral health services	CAP	N/A	Closed

[15] The enrollment numbers are as of April 30, 2017, which was the last month of the contract term.

Health Plan Name	Aetna Better Health of Missouri LLC			
06/01/2016	Reporting – encounter data	Withhold	$706,489	Closed
03/04/2016	Failure to notify state of subcontractor agreement (vendor)	Sanction	$16,300	Paid
03/01/2016	Encounter data reporting	Withhold	$142,384	Paid
02/01/2016	Encounter Data Reporting	Withhold	$1,669,687	Paid
12/14/2015	Claims Payment Concerns	CAP	N/A	Closed
9/8/2015	Failure to comply with contractually required administrative services	CAP	None	Closed
8/4/2015	Marketing violations-participation in community partners event without approval	CAP	None	Closed

Health Plan Name	Coventry Health Care of Nebraska, Inc. dba Aetna Better Health of Nebraska		
Client Name	Nebraska Department of Health and Human Services		
Lead State Program Manager Contact Information	Name	Heather Leschinsky	
	Title	Deputy Director	
	Phone Number	402-471-9185	
	Email	Heather.Leschinsky@nebraska.gov	
Populations Served	Medicaid and CHIP – TANF, CHIP, ABD	Number of Individuals Served	104,805[16]
		Health Plan Tenure in the State	April 2010 – December 2016
Key Responsibilities	Aetna Better Health of Nebraska provided managed care services for the TANF, CHIP, and ABD populations, including pregnant women, infants, children, children/youth with special health care needs, low-income families and adults, and individuals receiving SSI. Covered services included medical, vision, and NEMT. Key responsibilities included physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Final Contract Term (07/01/2015-12/31/2016)			
None			

Health Plan Name	Aetna Better Health of Nevada Inc. dba Aetna Better Health of Nevada	
Client Name	Department of Health and Human Services Division of Health Care Financing and Policy	
Lead State Program Manager Contact Information	Name	Tammy Ritter
	Title	Chief, Managed Care and Quality
	Phone Number	775-684-3655
	Email	tammy.ritter@dhcfp.nv.gov

[16] The membership number is as of December 2016, which was the last month of the contract term.

Health Plan Name	Aetna Better Health of Nevada Inc. dba Aetna Better Health of Nevada		
Populations Served	Medicaid and CHIP – TANF, CHIP, ACA	**Number of Individuals Served**	2,567[17]
		Health Plan Tenure in the State	July 2017 – August 2017
Key Responsibilities	Aetna Better Health of Nevada provided managed care services for the TANF, CHIP, and ACA populations, including pregnant women, infants, children, children/youth with special health care needs, and low-income adults. The scope of covered services included medical, BH, vision, dental, and NEMT. Key responsibilities included physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Final Contract Term (07/01/2017 – 08/31/2017)			
None			

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of New Jersey		
Client Name	**New Jersey Department of Human Services**		
Lead State Program Manager Contact Information	**Name**	Marc Gonzer	
	Title	Contract Manager	
	Phone Number	609-575-9389	
	Email	Mark.Gonzer@dhs.state.nj.us	
Populations Served	New Jersey FamilyCare – Medicaid and CHIP – TANF, CHIP-plus, ABD, ACA Expansion, LTSS, DDD, Dually Eligible Individuals	**Number of Individuals Served**	51,438
		Health Plan Tenure in the State	December 2014 – Present
Key Responsibilities	Aetna Better Health of New Jersey provides managed care services for Medicaid and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, low-income adults, children in foster care, individuals receiving SSI, ACA individuals, and individuals receiving LTSS. Covered services include medical, BH, pharmacy, vision, and dental. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (07/01/2018 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
12/31/2018	Duplicate encounters submission	Sanction	$8,374	Paid
09/21/2018	HEDIS data for calendar year 2016	Sanction	$369	Paid
09/18/2018	IPRO audit findings	CAP	N/A	CAP submitted

[17] The membership number is as of August 2017, which was the last month of the contract term.

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of New York		
Client Name	**New York Department of Health**		
Lead State Program Manager Contact Information	**Name**	Andrew Segal	
	Title	Director of LTSS	
	Phone Number	518-474-5515	
	Email	Andrew.Segal@health.ny.gov	
Populations Served	Managed Long-Term Care Partial Capitation Contract—LTSS	**Number of Individuals Served**	6,948
		Health Plan Tenure in the State	July 2012 – Present
Key Responsibilities	Aetna Better Health of New York arranges for covered benefits for LTSS members. Covered services include medical management, member services, provider relations, network contracting, and quality management. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (01/01/2016 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
05/01/2017	Deficiencies related to contracting, policies & procedures, notices to members, and approval of the quality plan	CAP	$0	Closed
06/2016	Capitation payments were made to the plan for members retro enrolled 11/2013 – 6/2016	Repayment of overpayment	$0	Closed
11/01/2017	Encounter submission completeness measure for Q1 and the accuracy measure for Q2	CAP	$115,000	Closed
04/01/2018	Encounter submission completeness measure for pharmacy	No sanction or penalty	$0	Closed after appeal
08/12/2018	Completeness measure for dental	No sanction or penalty	$0	Closed after appeal

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of New York	
Client Name	**New York Department of Health**	
Lead State Program Manager Contact Information	**Name**	Andrew Segal
	Title	Director of LTSS
	Phone Number	518-474-5515
	Email	Andrew.Segal@health.ny.gov
Client Name	**Centers for Medicare & Medicaid Services**	
CMS Contact	**Name**	Renee Bedell

Health Plan Name	**Aetna Better Health Inc. dba Aetna Better Health of New York**		
Information	**Title**	CMS Contract Administrator	
	Phone Number	212-616-2510	
	Email	Renee.Bedell@cms.hhs.gov	
Populations Served	Fully Integrated Duals Advantage program (MMP) – Duals	**Number of Individuals Served**	37[18]
		Health Plan Tenure in the State	September 2014 – December 2017
Key Responsibilities	Aetna Better Health of New York provided Medicare and Medicaid PH and BH care services to dually eligible members. Covered services include medical management, quality management, care management, member services, marketing, provider services, and network development. Key responsibilities included physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Current Contract Term (01/01/2016 – 12/31/2017)			
None			

Health Plan Name	**Aetna Better Health Inc. dba Aetna Better Health of Ohio**		
Client Name	**Ohio Department of Medicaid**		
Lead State Program Manager Contact Information	**Name**	Samuel Assoku	
	Title	Administrator	
	Phone Number	614-752-5552	
	Email	Samuel.Assoku@medicaid.ohio.gov	
Client Name	**Centers for Medicare & Medicaid Services**		
CMS Contact Information	**Name**	Kimberly D. Honey	
	Title	Regional Office Account Manager, CMS Division of Medicare Health Plans Operations	
	Phone Number	312-886-7903	
	Email	Kimberly.Honey1@cms.hhs.gov	
Populations Served	MyCare Ohio Plan (MMP) – Duals	**Number of Individuals Served**	25,015
		Health Plan Tenure in the State	June 2014 – Present
Key Responsibilities	Aetna Better Health of Ohio provides managed care services for dually eligible members. Covered services include medical, care management (waiver-only), pharmacy, dental, vision, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Current Contract Term (02/2014 – Present)			

18 The membership number is as of December 2017, which was the last month of the contract term.

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Ohio			
Date of Action	**Category**	**Compliance Action Type**	**Monetary Sanction (if applicable)**	**Final Disposition**
03/25/2019	PA urgent timeliness Q3 2018	NONC		Reconsideration pending
02/25/2019	Managed Care Plan (MCP) 3 HEDIS Quality Measures Results CY 2016 and CY 2017	NONC	$372,010 ($248,006 potentially refundable)	Open
11/19/2018	Prompt Pay Q2 2018	NONC	$59,077	Refunded
10/15/2018	Care management Program	Sanction	$5,000	Paid
02/13/2018	Network adequacy	NONC	N/A	$1,000 Sanction rescinded
02/08/2018	Network adequacy	NONC	$1,000	Rescinded
01/30/2018	Waiver incident reporting	Sanction and CAP	$10,000	Paid / Open
11/17/2017	Network adequacy	NONC	N/A	Closed
09/22/2017	Audit/review (EQRO)	CAP	N/A	Closed
08/03/2017	Deficiency in certain provider types	NONC	$2,000	Paid
05/10/2017	Care management chart audit found deficiencies	Response to Request for Reconsideration/ NONC/CAP and Sanction	$5,000	Paid/Closed
12/20/2016	Plan had a non-pharmacy prior authorization average turnaround time of 14 days and 18.733 hours for Q3 CY 2016	CAP	N/A	Closed
12/30/2016	Untimely incident reporting	NONC/CAP	N/A	Open
07/27/2016	Deficiency in certain provider type	NONC	$1,000	Rescinded
01/13/2016	MCPN file for 1/11/16	Sanction	$3,000	Paid
12/29/2015	Call centers (NA Nov)	CAP	$20,000	Paid/Closed
11/06/2015	MCPN file for October 2015	Sanction	$1,000	Paid
09/22/2015	Grievance file submissions	CAP/Sanction	$10,000	Paid/Closed
08/27/15	Care management Excel file	CAP	N/A	Rescinded
08/18/2015	MCPN file	Sanction	$13,000	Paid
08/14/2015	HSAG case management audit	CAP/Sanction		Paid/Closed
08/11/2015	Call centers (NA June 2015)	CAP/Sanction	$5,000	Paid/Closed
03/16/2015	Marketing materials	CAP/Sanction	$5,000	Paid/Closed
03/12/2015	Call centers (MS January 2015)	CAP	N/A	Closed
02/23/2015 & 03/10/2015	Marketing materials – joint NONC with CMS	NONC	N/A	Closed
03/05/2015	Alert reporting	CAP	N/A	Closed
01/06/2015	Call centers (MS November 2014)	CAP	N/A	Closed

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Ohio			
10/16/2014	Call centers (CM and BH August 2014)	CAP	N/A	Closed
09/02/2014	Morningstar	CAP	N/A	Closed
08/28/2014	Call centers (MS, BH, CM June and July 2014)	CAP	N/A	Closed
05/23/2014	Incident training	CAP	N/A	Closed

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Pennsylvania		
Client Name	**Pennsylvania Department of Human Services**		
Lead State Program Manager Contact Information	**Name**	Laurie Rock	
	Title	Bureau Director	
	Phone Number	717-772-6197	
	Email	lrock@pa.gov	
Populations Served	HealthChoices—Medicaid only—TANF, ABD, Medicaid Expansion	**Number of Individuals Served**	199,493
		Health Plan Tenure in the State	April 2010 – Present
Key Responsibilities	Aetna Better Health of Pennsylvania provides managed care services to the TANF, ABD, ACA expansion, and dually eligible individuals under age 21, including pregnant women, infants, children, children/youth with special health care needs, low-income adults, individuals receiving SSI, and ACA individuals. Covered services include medical, pharmacy, vision, dental, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (04/01/2010 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
08/20/2018	Access standards	CAP	N/A	Closed
12/05/2017	Claims processing accuracy	Sanction	$4,000	Paid
11/06/2017	Claims processing accuracy	Sanction	$333	Paid
06/06/2017	Claims processing accuracy	Sanction	$7,667	Paid
05/03/2017	Claims processing accuracy	Sanction	$8,667	Paid
04/28/2017	Policies and procedures	CAP	N/A	Closed
03/02/2017	Claims processing accuracy	Sanction	$333	Paid
01/25/2017	Reporting – other data	CAP	N/A	Closed
12/01/2016	Coverage of a drug marketed by a drug company (or labeler) who does not participate in the Medicaid Drug Rebate program; failure to submit formulary or preferred drug list to Department of Human Services for annual review	CAP	N/A	Open
08/01/2016	Claims processing timeliness	Sanction	$333	Sanction waived
Aug – 16	Claims processing timeliness	Sanction	$333	Sanction waived
Oct – 15	Claims processing timeliness	Sanction	$2000	Paid

Health Plan Name	Aetna Better Health Inc. dba Aetna Better Health of Pennsylvania			
Sept - 15	Claims processing timeliness	Sanction	$1333	Paid
Jan – 14	Access standards related to dental services	CAP	N/A	Closed
Jan – 14	Unclear and confusing wording on complaint/grievance decision letters also concern over Benefit Limit Exception explanation.	CAP	N/A	Closed
Aug – 13	DHS/Mercer program integrity review	CAP	N/A	Closed
Jan – 13	Claims processing timeliness	Sanction	$20,000	Paid
Dec – 12	Claims processing timeliness	Sanction	$20,000	Paid
Nov – 12	Claims processing timeliness	Sanction	$20,000	Paid
Nov – 12	Claims processing timeliness	Sanction	$10,666	Paid
Oct – 12	Claims processing timeliness	Sanction	$11,000	Paid
Aug – 12	Claims processing timeliness	Sanction	$8,667	Paid
July – 12	Claims processing timeliness	Sanction	$12,666	Paid
June – 12	Claims processing timeliness	Sanction	$9,000	Paid
May – 12	Claims processing timeliness	Sanction	$2,000	Paid
April – 12	Claims processing timeliness	Sanction	$4,000	Paid
Mar – 12	Claims processing timeliness	Sanction	$667	Paid
Jan – 12	5010 certifications, as of 1/24/2012 only 3 out of 7 transactions had been certified	CAP	N/A	Closed

Health Plan Name	Aetna Health Inc. dba Aetna Better Health Kids		
Client Name	Pennsylvania Department of Human Services		
Lead State Program Manager Contact Information	Name	Patricia Allan	
	Title	Director	
	Phone Number	717-787-9884	
	Email	pmallan@pa.gov	
Populations Served	CHIP	Number of Individuals Served	19,177
		Health Plan Tenure in the State	December 1993 – Present
Key Responsibilities	Aetna Better Health Kids provides a full scope of CHIP managed care services, including PH and BH services, operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Current Contract Term (12/01/2013 – Present)			

Health Plan Name	Aetna Health Inc. dba Aetna Better Health Kids			
Date of Action	**Category**	**Compliance Action Type**	**Monetary Sanction (if applicable)**	**Final Disposition**
Apr-18	National Committee for Quality Assurance (NCQA); one element (UM5D) fell below the 80% compliance rate for NCQA	CAP	N/A	Closed
Sept – 16	As a result of a finding in the annual A-133 audit related to income calculation deficiencies a CAP was submitted with the final report.	CAP	N/A	CAP was approved and accepted
Jan – 16	Income calculation utilized in determining eligibility was not done according to the CHIP Policy & Procedure Manual	CAP	N/A	CAP was approved and accepted
Sept – 14	Plan Pharmacy Encounters performance was 104% when the allowable variance is within 2% from the Standard Measure of 100%	CAP	$1,000	Sanction paid, CAP accepted

Health Plan Name	Aetna Better Health of Texas Inc. dba Aetna Better Health of Texas or Aetna Better Health		
Client Name	**Texas Health and Human Services**		
Lead State Program Manager Contact Information	**Name**	Trinita Harris, CTCM	
	Title	Manager II, Managed Care Compliance and Operations, Medicaid and CHIP Services	
	Phone Number	512-462-6348	
	Email	Trinita.Harris@hhsc.state.tx.us	
Populations Served	Medicaid STAR and CHIP MCO Programs—TANF and CHIP	**Number of Individuals Served**	83,422
		Health Plan Tenure in the State	September 2006 – Present
Key Responsibilities	Aetna Better Health of Texas provides managed care services to the TANF and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, and low-income adults. Covered services include medical, BH, pharmacy, and vision. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (03/01/2012 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
02/25/2019	Reporting – timeliness	Sanction	N/A	Waived
02/25/2019	Reporting – timeliness	Sanction	N/A	Waived
02/25/2019	Member hotline – call hold time	Sanction	$100	Paid
02/25/2019	Member complaint resolution timeliness	Sanction	$125	Paid

Health Plan Name	Aetna Better Health of Texas Inc. dba Aetna Better Health of Texas or Aetna Better Health			
02/25/2019	Reporting – timeliness; claims lag	Sanction	N/A	Waived
05/24/2018	Reporting – other data	Sanction	$250	Paid
11/08/2017	Reporting – encounter data	Sanction	$8,000	Paid
11/08/2017	Performance measures	Sanction	$25	Paid
09/30/2017	Reporting – timeliness	Sanction	N/A	Waived
09/30/2017	Member hotline – call hold time	Sanction	$100	Paid
06/02/2017	Reporting – encounter data	Sanction	$30,000	Paid
06/02/2017	Performance measures	Sanction	$500	Paid
03/20/2017	Reporting – encounter data	CAP	$5,000	Closed
03/20/2017	Delegation oversight	Sanction	$500	Paid
12/30/2016	Failure to meet contract standards	Sanction	N/A	Closed
12/30/2016	Claims processing timeliness	Sanction	$2,000	Paid
12/30/2016	Claims processing timeliness	Sanction	$2,000	Paid
12/30/2016	Reporting – encounter data	Sanction	$2,000	Paid
12/30/2016	Reporting – encounter data	Sanction	$15,000	Paid
12/30/2016	Reporting – encounter data	Sanction	$15,000	Paid
08/30/2016	Member complaint resolution timeliness	Sanction	$50	Paid
08/30/2016	Claims processing timeliness	Sanction	N/A	Waived
08/30/2016	Claims processing timeliness	Sanction	$1,000	Paid
08/30/2016	Claims processing timeliness	Sanction	N/A	Waived
08/30/2016	Reporting – encounter data	Sanction	$1,000	Paid
08/30/2016	Reporting – encounter data	Sanction	$250	Paid
06/28/2016	Claim appeal timeliness: the plan failed to meet the minimum state performance measure of processing 98% of provider claim appeals within 30 days.	Sanction	$1,000	Paid
06/28/2016	Reporting – encounter data	Sanction	$15,000	Paid
06/28/2016	Reporting – encounter data	Sanction	$15,000	Paid
06/28/2016	Reporting – encounter data	Sanction	$250	Paid
06/28/2016	Plan failed to provide timely response to HHSC contractor during audit requests for finance review	Sanction	$2,000	Paid
04/16/2016	Reporting – encounter data	CAP/Sanction	$5,000	Closed/Paid
04/16/2016	Reporting – encounter data	Sanction	$5,000	Paid
04/16/2016	Reporting – encounter data	Sanction	$250	Closed/Paid
04/16/2016	Reporting – encounter data	Sanction	$250	Paid
04/16/2016	Reporting – encounter data	Sanction	$250	Paid
04/16/2016	Reporting – encounter data	Sanction	$250	Paid
04/16/2016	Reporting - timeliness	CAP/Sanction	$1,000	Paid
04/16/2016	Network deficiency; pharmacy	CAP/Sanction	$100	Closed/Paid
04/16/2016	Network deficiency; pharmacy	Sanction	$100	Paid

Health Plan Name	Aetna Better Health of Texas Inc. dba Aetna Better Health of Texas or Aetna Better Health			
12/16/2015	SFY 2013 - Frew checkup participation rates did not meet standard	CAP	N/A	Closed
12/16/2015	Reporting – encounter data	CAP/Sanction	$250	Closed/Paid
12/16/2015	Reporting – encounter data	CAP/Sanction	$250	Closed/Paid
12/16/2015	Member appeals - timeliness	CAP	N/A	Closed
08/07/2015	Claims processing - timeliness	Sanction	N/A	Waived
08/07/2015	Claims processing - timeliness	Sanction	N/A	Waived
08/07/2015	Behavioral health hotline timely response	Sanction	N/A	Waived
03/04/2015	Frew checkup participation rates did not meet standard in the Dallas Service Area	CAP	N/A	Closed
03/04/2015	SFY 2012 Frew checkup participation rates did not meet standard in the Bexar and Tarrant Service Areas	CAP	N/A	Closed
01/16/2015	Reporting - timeliness	Sanction	$4,000	Paid
01/16/2015	Reporting - timeliness	Sanction	$300	Paid
01/16/2015	Reporting – timeliness	Sanction	$1,200	Paid
12/04/2014	Reporting - timeliness	Sanction	$200	Paid
11/21/2014	Disincentive/CAP -$136,230 for failure to achieve the required checkup participation rates for new members	CAP	N/A	Closed
11/21/2014	Disincentive/CAP -$691,695 ($308,845 in recouped capitation payments and $ 382,850 in applied disincentives) for failure to achieve the required checkup participation rates for new or existing members	CAP	N/A	Closed
09/29/2014	Reporting - timeliness and accuracy	Sanction	$1,300	Paid
09/23/2014	Reporting - timeliness	Sanction	$1,500	Paid
09/23/2014	Reporting – encounter data	CAP	$250	Paid
09/23/2014	Reporting – encounter data	CAP	N/A	Closed
09/03/2014	Claims processing timeliness	CAP/Sanction	$10,000	Paid
09/03/2014	Website updated without approval	Sanction	$1,000	Paid
09/03/2014	Spanish section of website not functional	CAP/Sanction	$1,000	Paid
09/03/2014	Member hotline – response time	CAP/Sanction	$600	Paid
09/03/2014	Reporting - timeliness	Sanction	$200	Paid
09/03/2014	Checkup participation rates non - compliant	CAP	N/A	Paid
08/21/2014	Member hotline – response time	Sanction	$40	Paid
08/14/2014	Reporting – encounter data	Sanction	$2,500	Paid
08/14/2014	Reporting – encounter data	CAP/Sanction	$2,500	Paid
08/14/2014	Reporting – encounter data	CAP/Sanction	$5,000	Paid
08/14/2014	Failure to provide notice of required coverage	CAP/Sanction	$10,000	Paid

Health Plan Name	Aetna Better Health of Texas Inc. dba Aetna Better Health of Texas or Aetna Better Health			
08/11/2014	Prohibited marketing practices	CAP/Sanction	$1,000	Paid
08/11/2014	Reporting - timeliness	CAP/Sanction	$525	Paid
06/03/2014	Received notice of assessment of Liquidated Damages	Sanction	$19,750	Paid
06/03/2014	Received notice of assessment of Liquidated Damages	Sanction	$64,100	Paid
06/03/2014	Received notice of assessment of Liquidated Damages	Sanction	$52,400	Paid
06/02/2014	Reporting - timeliness	CAP/Sanction	$6,150	Paid
06/02/2014	Reporting – timeliness	CAP/Sanction	$4,350	Paid
06/02/2014	Reporting - timeliness	CAP/Sanction	$2,000	Paid
06/02/2014	Reporting – encounter data	CAP/Sanction	$2,500	Paid
06/02/2014	Reporting – timeliness	CAP/Sanction	$3,450	Paid
06/02/2014	Reporting - timeliness	CAP/Sanction	$500	Paid
06/02/2014	Reporting – accuracy	CAP/Sanction	$400	Paid
06/02/2014	Reporting - timeliness	CAP	N/A	Closed
06/02/2014	Reporting – encounter data	CAP/Sanction	$3,600	Paid
06/02/2014	Claims processing - accuracy	CAP	N/A	Closed
06/02/2014	Claims processing - timeliness	CAP	N/A	Closed
06/02/2014	Reporting – encounter data	CAP/Sanction	$250	Paid
06/02/2014	Reporting – encounter data	CAP	N/A	Closed
06/02/2014	Reporting – encounter data	CAP/Sanction	$1,000	Paid
06/02/2014	Reporting – other data	CAP	N/A	Closed
06/02/2014	Reporting - timeliness	CAP/Sanction	$750	Paid
06/02/2014	Reporting – timeliness	CAP/Sanction	$850	Paid
06/02/2014	Reporting – timeliness	CAP	N/A	Closed
06/02/2014	Reporting – timeliness	CAP	N/A	Closed
06/02/2014	Reporting – timeliness	CAP/Sanction	$8,800	Paid
06/02/2014	Reporting – timeliness	CAP/Sanction	$8,800	Paid
02/02/2014	SFY 2011 checkup participation rates - non-compliant	CAP	N/A	Closed
06/10/2013	Reporting – encounter data	CAP/Sanction	$250	Closed
06/10/2013	Reporting – encounter data	Sanction	$250	Closed
06/03/2013	Reporting – encounter data	CAP/Sanction	$750	Closed
08/27/2013	Reporting – other data	CAP	N/A	Closed
05/29/2013	Other	Sanction	$1,200	Closed
05/29/2013	Other	Sanction	$1,000	Closed
08/17/2012	Reporting - accuracy	Sanction	$25	Paid
08/17/2012	Member hotline – call hold time	Sanction	$200	Paid
08/17/2012	Member hotline – call hold time	Sanction	$200	Paid
08/17/2012	Member hotline – call hold time	Sanction	$200	Paid
08/17/2012	Member hotline – call hold time	Sanction	$200	Paid

Health Plan Name	Aetna Better Health of Texas Inc. dba Aetna Better Health of Texas or Aetna Better Health		
Client Name	**Texas Health and Human Services**		
Lead State Program Manager Contact Information	**Name**	Trinita Harris, CTCM	
	Title	Manager II, Managed Care Compliance and Operations, Medicaid and CHIP Services	
	Phone Number	512-462-6348	
	Email	Trinita.Harris@hhsc.state.tx.us	
Populations Served	STAR Kids Program	**Number of Individuals Served**	4,687
		Health Plan Tenure in the State	November 2016 – Present
Key Responsibilities	Aetna Better Health of Texas provides managed care services to the STAR Kids population, including children and young adults receiving SSI. Covered services include medical, BH, pharmacy, LTSS, and vision. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (11/01/2016 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
02/25/2019	Nurse hotline call abandonment rate	Sanction	$650	Paid
02/25/2019	Claims summary report; claims adjudication timeliness	Sanction	$1,250	Paid
02/25/2019	Claims summary report; claims adjudication timeliness	Sanction	$2,500	Paid
02/25/2019	Claims summary report – timeliness and accuracy	Sanction	N/A	Waived
02/25/2019	Claims summary report – timeliness and accuracy	Sanction	$1,750	Paid
02/25/2019	Claims summary report – timeliness and accuracy	Sanction	$1,750	Paid
09/30/2017	Nurse hotline call abandonment rate	Sanction	$650	Paid
09/30/2017	Member complaints and appeals resolution timeliness	Sanction	$125	Paid
09/30/2017	Claims lag report timeliness	Sanction	N/A	Waived
09/30/2017	Claims summary report; claims adjudication timeliness	Sanction	$1,250	Paid
09/30/2017	Claims summary report; claims adjudication timeliness	Sanction	$2,500	Paid
09/30/2017	Claims summary report timeliness	Sanction	N/A	Waived
09/30/2017	Claims summary report timeliness	Sanction	$1,750	Paid
09/30/2017	Claims summary report timeliness	Sanction	$1,750	Paid

Health Plan Name	Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia	
Client Name	**Virginia Department of Social Services**	
Lead State Program Manager Contact Information	**Name**	Daniel Plain
	Title	Director, Health Care Services Division
	Phone Number	804-588-4883

Health Plan Name	Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia		
	Email	Daniel.Plain@dmas.virginia.gov	
Populations Served	Medallion 4.0—Medicaid Only—TANF, CHIP[19]	Number of Individuals Served	61,142
		Health Plan Tenure in the State	July 1996 – Present
Key Responsibilities	Aetna Better Health of Virginia provides managed care services to the TANF and CHIP Family Access to Medical Insurance Security populations, including Low Income Families with Children and ABD populations, as well as two recent expansion groups that include foster care/adoption assistance and the Health and Acute Care Program population. Covered services include medical, BH, pharmacy, vision, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (08/01/2018 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
03/14/2019	Inaccurate monthly report	NONC	N/A	Closed
03/14/2019	Inaccurate monthly report	NONC	N/A	Closed
03/14/2019	Inaccurate monthly report	NONC	N/A	Closed
03/14/2019	Inaccurate monthly report	NONC	N/A	Closed
03/14/2019	Inaccurate monthly report	NONC	N/A	Closed
02/01/2019	Late monthly report	NONC	N/A	Closed
02/01/2019	Inaccurate monthly report	NONC	N/A	Closed

Health Plan Name	Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia		
Client Name	Virginia Department of Social Services		
Lead State Program Manager Contact Information	Name	Daniel Plain	
	Title	Director, Health Care Services Division	
	Phone Number	804-588-4883	
	Email	Daniel.Plain@dmas.virginia.gov	
Populations Served	Commonwealth Coordinated Care Plus (CCC+) – LTSS, ABD	Number of Individuals Served	30,756
		Health Plan Tenure in the State	August 2017 – Present

[19] Prior to the Medallion 4.0 contract, Aetna Better Health of Virginia held the Medallion 3.0 contract, which served the TANF, CHIP, and ABD populations. In January 2018, ABD members transitioned from the Medallion 3.0 contract to the Commonwealth Coordinated Care Plus (CCC+) contract. The Medallion 3.0 contract ended in December 2018 and was replaced by the current Medallion 4.0 contract, which now serves TANF and CHIP members only.

Health Plan Name	Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia
Key Responsibilities	Aetna Better Health of Virginia provides managed care services to the LTSS population, including members age 65 or older, children and adults with disabilities, nursing facility residents, and members receiving services through a HCBS waiver. Covered non-developmental disability waiver services include medical, behavioral, substance use disorder, pharmacy, and transportation to non-waiver services. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.

Compliance Actions During the Current Contract Term (08/01/2017 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
02/14/2019	Waivers claims not paid timely	NONC	N/A	Open
12/21/2018	Hospice claims not paid timely	NONC	N/A	Open
07/06/2018	Nursing facility claims not paid timely	NONC	N/A	Closed

Health Plan Name	Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia		
Client Name	West Virginia Department of Health and Human Resources		
Lead State Program Manager Contact Information	Name	Jeff Wiseman	
	Title	Executive Assistant to the Deputy	
	Phone Number	304-558-6052	
	Email	Jeff.A.Wiseman@wv.gov	
Populations Served	Mountain Health Trust—TANF, ACA, ABD, SSI	Number of Individuals Served	119,125
		Health Plan Tenure in the State	July 1996 – Present
Key Responsibilities	Aetna Better Health of West Virginia provides managed care services to TANF, ABD, SSI, and ACA expansion populations. Covered services include medical, children's dental, and BH services.		

Compliance Actions During the Current Contract Term (07/01/2018 – Present)

Date of Action	Additional Category Specification (if applicable)	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
01/16/2019	Untimely response to ad hoc request	Sanction	$1,500	Paid
11/14/2018	Failure to provide timely MCO-covered services	NONC	N/A	
03/12/2019	Failure to comply with the timely payment requirement	CAP	N/A	Pending closure by the State

Medicaid Health Plans Not Affiliated with Aetna Better Health of Louisiana but Managed by Aetna

The health plans listed in **Table 2.10.2.4-3** are not affiliated with Aetna Better Health of Louisiana, but Aetna's Medicaid organization provides management services for these plans. The health plans within this table, rather than Aetna, have or had direct contractual relationships with the State agencies in their respective states. The contracts are listed alphabetically by state, and the membership numbers are as of December 2018, unless otherwise indicated.

Table 2.10.2.4-3: Proposer Reference Contact Information—Medicaid Health Plans Not Affiliated with Aetna Better Health of Louisiana but Managed by Aetna

Health Plan Name	**Mercy Care**		
Client Name	**Mercy Care**		
Client Contact Information	**Name**	Linda Hunt	
	Title	Chair, Board of Directors	
	Phone Number	602-406-6090	
	Email	linda.hunt@dignityhealth.org	
Populations Served	Arizona Health Care Cost Containment ACC (formerly Acute Care) —TANF, CHIP, ACA	**Number of Individuals Served**	312,839
		Health Plan Tenure in the State	May 2002 – Present
Key Responsibilities	Mercy Care Plan provides managed care services to the LTSS population, including members who are age 65 or older, blind, have a developmental disability, or have a disability at any age and require ongoing nursing facility level care. Covered services include medical, BH, case management, palliative care, vision, children's rehabilitative services, and podiatry. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (10/01/2018 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
01/22/2019	Reporting – encounter data	Sanction	$27,395	Paid
12/14/2018	Dental uniform prior authorization list	NONC	N/A	Open
12/11/2018	Administrative performance measures	Sanction	$100,000	Paid
11/08/2018	Reporting – encounter data	Sanction	$26,700[20]	Paid
10/29/2018	Telephone performance standards	Sanction	$50,000	Paid

Health Plan Name	**Mercy Care**		
Client Name	**Mercy Care**		
Client Contact Information	**Name**	Linda Hunt	
	Title	Chair, Board of Directors	
	Phone Number	602-406-6090	
	Email	linda.hunt@dignityhealth.org	
Populations Served	Arizona Health Care Cost Containment System Arizona Long Term Care System – LTSS	**Number of Individuals Served**	12,834
		Health Plan Tenure in the State	May 2002 – Present

[20] This sanction applied across ACC, ALTCS, and DDD and was not specific to a particular contract.

Health Plan Name	Mercy Care
Key Responsibilities	Mercy Care Plan provides managed care services to the LTSS population, including members who are age 65 or older, blind, have a developmental disability, or have a disability at any age and require ongoing nursing facility level care. Covered services include medical, BH, case management, palliative care, vision, children's rehabilitative services, and podiatry. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.

Compliance Actions During the Current Contract Term (10/01/2017 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
01/22/2019	Reporting – encounter data	Sanction	$1,450	Paid
08/08/2018	Reporting – encounter data	Sanction	$1,775	Paid
04/24/2018	Reporting – encounter data	Sanction	$1,410	Paid
03/08/2018	Reporting – encounter data	Sanction	$970	Paid

Health Plan Name	Mercy Care		
Client Name	Mercy Care		
Client Contact Information	Name	Linda Hunt	
	Title	Chair, Board of Directors	
	Phone Number	602-406-6090	
	Email	linda.hunt@dignityhealth.org	
Populations Served	Department of Economic Security Division of Developmental Disabilities DD/ABD	Number of Individuals Served	28,585
		Health Plan Tenure in the State	May 2002 – Present
Key Responsibilities	Mercy Care Plan provides services to DD/ABD populations, including acute care services to individuals enrolled with the Department of Economic Security/Division of Developmental Disabilities who are Arizona Long Term Care System (ALTCS)-eligible within the awarded geographic service areas. Covered services include those acute care services outlined within the managed care system to ensure members receive the most appropriate level of care. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (10/01/2011 – Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
02/01/2019	Reporting – encounter data	Sanction	$2,540	Paid
10/23/2018	Reporting – encounter data	Sanction	$1,235	Paid
10/04/2018	Reporting – encounter data	Sanction	$230	Paid
09/27/2018	Reporting – encounter data	Sanction	$1,230	Paid
08/08/2018	Reporting – encounter data	Sanction	$16,550	Paid
08/06/2018	Reporting – encounter data	Sanction	$13,550	Paid
05/02/2018	Reporting – encounter data	Sanction	$7,690	Paid
03/19/2018	Reporting – encounter data	Sanction	$835	Paid
04/28/2017	Reporting – encounter data	Sanction	$945	Paid

Health Plan Name	Mercy Care			
05/01/2016	Reporting – encounter data	Sanction	$8,455	Paid
01/04/2016	Reporting – encounter data	Sanction	$2,025	Paid
08/26/2015	Reporting – encounter data	Sanction	$860	Paid
05/07/2015	PCP transition log	Sanction	$500	Paid
03/17/2015	Reporting – encounter data	Sanction	$640	Paid
12/22/2014	Reporting – encounter data	Sanction	$840	Paid
09/05/2014	Reporting – encounter data	Sanction	$5,470	Paid
06/24/2014	Reporting – encounter data	Sanction	$6,325	Paid
12/27/2013	Reporting – encounter data	Sanction	$6,975	Paid
02/07/2013	Reporting – encounter data	CAP	N/A	Closed

Health Plan Name	Mercy Care		
Client Name	**Mercy Care**		
Client Contact Information	**Name**	Linda Hunt	
	Title	Chair, Board of Directors	
	Phone Number	602-406-6090	
	Email	linda.hunt@dignityhealth.org	
Populations Served	Regional Behavioral Health Authority Maricopa—TANF, ABD, SMI, ACA	**Number of Individuals Served**	48,622
		Health Plan Tenure in the State	April 2014 – Present
Key Responsibilities	Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions During the Current Contract Term (04/01/2014 – Present)

Date of Action	Date of Action	Date of Action	Date of Action	
01/22/2019	Arnold v. Sarn Quality Service Review, Service Capacity Assessment and SAMHSA Fidelity Review	CAP	N/A	Under appeal
06/21/2018	Notice of concern for Community Service Agencies (CSA) recredentialing. An action plan was submitted to AHCCCS on July 2, and AHCCCS accepted the plan on July 25, 2018.	CAP	N/A	Open
09/27/2018	Reporting – encounter data	Sanction	$16,085	Paid
04/24/2018	Reporting – encounter data	Sanction	$7,725	Paid
03/08/2018	Reporting – encounter data	Sanction	$6,765	Paid
03/01/2018	Data validation audit	Sanction	$1,207	Paid
11/16/2017	Reporting – encounter data	Sanction	$840	Paid
11/07/2017	BH services	NONC	N/A	Open
10/06/2017	AHCCCS issued a letter of concern regarding completions of Court Ordered Evaluations (COE) in an inpatient setting.	NONC	N/A	Open—continued monthly reporting to regulator
08/23/2017	SAMHSA fidelity review findings	NONC	N/A	Closed

Health Plan Name	Mercy Care			
07/25/2017	Reporting – encounter data	Sanction	$6,730	Paid
07/17/2017	Audit/review; overall compliance score of 97%. Standards that scored less than 95% required a corrective action plan.	CAP	N/A	Closed
10/12/2016	Arnold v. Sarn Quality Service Review, Service Capacity Assessment and Year Two Results of the SAMHSA Fidelity Tool Implementation reports	CAP	N/A	Closed
09/27/2016	Reporting - Arnold v. Sarn Fidelity Reporting related to reporting requirements of the Arnold v. Sarn lawsuit settlement agreement	Notice to Cure	N/A	Closed
01/04/2016	Reporting -inaccurate/incomplete regulatory reporting	Sanction	$2,000	Paid
10/23/2015	Reporting – encounter data	CAP	N/A	Closed
09/29/2015	Notification and documentation of SMI persons determined to require special assistance	Notice to Cure	N/A	Closed
09/01/2015	Reporting – encounter data	Sanction	$2,000	Paid
08/07/2015	Reporting – encounter data	Sanction	$7,895	Paid
07/24/2015	Supervisory Care Home monthly census report	Sanction	$500	Paid
07/15/2015	Grievance system report	Sanction	$1,000	Paid
07/02/2015	Report of each use of seclusion/ restraint concerning persons with SMI	Sanction	$3,500	Paid
07/02/2015	Subcontractor compliance with appointment standards	Notice to Cure	N/A	Closed
06/23/2015	Outpatient Commitment Monitoring report	Sanction	$1,000	Paid
06/02/2015	Grievance System report	Sanction	$1,000	Paid
06/02/2015	Provider notice: appointment availability and timeliness	Sanction	$1,000	Paid
05/28/2015	Reporting – encounter data	Sanction	$5,010	Paid
05/28/2015	Reporting – encounter data	Sanction	$1,605	Paid
05/15/2015	Appointment standards and timeliness of services for BH providers	Notice to Cure/ Sanction	$1,000	Paid
05/06/2015	PCP transition log	Sanction	$500	Paid
05/01/2015	Appointment standards and timeliness of services for BH providers	Notice to Cure	N/A	Paid
04/23/2015	Internal and external audit reports and findings	Sanction	$1,000	Paid
04/17/2015	Outpatient Commitment Monitoring report	Sanction	$1,000	Paid
04/15/2015	Grievance System report	Sanction	$1,000	Paid
04/10/2015	Corporate compliance ride-along program/ data validation review	Sanction	$1,000	Paid
04/03/2015	Grievance System report	Sanction	$3,000	Paid

Health Plan Name	Mercy Care			
04/01/2015	Emergency room wait times	Letter of Concern	N/A	Closed
03/30/2018	MM/UM Indicator report	Sanction	$500	Paid
03/30/2015	Pharmacy Utilization report	Sanction	$4,000	Paid
03/30/2015	Prior Authorization Data report	Sanction	$1,000	Paid
03/16/2015	Transportation services	Sanction	$100,000	Paid
02/27/2015	Recipient and provider over- and under-utilization report	Sanction	$3,000	Paid
02/13/2015	NEMT timeliness (delegate)	CAP	N/A	Closed
02/01/2015	Reporting – denials of credentialing and recredentialing of providers	Notice to Cure	N/A	Closed
02/01/2015	Rate of service delivery	NONC	N/A	Closed
01/27/2015	MM/UM data file submissions	Notice to Cure	N/A	Closed
11/28/2014	MM/UM data file submissions	CAP	N/A	Closed
10/27/2014	Seclusion and restraint reporting	CAP	N/A	Closed
08/22/2014	Pharmacy prior authorizations	CAP	N/A	Closed
08/11/2014	Pharmacy – prescription needs of members transitioning to plan	CAP	N/A	Closed
05/02/2014	Call center reporting	Notice to Cure	N/A	Closed

Health Plan Name	Maryland Care, Inc. dba Maryland Physicians Care		
Client Name	**Maryland Physicians Care**		
Client Contact Information	**Name**	Cynthia M. Demarest	
	Title	Chief Executive Officer	
	Phone Number	410-412-9701	
	Email	cdemarest@mci-mcmi.com	
Populations Served	Medicaid and CHIP—TANF, CHIP, ABD, ACA	**Number of Individuals Served**	216,398[21]
		Health Plan Tenure in the State	September 1996 – June 2017
Key Responsibilities	Maryland Physicians Care provided managed care services for the TANF, CHIP, ABD, and ACA populations, including pregnant women, infants, children, children/youth with special health care needs, low-income adults, individuals receiving SSI, and ACA individuals. Covered services included medical, BH, pharmacy, vision, dental, and NEMT. Key responsibilities included physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		
Compliance Actions During the Final Contract Term (12/23/2014 – June 30, 2017)			

[21] The membership number is as of June 2017, which is the last month Aetna managed this health plan.

Health Plan Name	Maryland Care, Inc. dba Maryland Physicians Care			
Date of Action	**Category**	**Compliance Action Type**	**Monetary Sanction (if applicable)**	**Final Disposition**
None				

Health Plan Name	Parkland Community Health Plan, Inc.		
Client Name	**Parkland Community Health Plan, Inc.**		
Client Contact Information	**Name**	Robert Kowalski	
	Title	Interim Executive Director	
	Phone Number	214-266-2107	
	Email	Robert.Kowalski@phhs.org	
Populations Served	Texas Health and Human Services Commission—TANF, CHIP	**Number of Individuals Served**	187,665
		Health Plan Tenure in the State	1999 – Present
Key Responsibilities	Parkland provides managed care services for the TANF and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, low-income adults, and families. Covered services include medical, pharmacy, vision, and NEMT. Key responsibilities include physical and behavioral health services administration, medical management, quality, compliance, pharmacy, program integrity, finance, and business continuity activities.		

Compliance Actions[22] During the Current Contract Term (03/01/2012 to Present)

Date of Action	Category	Compliance Action Type	Monetary Sanction (if applicable)	Final Disposition
12/04/2014	Frew Annual Provider Training Reporting - timeliness	Sanction	$2,100	Paid
08/21/2014	Member appeals resolution rate - 95% of member appeals were resolved within 30 calendar days when the required resolution rate was 98%.	Sanction	$50	Paid
08/21/2014	Provider hotline reporting - timeliness	Sanction	$25	Paid
06/02/2014	Reporting – other data; not meeting minimum performance requirements	CAP/Sanction	$600	Paid
06/02/2014	Claims reporting – timeliness	CAP/Sanction	$500	Paid
06/02/2014	Claims reporting – timeliness	CAP/Sanction	$325	Paid
06/02/2014	Network reporting – timeliness	CAP/Sanction	$4,400	Paid
05/29/2013	Acute claims performance	Sanction	$500	Closed

[22] The compliance actions reported here are those attributable to Aetna in accordance with its administrative services contract with Parkland Community Health Plan, Inc.

2.10.2.5 NCQA Accreditation

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2.10.2.5 NCQA Accreditation

National Committee for Quality Assurance (NCQA) accreditation demonstrates a commitment to quality, outstanding clinical performance, and consumer experience. Eleven of the Aetna Medicaid organization's health plans are NCQA-accredited, three of which—Aetna Better Health® of Florida, Aetna Better Health of Kentucky, and Aetna Better Health of West Virginia—achieved an NCQA accreditation level of Commendable. Aetna Better Health of Louisiana received Interim accreditation in February 2017 and, during our first survey in August 2018, obtained Accredited status in August 2018 with results totaling 79.1663, less than 1 point below the Commendable level of 80.00. We are implementing quality-improvement measures to meet our objective of achieving Commendable status. Aetna provides a copy of our NCQA certificate of accreditation in **Attachment D.**

Aetna Better Health of Louisiana is committed to quality, ready access, and innovation to maximize enrollee health, advance health equity, and address social determinants of health within a flexible value-based approach. To achieve this, we make quality a health plan-wide focus. We use an integrated approach that involves every functional area to align organization objectives, interventions, monitoring plan, and metrics with our Quality Assurance and Performance Improvement (QAPI) program. The quality management (QM) program applies to all departments, staff, enrollees, and providers. We integrate QM and continuous quality improvement processes into all departments, with each department responsible for selected processes, functions, and monitoring activities. As part of our commitment to continuous quality improvement, all Aetna staff members must complete Lean Six Sigma white-belt certification, and we require all managers to obtain yellow-belt certification within one year of hire.

Aetna's QAPI program provides a framework for the planning, implementation, and monitoring of all processes that contribute to our commitment to providing integrated and high-value care. We evaluate the quality of our health care services using specific, objective performance and outcome measures from multiple data sources, including but not limited to the following:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- LDH non-HEDIS performance measures
- Consumer Assessment of Healthcare Providers and Systems
- Behavioral health enrollee experience surveys
- Provider satisfaction surveys
- Availability and accessibility studies
- Provider directory usability studies
- Care management rates
- Utilization management rates
- Provider profile reports
- Enrollee and provider grievances and appeals
- Telephone enrollee services
- Medical record and treatment record audits

The data is continually monitored to identify opportunities where we can better serve Healthy Louisiana enrollees, stakeholders, and the community. In addition to cross-functional staff across Aetna Better Health of Louisiana, QM is also supported by a dedicated national QM team. This unit will support the Louisiana QM team by providing monthly quality metric reports, provider and enrollee gaps-in-care reports, year-over-year trajectory reports, HEDIS vendor oversight, accreditation support, and innovative enrollee/provider interventions. Our organization-wide continuous quality improvement efforts lead to improved enrollee and provider experiences; helps to advance evidence-based practices, high-value care, and service excellence; and supports innovation and a culture of continuous quality improvement in Louisiana.

Aetna's quality committees evaluate QM effectiveness monthly, quarterly, and annually. The scope, goals, objectives, structure, staffing, and responsibilities of the QAPI program are modified based on our analyses, and changes to LDH contract and accreditation standards. Aetna Better Health of Louisiana plan leadership, providers, enrollees and/or enrollee agency representative, community agencies, and multiple departments work together as a team to improve our organization's performance. Our innovative continuous quality improvement (CQI) approach encompasses an extensive array of activities and allows us to involve providers, enrollees, and the day-to-day operations team in our efforts. It also ensures year-over-year review of all standing or innovative QAPI program elements, and frequent modifications to the program in support of a Plan-Do-Study-Act (PDSA) framework. PDSA guides our approach to developing, testing, and implementing changes as part of Aetna performance improvement projects (PIPs) and QAPI programs.

Using the QAPI components Aetna maintains a robust quality program by doing the following:

- Maintaining a process to regularly evaluate the impact and effectiveness of the QAPI program through a committee structure that engages and solicits input from cross-functional Aetna teams, enrollees, community-based organizations, and active network providers
- Having a committee structure that supports Aetna's clinical and quality leadership engagement in public health issue discussions in the state, which will allow Aetna to leverage experience across different Medicaid states to collaborate successfully with LDH to support Healthy Louisiana goals
- Using data-driven, objective, and rigorous measurement to support an outcomes-based continuous quality improvement process
- Having a structure in place to identify and remove barriers by which to address unmet enrollee or provider needs and monitoring the effectiveness of improvement programs, including evaluation of enrollee and provider surveys
- Monitoring provider performance to support a network that demonstrates understanding and ability to address health needs of enrollees while supplying accessible, high-quality care and services and to support value-based payment programs to drive high-value care
- Promoting equity through reduction or elimination of health disparities and regularly stratifying and reporting upon health outcomes to develop interventions that improve quality disparities based on age, race, ethnicity, sex, primary language, geography, and key population groups

A detailed QAPI program allows us to systematically monitor, evaluate, and improve the quality, appropriateness, efficiency, and effectiveness of the care and services rendered to our enrollees. The Aetna Medicaid organization's extensive multistate Medicaid experience allows us to design an adaptable program that provides us the flexibility to address the unique needs and diverse regions and populations of Louisiana.

2.10.3 Enrollee Value-Added Benefits

Aetna believes in promoting healthier living through education in nutrition and preventive medicine. Keeping with our mission to promote healthier lifestyles, the Community Outreach team provides healthy options, like oranges and apples, at all our events throughout Louisiana communities.

2.10.3 Enrollee Value-Added Benefits

Aetna is proud to be a part of Louisiana's diverse health care community. We have supported our fellow Louisianans since 2015 by providing Medicaid services that address the specific needs of our communities. We work with providers who are focused on person-centered care, and we regularly participate in local health fairs as well as school and neighborhood center events. Our enrollees are much more than the population we serve—they are our neighbors.

Aetna is committed to offering all six optional value-added benefits to its enrollees as identified by LDH. We believe these value-added benefits are a critical component of the overall program, which will provide another path that leads to achieving the Triple Aim for our enrollees. We designed our enrollee value-added benefits to **address Louisiana's public health goals** as outlined in the Louisiana State Health Assessment and Improvement Plan, *Creating a Blueprint for our Future 2016–2020*, to **improve health outcomes**, **lower costs by reducing the need for more expensive care, and improve the lives of our enrollees.** Our experience both locally and nationally has taught us that the health and well-being of our enrollees are enhanced by their ability to access the services and supports not covered by Medicaid. We are committed to making sure our enrollees receive value-added benefits that support their overall health and quality of life while addressing the whole person.

Aetna is developing innovative enhancements to our enrollee mobile application and enrollee web portal in order to engage and educate enrollees about our value-added benefits. They will be able to see the value-added benefits for which they are eligible, as well as view information on the utilization of those benefits, and where applicable, request to receive the benefits or get more information. Enrollees can also receive assistance accessing these services through our Enrollee Services and Care Management staff.

To improve the quality and impact of these benefits, we are developing a new Aetna Better Benefit platform that allows our Oversight staff to track and monitor eligibility, engagement, effectiveness, and spend for all enrollee value-added benefits. This innovative and proprietary web-based tool will be available at contract implementation. It streamlines all oversight functions, including the following:

- Addressing health disparities by proactively monitoring under-utilization trends among key at-risk populations
- Preventing fraud, waste, and abuse through benefit design and utilization management
- Identifying opportunities to better promote and improve our value-added benefits to meet the needs of our enrollees
- Measuring benefit impact through enrollee satisfaction, and where applicable, health outcomes

Under the leadership of Aetna's chief operating officer, our dedicated Oversight staff will conduct monthly reviews of our value-added vendors and subcontractors to ensure performance, compliance with the terms and conditions of their contract, and compliance with the terms of the Healthy Louisiana contract. As part of this process, we will also conduct regular, ongoing audits, performance reviews, and financial monitoring. Corrective action plans will be put into place as needed to ensure ongoing compliance. All providers will continue to be credentialed through Aetna's credentialing process.

We Honor Our Commitments

Aetna Better Health of Louisiana's value-added benefit spend for the last full year of the Louisiana Medicaid current contract term was 257%. Our contract commitment was $2.15 per member per month (PMPM), and the 2018 calendar spend was $5.53 PMPM.

Dental Benefits for Adults

According to the 2018 Louisiana Department of Health Oral Health Workforce Assessment, **Louisiana remains below the national average in oral health indicators among adults, and there are significant oral health disparities throughout the state**[1]. For example, **black males in Louisiana face significantly higher rates of certain cancers, including oral cavity cancers, than the corresponding national population**[2]. Untreated dental disease can lead to serious health issues, including pain, infection, and tooth loss. Aetna remains committed to addressing this challenge for all of our enrollees by offering robust adult dental benefits. To better support those most impacted by these oral health disparities, we will monitor dental benefit utilization for various adult populations and proactively engage enrollees to help them access this benefit:

- **Population:** Enrollees 21 years of age and older who do not have other dental benefits may self-refer to network providers.
- **Scope:** Procedure codes D0120, D0274, D3230, D3240, D1206, D1208, D5110, D5120, D5130, D5140, D5211–D5214, D5221–D5226, D5282, and D5283; enrollees are eligible to receive up to $500 per year toward dental care (exams, bitewing X-rays, and cleanings limited to twice per year, as well as fillings, restorative services, and dentures). This value-added benefit is not an existing Louisiana Medicaid covered benefit.
- **Proposed copayments:** A copayment will not be required.
- **How the benefit will be provided:** DentaQuest is the subcontractor. Enrollees can call DentaQuest at (844) 234-9834, Monday through Friday, 8 a.m. to 5 p.m. A referral to see a network dental provider is not required. Enrollees can find dental providers in our online provider directory at www.aetnabetterhealth.com/louisiana or by calling Enrollee Services. Enrollees can find information on their remaining available benefits by contacting Enrollee Services, their care manager, or through the enrollee app or enrollee portal. Enrollees who schedule services that exceed their available benefits will be notified prior to their appointment.
- **Oversight:** We will utilize the Aetna Better Benefit platform to track and monitor eligibility, engagement, effectiveness, and spend of this benefit. Our dedicated Oversight staff will perform monthly reviews of DentaQuest to ensure performance, compliance with the terms and conditions of their contract, and compliance with the terms of the Healthy Louisiana contract.
- **PMPM:** The PMPM cost for dental benefits assuming an enrollment of 375,000 members is [redacted].

Evidence-based Non-pharmacologic Alternatives to Opioids

According to LDH, **more than 400 Louisianans died of an opioid overdose in 2017**[3]. With opioid addiction on the rise, providers are seeking effective alternative pain management options for their patients. To support these efforts, Aetna will offer coverage for evidence- based **acupuncture and chiropractic services**.

Chiropractic treatment is the most common non-surgical treatment for back pain. Research suggests that chiropractic services may also be helpful for headaches, neck pain, whiplash, and certain arm and leg conditions. Acupuncture reduces pain by increasing the release of endorphins, which block the messages of pain from being delivered to the brain.

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[1] "Closing the Gap on Dental HPSAs: Louisiana Oral Health Workforce Assessment": accessed April 11, 2019; http://ldh.la.gov/assets/oph/pcrh/OH_Assessment_Report_8_31_18_final_.pdf

[2] "Louisiana Health Report Card 2017": accessed April 11, 2019; http://ldh.la.gov/assets/oph/Center-PHI/BRFSS/2017_Health_Report_Card.pdf

[3] "Panel of Experts Makes Six Recommendations to Fight the Opioid Epidemic in Louisiana": accessed April 11, 2019; http://ldh.la.gov/index.cfm/newsroom/detail/4991

- **Population:** Enrollees 21 years of age and older who contact their care manager (if applicable), Enrollee Services, or visit the enrollee portal to access covered pain management services.
- **Scope:** Procedure codes 97810, 97811, 97813, 97814, and 98940–98943; enrollees 21 years of age and older can receive up to $150 in acupuncture services, and up to three chiropractic visits per year. This value-added benefit is not an existing Louisiana Medicaid covered benefit.
- **Proposed copayments:** A copayment will not be required.
- **How the benefit will be provided:** A subcontractor will not be utilized. A referral to see a network acupuncture or chiropractic provider is not required. Transportation for chiropractic and acupuncture services will be provided. Enrollees can find providers in our online provider directory at www.aetnabetterhealth.com/louisiana or by calling Enrollee Services. Enrollees can also find information on their remaining available benefits by contacting Enrollee Services or their care manager, or via the enrollee app or enrollee portal.
- **Oversight:** We will utilize the Aetna Better Benefit platform to track and monitor eligibility, engagement, effectiveness, and spend of this benefit. Our care managers will regularly contact enrollees receiving this benefit to measure the effectiveness of the services provided as non-pharmacological alternatives to opioids. All providers are credentialed through Aetna's credentialing process.
- **PMPM:** The PMPM cost for chronic pain management services assuming an enrollment of 375,000 members is [redacted].

Respite Care Model Targeting Homeless Population with Post-acute Medical Needs

An estimated 3,059 Louisianans experience homelessness on any given day[4].

According to the National Health Care for the Homeless Council, homeless persons are three to four times more likely to die prematurely than their housed counterparts are, largely because their conditions are exacerbated by life on the streets or in shelters. They are often discharged from hospitals with care instructions that are difficult to follow while living on the streets, and their lack of a stable home environment diminishes the effectiveness of their health care. To help address this important issue, Aetna has invested $14 million into affordable housing in Louisiana in the last five years. In addition to our history of investing in the development of affordable family units in Louisiana, Aetna has created an innovative partnership with the Salvation Army to target homeless enrollees with post-acute medical needs. We are offering a value-added benefit and respite care model designed to identify housing instability, provide respite care, and address post-acute medical needs for homeless enrollees. **Figure 2.10.3-1** illustrates how a homeless enrollee with post-acute medical needs will transition from a hospital setting to stable housing utilizing our respite care model:

Figure 2.10.3-1: Aetna's Respite Care Model for the Homeless Population with Post-acute Medical Needs

Our collaboration with the Salvation Army helps homeless enrollees safely transition from a medical facility to stable housing while providing services and programs to meet an enrollee's needs.

[4] "Louisiana Homelessness Statistics": accessed April 11, 2019; https://www.usich.gov/homelessness-statistics/la/

- **Population:** Enrollees 18 years of age and older who are referred through our care management and housing coordinator via post-acute medical discharge
- **Scope:** Procedure code G9006; this value-added benefit is not an existing Louisiana Medicaid covered benefit.
  - **Respite care and wraparound services:** The Salvation Army will provide short-term residential care with wraparound medical respite services (including post-acute medical services, counseling, nutrition, housing stabilization, and transitional care) to allow homeless enrollees the opportunity to live in a safe environment while accessing needed medical care. Our respite care model will build upon the Salvation Army's success and experience in providing these services to the homeless veteran community. In Alexandria, the Salvation Army has successfully demonstrated its ability to meet the medical, social, and housing needs of homeless veterans. The Salvation Army's Center of Hope in New Orleans has a contract with Tulane Medical Center to provide medical services to homeless veterans who are living in shelters and supportive housing locations. All medical services are provided at the Salvation Army location, unless the enrollee needs to be treated at a medical facility. The Salvation Army will transport the enrollee for medical services. Aetna's care manager and housing specialist will identify an enrollee's transitional needs and coordinate with the Salvation Army case manager. **Aetna will pay for up to 14 days of housing, respite, and wraparound services.** The enrollee will be given the opportunity to remain at the Salvation Army and utilize their housing programs and support services, or they can choose to work with the Aetna housing specialist to identify the next phase of housing security.
  - **Housing:** Our housing specialist will create a long-term transition plan for stable housing in coordination with the Salvation Army case manager based on the enrollee's desired location and required services. We will leverage all Salvation Army facilities across the state as part of the discharge plan. The Salvation Army has permanent supportive housing locations in Alexandria, Baton Rouge, Lafayette, Lake Charles, Monroe, New Orleans, and Shreveport.
- **Proposed copayments:** A copayment will not be required.
- **How the benefit will be provided:** The Salvation Army is the provider. Our housing specialist will work with our care managers, community health workers, hospital discharge planners, housing continuum of care providers, and other community agencies to identify Aetna enrollees in need of housing placement and post-acute medical services. Our housing specialist and care manager will also collaborate with the Salvation Army case manager and our enrollee to establish a transition plan to ensure placement and all necessary post-acute medical services and supports are provided.
- **Oversight:** Oversight will be provided by our care management coordinator. Additionally, we will evaluate the impact of these services on our enrollees' lives through monitoring inpatient readmission rates and other quality outcomes.
- **PMPM:** The PMPM cost for the respite care model assuming an enrollment of 375,000 members is [redacted].

Aetna Affordable Housing Investments in Louisiana

- $14 million invested in affordable housing in the last five years
- Thirty-nine communities in 27 cities
- 2,400 units

Aetna supported the Capital Area Alliance for the Homeless One Stop Homeless Services Center in 2018 with a $25,000 grant. We also work with Brotherhood, Inc., the Louisiana Coalition Offender Resources, and AcadianaCares, all of which provide services to support stable housing.

Aetna works to make homelessness rare, brief, and one-time.

Newborn Circumcision Benefits

The American Academy of Pediatrics formed a task force to review and update previously published data regarding circumcisions. According to the Academy, **the benefits of circumcision outweigh the risks**. Some of the most significant research found the following[5]:

- The protective effects of circumcision reduced the incidence of heterosexually transmitted HIV by 40 to 60 percent
- Cases of herpes simplex virus Type 2 were 28 to 34 percent lower in circumcised men
- There was a 30 to 40 percent reduction in risk of HPV infection
- Circumcised males had a much lower risk of urinary tract infections (UTIs) in their first year of life

One of the major reasons that circumcision is performed during the newborn period is because it provides protection against UTIs, as they are most likely to occur during the first year of life[6]. The likelihood of circumcision complications increase as children get older, from less than 1 percent during the newborn period to 1.1 to 9 percent in non-newborns[7]. Aetna provides this value-added benefit to our enrollees to prevent the potential for future infections, sexually transmitted diseases, and both penile and cervical cancers, as well as to lower the overall costs of care. We will continue to actively promote awareness of this benefit to our pregnant enrollees through our maternity benefits program:

- **Population:** Newborn males
- **Scope:** Procedure codes 54160 and 54161. The circumcision will be performed on newborn males. This value-added benefit is not an existing Louisiana Medicaid covered benefit.
- **Proposed copayments:** A copayment will not be required.
- **How the benefit will be provided:** A subcontractor will not be utilized. The circumcision will be performed prior to hospital discharge. If the procedure has to be performed later (for example, the newborn male is born premature), a prior authorization is required.
- **Oversight:** We will utilize the Aetna Better Benefit platform to track and monitor eligibility, engagement, effectiveness, and spend of this benefit. All providers must be approved through Aetna's provider credentialing process.
- **PMPM:** The PMPM cost for newborn circumcision benefits assuming an enrollment of 375,000 members is [redacted].

Tobacco Cessation Benefits, Not Including Medications

The prevalence of cigarette smoking among adults in Louisiana is nearly 22 percent, which far exceeds the national average of 17 percent[8]. Estimates indicate that health care costs in Louisiana directly caused by smoking amount to nearly **$2 billion annually**. Tobacco cessation is a difficult task for individuals to achieve on their own, and many individuals repeatedly fail without the benefit of support. We will work closely with and support the Well-Ahead Louisiana program to help Louisianans '*geaux* tobacco-free' by aligning with Well-Ahead's Goal Area 3: Promote Quitting among Adults and Young People.

In 2014, CVS Health became the first national pharmacy retailer to remove tobacco products from their CVS Pharmacy locations as part of their commitment to helping people on their path to better health. To further this commitment, CVS Health also proudly serves as the national presenting sponsor of the American Lung Association's LUNG FORCE initiative to bring women and their loved ones to stand together against lung cancer and increase lung health awareness. One of the American Lung Association's

[5] "Health Benefits Linked to Newborn Circumcision": accessed April 11, 2019; https://www.aappublications.org/content/33/9/1.2.full
[6] Ibid.
[7] Ibid.
[8] "Patient Tobacco Use, Quit Attempts, and Perceptions of Healthcare Provider Practices in a Safety Net Healthcare System": accessed April 11, 2019; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3776512/#i1524-5012-13-3-367-b04

strategic imperatives is to eliminate tobacco use and tobacco-related diseases. Lung cancer is the number-one cancer killer of women and men, and together, CVS Health and the American Lung Association have worked to raise awareness of this serious lung disease through LUNG FORCE. Aetna stands with both CVS Health and the American Lung Association to help promote a tobacco-free lifestyle for all Louisianans.

CVS Health's partnership with LUNG FORCE is part of Be The First, their five-year, $50 million commitment to helping deliver the first tobacco-free generation through comprehensive education, advocacy, tobacco control and healthy behavioral programming.

In order to maximize our enrollees' chance of success, Aetna will provide coverage for effective tobacco cessation coaching programs, such as Get Help/Quit Smoking and Start to Stop®:

- **Population:** Enrollees 18 years of age and older who smoke; enrollees under the age of 18 may enroll with written consent from their parent or legal guardian.
- **Scope:** Procedure codes 4000F, 4001F, 99406, 99407, and S9453. This value-added benefit is not an existing Louisiana Medicaid covered benefit.
- **Proposed copayments:** A copayment will not be required for either program.
- **How the benefit will be provided:**
  - **Get Help, Quit Smoking**. The Smoking Cessation Trust is the provider. Smoking Cessation Trust (the Trust) resources are available to those who live in Louisiana and who smoked a cigarette prior to September 1, 1988. Aetna will contract with the Trust to go **above and beyond** to cover these same services on a fee-for-service basis for enrollees who do not qualify under the Trust. This program will be offered to enrollees who are qualified. The following resources are available to program participants:
    - Office visits and counseling with smoking cessation service providers.
    - Unlimited toll-free calls to the program quit line, which is available 24/7.
    - Access to a quit coach who creates a personalized quit program for each participant.
    - Online smoking cessation information and tools, as well as printed educational/motivational materials.
  - **Start to Stop Program®:** MinuteClinic Diagnostic of Louisiana, L.L.C. is the provider. Enrollees 18 years of age and older are eligible this program, which offers face-to-face counseling with a nurse practitioner. The program includes the following:
    - A one-on-one consultation with a practitioner, including a nicotine-dependence assessment
    - An individualized smoking cessation plan and education based on the enrollee's needs and goals
    - Ongoing coaching and support in the enrollee's efforts to quit smoking
- **Oversight:** We will utilize the Aetna Better Benefit platform to track and monitor eligibility, engagement, effectiveness, and spend of this benefit. Program effectiveness will be evaluated by monitoring enrollee health outcomes and measuring before and after costs related to smoking.
- **PMPM:** The PMPM cost for tobacco cessation services assuming an enrollment of 375,000 members is [redacted]

Vision Benefits for Adults

Many Louisianans struggle to afford the corrective eyewear needed to help them excel in their daily lives. Improper or lack of corrective eyewear is a common and significant barrier that affects driving, classroom learning, job performance, and quality of life. For this reason, Aetna is committed to providing up to $100 annually toward the corrective eyewear our enrollees need:

- **Population:** Enrollees 21 years of age and older
- **Scope:** No procedure codes; enrollees will receive $100 annually toward eyewear (frames, lenses for glasses, and contact lenses). This value-added benefit is not an existing Louisiana Medicaid covered benefit.

- **Proposed copayments:** A copayment will not be required.
- **How the benefit will be provided:** Louisiana Vision Supplies, LLC is the provider. Referrals are not needed to see an in-network vision provider. Enrollees can find a vision provider in our provider directory online at www.aetnabetterhealth.com/louisiana, via the enrollee mobile app, or by calling Enrollee Services or Care Management. Enrollees can find information regarding their remaining available benefits by contacting Enrollee Services, their care manager, or via the enrollee app or enrollee portal.
- **Oversight:** We will utilize the Aetna Better Benefit platform to track and monitor eligibility, engagement, effectiveness, and spend of this benefit. Our dedicated Oversight staff will conduct monthly reviews of Louisiana Vision Supplies, LLC. to ensure performance, compliance with the terms and conditions of their contract, and compliance with the terms of the Healthy Louisiana contract. All providers must be approved through Aetna's provider credentialing process.
- **PMPM:** The PMPM cost for vision benefits assuming an enrollment of 375,000 members is [redacted].

Value Added Services Actuarial Certification

Value Added Service: Adult Dental	
Members	375,000
Assumptions	Only Adults are Eligible
PMPM Actuarial Cost	[redacted]

Value Added Service: Non-Pharmacy Pain Management	
Members	375,000
Assumptions	Only Adults are Eligible
PMPM Actuarial Cost	[redacted]

Value Added Service: Respite Care for Homeless	
Members	375,000
Assumptions	Only Homeless with Inpatient Admissions are eligible
PMPM Actuarial Cost	[redacted]

Value Added Service: Newborn Circumcision	
Members	375,000
Assumptions	Only Newborns are eligible
PMPM Actuarial Cost	[redacted]

Value Added Service: Tobacco Cessation excluding Pharmacy	
Members	375,000
Assumptions	Only Smokers are Eligible
PMPM Actuarial Cost	[redacted]

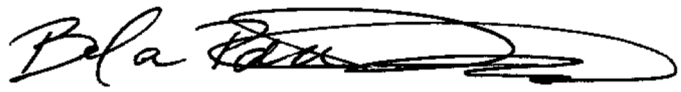
Value Added Service: Adult Vision	
Members	375,000
Assumptions	Only Adults are Eligible
PMPM Actuarial Cost	[redacted]

Actuarial Certification

I, Bela Patel Fernandez, am a Senior Director of Actuarial Services for the Aetna Medicaid organization and a member of the American Academy of Actuaries. I meet the qualification standards established by the American Academy of Actuaries.

In my opinion, the assumptions used to calculate the value-added services in this memorandum are reasonable and consistent with Aetna's expectations. These assumptions were determined by using my best judgment augmented with clinical information from the Centers for Disease Control and Prevention. The cost estimates for services were determined by using Aetna historical experience.

To the extent that Aetna's actual enrollment differs from the membership assumed in this calculation, annual expenditures may vary significantly from these estimates. Aetna guarantees an overall spend for value added services of [redacted] per member per month.



Bela Patel Fernandez
Senior Director, Actuarial Services
April 16, 2019

Statement of Commitment

The aforementioned benefits are tailored to the Louisiana population. Aetna commits to providing all of the value-added benefits proposed in this response for the entire 36-month term of the initial contract and for any extensions, if applicable.

2.10.4 Population Health

As an avid supporter of healthy lifestyle afterschool activities for children of all ages, Aetna partners with the Boys & Girls Clubs of America to celebrate and recognize all of the hard work the Clubs do throughout the school year. Aetna CEO Rick Born is a board member of the Baton Rouge Boys & Girls Club and supports several programs for school-aged youth focused on academics, health, and character.

2.10.4 Population Health

Aetna acknowledges, understands, and will comply with all of the requirements of **Section 2.6** of **Appendix B: Model Contract**.

Improving Population Health for Medicaid Populations (2.10.4.1)

Population health improvement is essential to our efforts to achieve the Triple Aim of better health, better care, and lower costs. With our experience serving Louisianans since 2015, Aetna understands the needs of the local population; we are deeply invested in Louisiana's local communities, and we have demonstrated success improving the lives and health of enrollees with complex physical and behavioral health needs. Drawing on the expertise of our national Health Care Equity team, Aetna brings clinical, financial, social, and operational data together to create actionable analytics that identify and address health disparities in at-risk populations. Our Population Health Strategic Plan outlines our approach, which aligns with the Louisiana Medicaid Managed Care Quality Strategy (as required in **Section 2.6.1.1** of the **Model Contract**) and with National Committee for Quality Assurance (NCQA) standards.

Aetna's population health program integrates staff from departments across the organization, including Medical Management (i.e., Care Management and Utilization Management), Behavioral Health, Quality Management, Pharmacy, and Community Outreach into a multidisciplinary team of subject matter experts. Our population health approach allows us to assess the health status and health needs of the entire population we serve in Louisiana and target subpopulations (e.g., African-American women at risk for breast cancer and specific parishes with high chronic disease burden). This approach incorporates adapting, implementing, and evaluating evidence-based interventions that are designed to improve the health of individuals, communities, and the population of the state as a whole, such as our Healthy Kids program focused on preventive care. We efficiently provide care for enrollees in our population health programs in a manner that is consistent with their culture, values, linguistic preferences, and health resource needs. For example, we refer enrollees to the Children's Coalition for Northeast Louisiana, which serves the Hispanic population in the region, for parental education and prenatal care linkages.

Our population health strategy is data-driven, evidence-based, and person-centered. Our programs emphasize assisting enrollees to navigate the health care system and to address their social needs. We recognize the unique needs of our enrollees and understand the community characteristics that contribute to our population health outcomes (e.g., availability and affordability of healthy food options; number and location of bus stops). Our current initiatives support Aetna enrollees as follows:

- **Healthy Kids** focuses on prevention, childhood immunization, and outpatient services and follows Early and Periodic Screening, Diagnostic and Treatment (EPSDT) recommendations published by Centers for Medicare & Medicaid Services (CMS) and NCQA Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications for enrollees under age 21
- **Healthy Pregnancies and Babies** promotes prenatal and postpartum care, emphasizing screenings, evidence-based interventions, including initiation and engagement of alcohol and other drug abuse or dependence treatment, and collaboration with providers
- **Breast, Cervical, and Colorectal Cancer Screening** promotes health screenings and wellness visits
- **Flu Vaccination Program** incorporates educational activities to promote annual flu vaccination
- **Diabetes Management Program** supports self-management of chronic conditions, with specific emphasis on diabetes control for enrollees with schizophrenia and bipolar disorder
- **Reduction of Hospital Readmissions** uses discharge planning, medication reconciliation, and follow-up with the primary care provider (PCP) and/or specialist to reduce unnecessary readmissions
- **Antidepressant Medication Management** improves antidepressant medication adherence rates for those who lack access to behavioral health (BH) specialists

- **Reduction of Emergency Department Visits** reduces unnecessary emergency department (ED) utilization that leads to hospital stays of two days or more

Aetna has demonstrated our commitment to reducing disparities that advance health equity. Our Health Care Equity and Cultural Competency programs implement U.S. Department of Health and Human Services (DHHS) Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. They follow DHHS' *A Blueprint for Advancing and Sustaining CLAS Policy and Practice,* to inform the annual revision of our policies. Aetna has a team dedicated to predictive analytics to identify moderate- and high-risk populations prior to a crisis or increased utilization. We use our Health Care Equity, Demographic Distribution for ED Utilization, and Opioid dashboards to identify and stratify health outcomes by race/ethnicity, gender, geography, and other factors for the programs described herein. We use robust population data analytics and nationally recognized quality metrics to analyze data and determine root causes of poor health outcomes and disparities. The resulting analysis combined with our policies and evidence-based practices (EBPs) allows us to focus our activities for distinct enrollee subpopulations throughout the continuum of care.

Aetna Inc. has collaborated with the National Council on Behavioral Health to assess the impact of trauma on enrollees. Aetna has trained all staff on trauma-informed principles and practices, including motivational interviewing, and is working with providers in a yearlong collaborative to assess and develop standards for trauma-informed care (TIC) for our enrollees.

We have invested in dedicated staff to address health equity and cultural competency. This Louisiana-based staff includes a full-time health care equity (HCE) director who supports Aetna's population health efforts through collaboration with State and community agencies, developing relationships to provide effective community education and outreach, and analysis of Aetna and publicly available data to identify opportunities for population health interventions. The HCE director is a certified technical assistance provider for the Smarter Lunchrooms Movement and collaborates with the Well-Ahead Healthy Schools Training Krewe to support local schools' strategies to foster healthy food choices for Louisiana children. She conducts annual trainings with Aetna's community outreach coordinators on the health status of the Louisiana population, assisting them to plan events in communities of high need for specific health concerns, and serves as a resource for Aetna care managers to aid in the identification of resources to address enrollees' social determinant of health (SDOH) needs.

Our population health approach includes prevention and wellness programs that are tailored to our enrollees' medical, behavioral, and social determinant needs (e.g., housing, transportation, physical safety, and food insecurity). The goal of our approach is to improve health outcomes and reduce health disparities while serving as a responsible steward of State resources. We emphasize education and self-management, integrating care management and utilization management to close gaps in care. Enrollees' care management teams link them to community-based resources for their non-medical needs (e.g., peer support). Our breast cancer community health worker (CHW) program is one example of how our Population Health team addresses disparities in Louisiana. In 2017, Louisiana had the 28th-highest incidence and the second-highest mortality rate of breast cancer in the country. Breast cancer was the second-leading cause of cancer deaths in Louisiana and in the United States.[1] Additionally, African-American women have the highest death rate of all racial and ethnic groups and are 42 percent more likely to die of breast cancer than white women are.[2] Our breast cancer CHW program was expanded in

1 Louisiana State University, Louisiana Tumor Registry, "Louisiana Cancer Facts and Figures 2017": accessed March 28, 2019; https://sph.lsuhsc.edu/louisiana-tumor-registry/data-usestatistics/statistics/

[2] American Cancer Society, "Cancer Facts and figures for African Americans 2016-2018": accessed March 28, 2019; https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/cancer-facts-and-figures-for-african-americans-2016-2018.pdf

2019 to further target this identified disparity for African-American women. Our CHWs are collaborating with the Louisiana Breast and Cervical Health Program (LBCHP) to support education on breast cancer screenings and linkages to screening resources. They work closely with community and faith-based organizations, such as Louisiana Baptists and Congregational Health Services, to identify educational prevention opportunities and to offer linkages to health screenings for both Aetna enrollees and the community at-large. Our CHWs serve as an integral member of the enrollee's multidisciplinary care team (MCT). CHWs work to address enrollees' immediate needs, such as access to transportation and access to preventive and early intervention activities. Our current program identifies health outcomes using the HEDIS Breast Cancer Screening measure. We are developing the capability to measure other outcomes including changes in knowledge, self-management, and lifestyle, such as increased exercise and tobacco cessation. We look forward to collaborating with LDH to implement the Penn Center for Community Health Workers IMPaCT model.

Baseline Health Outcome Measures and Targets for Improvement (2.10.4.1.1)

Aetna's approach to identifying baseline health outcome measures and targets for health improvements is **data-driven, integrated, and focused on maximizing enrollee health**. Our multidisciplinary Population Health team conducts an annual review of our HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Agency for Healthcare Research, Health Resources and Services Administration, CMS Child and Adult Core Sets, and State-defined measures (as presented in **Attachment G** of the **Model Contract**). Aetna creates reports for a wide range of HEDIS measures (e.g., Breast Cancer Screening, Comprehensive Diabetes Care HgA1c testing, Adolescent Well Care, and Antidepressant Medical Management), identifying differences by race, ethnicity, gender, language, parish, and age. We supplement analysis of internal data with review of publicly available population and subpopulation health data from sources such as County Health Rankings and the LDH's Annual Health Report Card. Using the findings of this multifaceted analysis of data, Aetna identifies baseline health outcome measures for our enrollee population and subpopulations which align with the aims, goals, and objectives of the Louisiana Medicaid Managed Care Quality Strategy.

Aetna identifies targets for health improvement through our continuous quality improvement (CQI) process. We set targets for improvement using historical measures, benchmarks on national or State-defined quality metrics, and in accordance with LDH requirements. When health care inequities are identified, Aetna establishes targets for the subpopulations experiencing disparities based on the health outcome measures of the highest performing subgroup, and we set targets for improvement in health outcome measures for the population as whole. Each year, through a comprehensive, formative, and impact evaluation of our initiatives, the Population Health team determines whether identified populations have been served as intended and the degree to which targets for health improvement have been met. Thorough review of this evaluation by the Quality team leads to changes in our larger population health program. For example, through analysis of our population health initiatives focused on maternal health, we identified the need to incorporate interventions focused specifically on pregnant women with substance use disorders (SUD) and adjusted the program accordingly.

According to the American Diabetes Association, Louisiana has the fifth-highest rate of diabetes in the country, with over 450,000 individuals diagnosed with diabetes in the state.[3] Our Diabetes Management program is designed to improve health outcomes statewide by making sure enrollees with diabetes get needed services including retinal exams, blood pressure checks, and hemoglobin HgA1c monitoring, including using remote patient monitoring for enrollees who have difficulty leaving their home

[3] American Diabetes Association, "The Burden of Diabetes in Louisiana": accessed March 25, 2019; http://main.diabetes.org/dorg/PDFs/Advocacy/burden-of-diabetes/louisiana.pdf

environment for services. Our current program is focused on improvement for the entire population of Aetna enrollees with diabetes. We plan to increase efforts in specific regions and with specific subpopulations based on our dashboard data review described previously. Our national Health Care Equity team has developed a Diabetes Disparities Resource Workbook to assist care management teams in serving populations facing disparities in diabetes-related health outcomes. Locally, we supported the American Diabetes Association Camp PowerUp program for higher risk youth in Region 1 at the Sojourner Truth Neighborhood Center. We use HEDIS Comprehensive Diabetes Care metrics as health outcome measures to assess program results. Aetna identified our target for improvement on both metrics at two percentage points for HEDIS 2018 over HEDIS 2017 scores, in alignment with LDH requirements. Additionally, our Population Health team has identified food insecurity as an important SDOH for diabetic enrollees and is integrating a food-insecurity metric to our Diabetes Management Program in 2019.

Population Health Status and Identification of Subpopulations (2.10.4.1.2)

Our approach to measuring population health status and identification of subpopulations **is supported by Aetna's robust health information technology capabilities,** and it integrates a wide range of data sources, as illustrated by **Table 2.10.4-1**. Aetna's Population Health team integrates data from the sources described in this section to complete our annual, proprietary Population Assessment and Membership Profile. The Population Assessment and Membership Profile forms a comprehensive picture of the physical and behavioral health and social determinant needs of our membership, at the state and parish level. This process assists in the identification of population health gaps and opportunities, and informs the development of our Population Health Strategic Plan. Through multiple data sources we use to identify subpopulations, we collect self-reported demographic information from enrollees, including geographic location, age, ethnicity, race, gender identity, sexual orientation, religion, income source, primary language, marital status, and disability status.

Table 2.10.4-1: Data Sources to Analyze Factors Related to Health and Identify Subpopulations

Data Source	Description	Factors Analyzed	Subpopulations
Consolidated Outreach and Risk Evaluation (CORE™)	Aetna's proprietary predictive modeling algorithm used to risk-stratify enrollees	Utilization of the ED, inpatient admissions, and medical, BH, and pharmacy claims	Subpopulation of enrollees with high utilization or at high risk for ED visits or inpatient admission
HMS Elli	Monthly prospective and retrospective risk analyses, from the point of enrollment	Enrollee diagnoses, historical utilization, and SDOH data	Subpopulation of enrollees with high utilization or multiple chronic conditions
Enrollment Files	Self-reported demographic characteristics; assigned PCP, limited medical history, Medicaid eligibility categories	Complete demographic information	Subpopulations of enrollees with special health care needs (e.g., enrollees with serious mental illness)
Health Needs Assessment (HNA)	Self-reported health status; functional and social determinant needs	Social, familial, cultural, and physical environmental factors	High social need subpopulations, including housing, food insecurity, physical safety, and transportation
Enrollee Self-referrals	Self-reported demographic characteristics, health status, functional needs, and SDOH data collected for referrals to appropriate Aetna, Office of Public Health (OPH) programs, or community-based organizations (CBOs)	Complete demographic information; enrollee diagnoses	Subpopulations with barriers to accessing care with social service needs or with diagnoses qualifying for specific OPH programs; care management or community-based referrals

Data Source	Description	Factors Analyzed	Subpopulations
Provider Referrals and Z-Code Data	Provider-reported health status, functional needs, and SDOH data	Demographic factors, enrollee diagnoses, SDOH data	Subpopulations experiencing poor health outcomes, or with diagnoses qualifying for OPH programs, integrated care management (ICM), or CBO referrals
Cost and Utilization Reports	Details on utilization of services and per member per month costs	Enrollee diagnoses; trends in utilization of services and cost	Subpopulation of enrollees with high utilization or high costs (i.e., super-utilizers)
Health Care Equity Contact Assessment	Self-reported demographic characteristics, health status, and functional and social determinant needs	Complete demographic information and SDOH data	Subpopulations with social determinant needs (i.e., food insecurity, transportation, personal safety, and housing)

In addition to the Population Health Assessment and Membership Profile, Aetna collaborates with community stakeholders and LDH to identify key subpopulations. For example, our collaboration has identified subpopulations by disease incidence (e.g., neonatal syphilis), national crisis (e.g., the opioid epidemic), and natural disasters (e.g., flooding). Louisiana reported 59 cases of congenital syphilis in 2017—a rate of 93 cases per 100,000 live births. In addition, across the state, African-American women have disproportionately high rates of low birthweight (15.2 percent compared to 10.6 percent for the population) and preterm birth (15.6 percent compared to 12.3 percent for the population). Our Healthy Pregnancies and Babies program targets these adverse outcomes and uses a combination of HEDIS outcomes measures (e.g., timelines of postpartum care) and LDH-identified measures (e.g., 17P injections, syphilis testing rates) to evaluate the effectiveness of the program and set targets for health improvement. Outcomes from our Healthy Pregnancies and Healthy Babies program include the following:

- Syphilis testing: from to 27.3 percent in HEDIS year 2016 to 84.2 percent in HEDIS 2018
- 17P injections: from 9.8 percent in HEDIS 2016 to 19.01 percent in HEDIS 2018
- Timeliness of postpartum care: from 58.28 in HEDIS 2016 to 63.5 percent in HEDIS 2018

Key Determinants of Health Outcomes and Reducing Disparities (2.10.4.1.3)

From the point of enrollment, throughout the course of their care, we continuously evaluate the key determinants of health outcomes of our enrollees and their respective communities. Starting in 2019, as a first adopter of Elli in Louisiana, Aetna will gain access to four years' of claims data collected from all managed care organizations in the state. The data will be available to us on day one of an individual's enrollment and enables us to engage enrollees in the appropriate tier of care management immediately. Aetna also contacts all enrollees to attempt to complete the HNA within 30 calendar days of enrollment. The HNA addresses key SDOH, including food insecurity, housing, transportation needs, and personal safety (please refer to subsection **Approach to Collection of Social Determinant Data** below**)**.

Aetna uses multiple data elements and analyses to identify opportunities to address disparities. The data is integrated by the HCE director into our proprietary Population Assessment and Membership Profile. We use these to identify key determinants of health outcomes at the regional and parish level. This allows Aetna to define health service needs for its population and subpopulations, to identify barriers to accessing care, and to guide strategies to develop targeted interventions to reduce disparities including the following:

- Promoting the delivery of health care services that meet the needs of culturally and linguistically diverse minority subpopulations—Aetna has hired two certified translation and language interpreters on its Enrollee Services team to serve the needs of Spanish-speaking enrollees, who comprise 1.2 percent of our overall membership and 2.6 percent in Region 1

- Identifying opportunities for collaboration with CBOs and State programs based on evaluation of social and physical determinants of health data— our community outreach coordinators assist women to access Women, Infants, and Children and Supplemental Nutrition Assistance Program benefits
- Identifying hotspots for conditions and developing network solutions—Aetna contracts with CrescentCare to support the needs of enrollees living with HIV or AIDS in Region 1 (e.g., wraparound services including legal support, peer support, and case management)

Aetna developed a pharmacy-specific strategy to reduce access disparities. Aetna offers support to enrollees through the Community Pharmacy Enhanced Services Network (CPESN) comprised of community-based pharmacies that develop relationships with enrollees and support medication management, social determinant needs identification, and care management. Aetna's Pharmacy team has direct vendor oversight, acts as a liaison between the community pharmacy and Aetna ICM teams, and supports identification of enrollees for referral. The program focuses on identifying enrollees at risk for adverse medication and health outcomes due to non-adherence and gaps in care, and actions are implemented to create a care plan that is shared with the enrollee's care team. CPESN pharmacists support enrollees to manage chronic conditions. In North Carolina, which has a significant rural population, CPESN pharmacies increased medication adherence rates by 4 to 5 percent over a 3-year period compared to non-CPESN pharmacies. Specifically, CPESN pharmacies saw a 5.8 percent increase in adherence to diabetes medications. Pharmacies in the CPESN network identify enrollees at high risk of opioid misuse and provide enrollee-specific education about their individual risk factors, dispense naloxone, and provide education to the enrollee or caregiver(s) about how to administer medications.

Integrated and Comprehensive Approach to Population Health (2.10.4.1.4)

As part of our population health approach, we emphasize health promotion and disease prevention through our ICM model. Our approach is supported by innovative health information technology solutions and it establishes data-driven initiatives with providers, working toward value-based payment arrangements that support population health. SDOH are addressed through provider and enrollee engagement, via community outreach strategies, and are integrated into our value-added benefits.

Integration of care management and population health: Aetna collects and analyzes social risk data from a wide range of sources, including the HNA, HCE Contact Assessment, enrollee and provider referrals, Z-codes, and Elli, as described in **Table 2.10.4-1**, and attempts to collect SDOH data on all enrollees. Our HNA currently asks questions such as, "Have you been hungry in the last 6 months? Do you have difficulty affording food? Do you use all of your food stamps each month if you receive them? Has transportation prevented you from getting to a medical visit? Do you feel safe in your home?" We integrate this with CORE, our proprietary predictive modeling algorithm, to risk-stratify enrollees, identifying enrollees with increasing health risks and high needs. The goal is to engage enrollees with the right level of clinical and social support at the right time. We provide population health interventions to enrollees at three levels of risk based on their individual needs. The subpopulation of enrollees identified with high risks and high needs (social, behavioral, or medical) are referred to the intensive level care management. Subpopulations with higher levels of social needs, such as transportation, housing, food insecurity, and personal safety are also risk-stratified and referred to the intensive, supportive, or population health level of ICM based on their whole health needs. For enrollees in these two levels, an MCT assesses physical, behavioral, and SDOH needs upon initial assessment, upon annual reassessment, or more often if indicated by a transition of care, change in status or another triggering event. All other Aetna enrollees are stratified to the population health level of ICM, and they receive quarterly mailers with information about prevention and wellness, including information on smoking cessation and weight management.

Population health management platform and other information sharing support: In support of our population health approach, Aetna engages in value-based purchasing (VBP) contracts with Louisiana

providers, which provide incentives for improved quality of care and lower costs for our enrollees. In 2018, 76 percent of Aetna enrollees had a PCP in VBP relationships and 51 percent of our total claims spend occurred through VBP arrangements (please refer to **Section 2.10.12** for complete details on our VBP arrangements). Our goal is to achieve 60 percent of our provider payments through VBP in 2020, 70 percent by 2021, and 75 percent by 2022. Aetna collaborates with high-volume providers to develop, promote, and implement targeted, evidence-based interventions for subpopulations experiencing health disparities. We deploy staff members and population health specialists (PHSs) to work directly with providers to educate them on the adoption and use of our population health management platform, and with the design and analysis of clinical workflows. Specifically, PHSs support our VBP providers to collect and understand population health data of their membership, with the aim of closing gaps in care and improving HEDIS measures on targeted outcomes. We are deploying a Pay-for-Reporting program to incentivize providers to collect social determinant data for enrollees using Z-codes. Our PHSs have access to a comprehensive suite of technology to support our providers. This includes access to Aunt Bertha, our repository for social needs, telehealth, and remote patient monitoring technology.

Population Health Specialists: Supporting Access Health's Maternal Care Coordination Pilot

Aetna PHSs identified a need for federally qualified health centers in our network to have timely reports of births to assist providers with improving their provision of postpartum care to new mothers. The Population Health team collaborated with Access Health to use available data to identify women's postpartum care needs, close gaps in care, and improve quality outcomes on the HEDIS Timeliness of Postpartum Care metric. PHSs worked with the Quality Management team to extract weekly reports of new mothers served by Access Health from LDH's Louisiana Electronic Event Registration System. Beginning in April 2017, specialists provided weekly reports on new live births to Access Health's maternal care coordinator (MCC) to inform them of new deliveries and assist them in identifying women to engage in postpartum care. The MCC met weekly with specialists to review enrollees needing care, remove barriers to care, and assure every effort was made to provide postpartum care within the HEDIS guidelines. The initiative also served to increase providers' actionable knowledge of women's need for postpartum services in a 21- to 56-day window after delivery. As a result of this program, Access Health increased its HEDIS Timeliness of Postpartum Care metric from 47.76 percent in 2016 to 63.28 percent in 2017, an improvement of almost 33 percent. The final 2017 HEDIS score also achieved the State target of 63.12 percent.

Enrollee and provider engagement: Aetna incorporates feedback from enrollees and providers regarding their satisfaction with our services, programs, and benefits into our population health programming. Enrollees are invited to complete satisfaction surveys (e.g., CAHPS) and providers complete an annual Provider Satisfaction Survey. Enrollees and providers voice any concerns about their experience with Aetna through the Enrollee Advisory Committee, Provider Advisory Council, and Hospital Advisory Committee. Through our grievance and appeals process, Aetna also learns about concerns regarding our population health program from providers and enrollees. All of this feedback is addressed by the Quality Management Oversight Committee, which includes enrollee participation. The quality management director incorporates this feedback into the annual Quality Assessment Performance Improvement plan evaluation. When necessary, this feedback also leads to updates to Aetna policies and procedures and informs training requirements for Aetna employees. As an example, through the grievance and appeals process, we learned about the need to complete a single case agreement so an enrollee with diabetes could acquire his insulin pack through a provider in his local community.

Integration with community outreach: We integrate community-based health and wellness strategies with a strong focus on SDOH, creating health equity and supporting efforts to build communities that are more resilient into our population health approach. Aetna understands the unique needs of Louisiana's populations and subpopulations, and we leverage our relationships with CBOs to provide preventive services and peer support to enrollees and to address access to care issues due to social determinant needs.

We conducted 467 outreach events with over 200 community organizations, including 98 health and wellness fairs, 24 sponsored conferences, and 22 back-to-school events. For example, the Louisiana Healthy Communities Coalition in Region 9, a predominately-rural region, identified gaps in access to wellness services. Based on this input, Aetna opted to participate alongside the Bogalusa Strong collaborative partnership of community leaders, businesses, and social service organizations in its Business on the Block program. With the support of Aetna's Community Outreach team, the eighth annual Business on the Block event was the first year that the event included a health and wellness component. Aetna provided health screenings, offered flu shots, held yoga and line-dancing sessions, and set up an Aetna informational table, providing resources to over 1,000 potential and current enrollees.

Using value-added benefits for enrollees to address population health: Our enrollee value-added benefits are uniquely designed to address Louisiana's population health goals, as outlined in Creating a Blueprint for our Future. According to LDH, more than 400 Louisianans died of an opioid overdose in 2017. [4] With opioid addiction on the rise, providers are seeking effective alternative pain management options for their enrollees. To support these efforts, Aetna will offer coverage for acupuncture and chiropractic services.

Other Population Health Considerations (2.10.4.1.5)

Aetna's population approach incorporates our adoption of national opioid strategy, a commitment to providing trauma-informed care for enrollees, and our emphasis on building the capacity of local communities through strategic investment.

Aetna's national Medicaid opioid strategy: Aetna has developed a multifaceted, national strategy for combating the complex issue of inappropriate use of opioids, focused on prevention, intervention, and support. We are implementing this strategy in Louisiana, and 15 other states where we operate Medicaid plans. We bring our national expertise to our partnerships with local, state, and federal governments, as well as local stakeholder groups, such as first responders and public health agencies. Aetna emphasizes care coordination and continuity of care by reducing barriers that restrict access to SUD treatment, medication-assisted treatment, support programs, and non-pharmaceutical alternatives through our extensive provider network, use of telemedicine, remote patient monitoring, and our comprehensive Medicaid and value-added benefits package. We have created our Opioid dashboard, which uses pharmacy and medical claims data to trend key metrics to help us combat inappropriate use of opioids in Louisiana. Data from our Opioid dashboard shows our success in Louisiana; since January 2017, we have the following outcomes:

- Increased the rate of non-opioid treatment for chronic pain by 43.3 percent
- Decreased the rate of opioid prescriptions for enrollees with OUD by 42.9 percent
- Decreased the rate of a 7-day opioid prescription after an acute procedure by 71.5 percent

Aetna's transformation into a trauma-informed organization: According to the most recent report from Child Trends, 50 percent of children in Louisiana have experienced at least one adverse childhood event.[5] Aetna is undertaking a systemwide transformation initiative to develop a system that includes trauma-informed network capacity and addresses the impact of trauma, including adverse childhood experiences (ACEs), in our enrollee population. This transformation prepares all Aetna enrollee-facing staff to serve Louisianans who are particularly vulnerable because of ACEs and other experiences of trauma. Aetna subscribes to the following tenets as established by the National Institute for Trauma-Informed Care: We realize that trauma is common; we recognize how trauma affects individuals seeking care; we respond by implementing TIC best practices; and we resist causing additional trauma. In support

[4] "Panel of Experts Makes Six Recommendations to Fight the Opioid Epidemic in Louisiana": accessed March 16, 2019; http://ldh.la.gov/index.cfm/newsroom/detail/4991

[5] Sacks, Melissa, Murphey, David, and Moore, Christian, "Adverse Childhood Experiences: National and State-Level Prevalence": accessed March 28, 2019; https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

of this initiative in Louisiana, over 128 of 136 (over 94 percent) Aetna employees have completed "The Urgency to Address Trauma" training and almost half have completed Taking a Deeper Dive training. By 2020, we anticipate that 100 percent of Aetna employees will have begun training in TIC.

Reducing Trauma for Foster Care Children

Each month, Louisiana serves more than 4,700 foster children, and more than half of these children are under the age of 5. In 2018, Aetna provided a $50,000 grant to Geaux 4 Kids, Inc. to support Project Geaux Bags. Geaux Bags is a project to help children in foster care in the first 24 hours of a new placement with a basic bag of right-sized necessities to make the first night in a new home or placement a little easier. Geaux Bags help to reduce the trauma children face being separated from their birth family or previous foster family. Aetna has targeted its donation to the expansion of the project to Region 5, where there is disproportionate need based on the number of children with Department of Child and Family Services involvement.

Strategic community investments: Aetna commits community investment dollars to programs that address physical health, behavioral health, prevention and wellness, housing, food insecurity, transportation, and personal safety needs of our enrollees and communities. Aetna's strategic community investments align with the five strategic priorities outlined in LDH's *Creating a Blueprint for our Future*. In 2018, $400,000 in community investment grants was made to 21 organizations throughout Louisiana, $300,000 from Aetna, and $100,000 from the Aetna Foundation.

Addressing Population Health in the First Year of the Contract (2.10.4.2)

Table 2.10.4-2 identifies Aetna's population health strategic goals for the first year of the contract, and presents activities, milestones (when applicable), and timeframes for each goal. Aetna will implement activities outlined in **Section 2.6** of the **Model Contract**, as required, and according to established timeframes. We will incorporate new activities outlined in the contract to our existing population health strategy as necessary (e.g., implementation of activities to prevent avoidable use of opioids and treat enrollees with opioid use disorder). Aetna will have a fully developed Population Health Strategy Plan document submitted to LDH by March 1, 2020 as per **Section 2.6.1.1** of the **Model Contract**.

Table 2.10.4-2: Aetna's Plans for Addressing Population Health in the First Year of the Contract

Goal	Activities/Milestone	Timeframe
Develop a Population Health Strategic Plan	Submittal and approval of a Population Health Strategic Plan, including baseline population health measures and targets for improvement, to align with LDH's selected population health priorities outlined in Section **2.6.1.1.1-2.6.1.1.11** of the **Model Contract**	By March 1, 2020
Conduct Population Assessment and Membership Profile	Review all population health data sources and complete the Aetna Population Assessment and Membership Profile templates	By March 31, 2020
Establish programs to address all LDH priority populations	Develop population health programs to address key health issues facing Louisianans (e.g., obesity, infant mortality, smoking cessation)	By December 31, 2020
Support LDH's public health initiatives and coordinate with existing public health programs	Conduct enrollee and provider education on programs; coordinate referrals with public agencies; participate in data sharing and complete data-related agreements	Ongoing throughout 2020
Increase capacity of existing VBP providers to collect SDOH data and refer enrollees to appropriate agencies	Identify gaps in VBP provider ability to collect SDOH data; educate all current VBP providers on our population health management platform and the collection of Z-codes; educate identified providers (at least 40) on the use of Aunt Bertha to identify resources for SDOH needs	Ongoing throughout 2020
Establish new VBP contracts with providers who serve relevant subpopulations	Network Management outreaches to at least 30 providers to explore the potential of developing VBP agreements; completion of at least 15 new VBP arrangements	Ongoing throughout 2020

Goal	Activities/Milestone	Timeframe
Evaluate Population Health Programs	Review all quantitative and qualitative population health data sources and complete process and impact evaluation of Aetna's population health programs	Ongoing throughout 2020
Expand collaboration and care management referrals to CBOs	Complete assessment of current collaborations and engage 10 new organizations to address key determinants of health outcomes, in particular agencies to address ACEs and interpersonal safety	Ongoing through 2020
Required reporting to LDH	Submit all required reports and updates as outlined in **Section 2.6** of the **Model Contract**	By the LDH-established date
Increase enrollee and provider awareness of OPH programs and CBO resources	Create informational materials about Aetna's collaborations with public health agencies and community-based resources; dissemination of materials to all enrollees and contracted providers	Ongoing through 2020
Advance use of EBPs across population health programs	Conduct literature reviews to identify best practices for population health interventions, and include enrollees of target populations to tailor EBPs to the local environment and culture	Ongoing through 2020
Expand awareness of CLAS standards	All staff receive training on CLAS standards	Ongoing through 2020
Provider, staff, and contractor training	All appropriate providers, staff, and designated contractor staff are trained to understand and collect SDOH data; staff are trained to document SDOH data in the electronic care management platform	Ongoing through 2020

Experience Utilizing and Approach to Collecting SDOH Data (2.10.4.3)

Aetna collects and utilizes data regarding SDOH to improve the health status of targeted populations. Aetna's approach to data collection and utilization fosters enrollee engagement in self-reporting their social determinant needs, involves Care Management and Enrollee Services staff, and includes PCPs and other providers. In 2018, Aetna began stratifying data across demographic characteristics to identify social determinant of health disparities in our population and subpopulations. For example, by aggregating HCE Contact Assessment data, we identified that 34 percent of enrollees need a dentist. We offer dental care as an enrollee value-added benefit (please refer to **Section 2.10.3** for complete details). We are continuously developing new ways to stratify social determinant data to identify disparities, and learn from best practices developed in Aetna health plans across the country.

Approach to Collection of Social Determinant Data

Aetna uses enrollee-level demographic and social risk data to target interventions to improve population health. Our approach to the collection of SDOH data includes collection of both individual-level self-report and claims data and internal and publicly available population-level data. We analyze this data annually, and it informs the development of our proprietary Regional Health Profiles, Population Assessment, and Membership Profile where specific reference to enrollee food, housing, transportation, and personal safety are addressed. In addition, our ED Utilization Dashboard identifies opportunities to reduce preventable ED visits that may be due to health inequities, such as a lack of access to preventive care or poor housing conditions. The specific strategies Aetna uses to collect SDOH data include the following:

HNA: Aetna contacts 100 percent of enrollees, using multiple outreach attempts, to complete the HNA within 30 days of enrollment. This allows for stratification into an appropriate level of service and enrollment in the care management program immediately, if the need is identified. A comprehensive assessment is completed for 100 percent of enrollees who responded that they have a physical, behavioral, or any social determinant need. The comprehensive assessment is completed annually or more often when required by a change in health status, transition of care, or a change in social need (e.g., new homelessness). Aetna looks forward to and will implement the LDH Health Needs Assessment Instrument (**Section 3.1.15** of the **Model Contract),** when it is available**.**

Health Care Equity Contact Assessment: The Health Care Equity Contact Assessment assists with documenting, tracking, and reporting on enrollees' social determinants needs, inclusive of housing, transportation, food insecurity, and personal safety, and identifies enrollees who may benefit from additional interventions and education to address them. The demographic characteristics included in the Health Care Equity Contact Assessment include race, ethnicity, gender, sexual orientation, and geographic location, among others. Staff on the enrollee's MCT conducts the Health Care Equity Contact Assessment for all enrollees engaged in care management, and documents self-reported SDOH data in our electronic care management system. The intent is for the captured SDOH data to be incorporated into the development of the individualized person-centered care plan. When they identify a social determinant need, they can use our technology, such as Aunt Bertha, connect with Aetna's housing specialists, or engage CBOs to identify resources to meet their needs. For example, almost 20 percent of our enrollees who completed the HCE Contact Assessment reported that they sometimes or often did not have enough food. Through Aunt Bertha, an enrollee in Shreveport facing food insecurity can locate a food pantry, such as Noel Neighborhood Ministries.

Social determinant of health data we collect at the **population level** primarily derives from Community Commons, State Health Improvement Plans, and Community Health Improvement Plans. Community Commons is an online resource that aggregates and reports on publicly available data from a wide range of sources (e.g., U.S. Census Bureau and American Community Survey, Centers for Disease Control and Prevention WONDER, 500 Cities, etc.). This data is aggregated into a Community Health Needs Assessment by parish, and highlights social determinant needs of communities, including transportation, housing, and food security, in addition to a range of other economic, cultural, and physical environmental factors. Aetna has collaborated with U.S. News & World Report to create a database that can identify risk in 10 areas of social determinants and can compare any two cities across the United States.

Addressing Gaps in Care and Health Literacy through our Healthy Kids Program

Aetna has experience using population health data to identify gaps in care that affect our membership. We identified gaps in preventive care for children and adolescents as a priority issue affecting our enrollees in Louisiana. A root cause analysis identified gaps in health literacy of parents as a social determinant affecting enrollees' ability to access pediatric preventive care. Our Healthy Kids program is designed to increase use of preventive and outpatient services and follows EPSDT recommendations published by CMS and NCQA HEDIS technical specifications for improving health outcomes for enrollees. Without preventive care or treatment, pediatric and adolescent populations are at greater risk for poor health outcomes, such as childhood obesity, diabetes, and exposure to communicable diseases.

The Healthy Kids program enhances enrollee knowledge by increasing access to easy-to-understand information related to the importance of wellness exams and immunizations. Information about our program is distributed by enrollee newsletter, website, flyers, and the enrollee handbook, and based on cultural or linguistic minority enrollee needs. Specific interventions include the following:

- Updating the Aetna website to include an activity calendar, interactive activities explaining when to get annual wellness checkups, developmental screenings, and immunizations, along with periodicity tables and immunization schedules based on the enrollee's stage of growth and development
- Sending enrollees newsletters, mailers, flyers, and text messages throughout the year, with a focus on the importance of getting annual wellness examinations and needed tests or screenings
- Making interactive phone calls to enrollees or their parent regarding the importance of annual wellness screenings, through which they are prompted to schedule an appointment with their PCP
- Providing information through Enrollee Services and Care Management about the benefits of our program during outreach calls, and assisting in the coordination of care with the enrollee's PCP

Children who attend well visits and dental visits, as well as receive shots, earn rewards through our **Healthy Milestones Incentive Program**. Aetna is developing evaluation tools to determine the return on investment for the activities described.

Aetna conducts an annual evaluation of the Healthy Kids program to assess overall effectiveness of our initiatives, including opportunities for CQI. The evaluation of the Healthy Kids program identified potential barriers enrollees face in participation and associated opportunities for improvement. For example, we identified that enrollees' PCP may not communicate to their parent or legal guardian the need for an annual wellness visit and/or immunizations. To address this barrier we are conducting provider education to encourage office managers to schedule well-child visit appointments in advance and to encourage providers to complete all preventive testing and screening during the annual wellness visit. In addition, our Quality Management department trends HEDIS measures, such as changes in disparities for subpopulations, to assess quality performance. **Table 2.10.4-3** demonstrates some of the outcomes of the Healthy Kids programs. In measurement year 2018, Aetna achieved the State Target Goals for each of the measures in **Table 2.10.4-2**, three of which were not met in the previous measurement year.

Table 2.10.4-3: Aetna Healthy Kids Program Outcomes

Measure	HEDIS 2016	HEDIS 2017	HEDIS 2018	State Target Goal
Adolescent Well Care	31.71%	42.82%	46.72%	40.69%
Well Child - 15 Month	N/A	53.94%	63.99%	62.06%
HPV for Female Adolescents	N/A	15.28%	30.17%	21.76%
Immunization Adolescents Combination 1	N/A	63.66%	80.05%	77.62%

The Healthy Kids approach provides a model for developing and implementing prevention and population health management programs to encourage improved health and wellness among enrollees (an LDH population health priority described in **Section 2.6.1.1** of the **Model Contract**). The process begins with data-driven identification of a gap in preventive care stratified by subpopulation and planning targeted interventions to impact quantifiable outcome measures. It incorporates assessing community resources and development of strategic collaborations with CBOs and other external stakeholders. This approach can be applied to multiple health priorities, as outlined in our Population Health Management Strategy.

Contracting with Community-based Organizations and OPH (2.10.4.4)

Aetna will collaborate with the LDH, OPH, and CBOs to align population health strategies, and address socioeconomic, environmental, and or policy domains. Aetna's approach to contracting with CBOs and OPH to expand population health improvement strategies is in alignment with our broader population health strategy and is based on an in-depth understanding of the medical, behavioral, and social determinant needs of our membership. We use data about the adequacy of our network-specific geographic areas to inform recruitment of providers of various types to meet enrollees' needs. We use publicly available data and leverage data tools (e.g., Community Commons) to identify food deserts and areas of high chronic disease burden to assist with selection of strategic community investments and collaborations with CBOs. We listen to the experiences and concerns of our enrollees and we respond to issues identified by LDH and other public agencies.

Locally, we have entered into collaborative agreements with multiple CBOs, including LBCHP. Our current agreements define data-sharing responsibilities and reporting requirements. We seek to continue to develop these agreements into formal contractual relationships in 2020 and beyond. In multiple Medicaid markets, including Ohio, Texas, and Virginia, we contract with CBOs to provide care coordination and care management, and wraparound services to address social determinant needs of our enrollees. Aetna contracts with local area agencies on aging, and supports them to develop their business models, health information technology capacity to exchange data, and overall capacity to provide services to our enrollees. Our contracts define payment arrangements, quality assurance and quality improvement targets, and roles and responsibilities for care coordination. Aetna will leverage this experience to develop its contracting with OPH and CBOs in Louisiana to further coordinate population health strategies.

2.10.4.5 Community Health Worker (CHW) Demonstration Project

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2.10.4.5 Community Health Worker (CHW) [OPTIONAL]

Aetna understands, acknowledges, and will comply with all the requirements related to community health workers (CHWs) in **Section 2.6.3.2.3** of the **Model Contract**.

Piloting a Community Health Worker Demonstration Project (2.10.4.5)

Aetna is deeply invested in Louisiana's local communities, and we have demonstrated success improving the lives and health of enrollees with our current CHW program for enrollees with complex physical and behavioral health needs.

Aetna's Interest in this Opportunity (2.10.4.5.1)

Getting Enrollees Engaged in Care: CHW Success in Pennsylvania

In our Medicaid plan in Pennsylvania, Aetna's 35 CHWs were deployed to engage at least 500 enrollees in individualized care planning in 2017. The CHWs far exceeded their target, getting over 700 enrollees engaged.

Aetna is excited about the opportunity to expand its current CHW program and work with LDH to create a sustainable, scalable CHW program for all Louisiana Medicaid enrollees. Aetna understands the value of CHWs to improving enrollee health and includes them as key members of the Care Management team. Aetna has both employed and/or collaborated with CHWs in community-based organizations (CBOs) in Louisiana since 2015. In Arizona, in partnership with the Arizona Community Health Workers Association, our CHWs are teaming with our enrollees with serious mental illness and diabetes to address educational needs and diabetes health literacy. In Louisiana, our current CHW program is focused on Region 4 to evaluate and increase enrollees' access to breast cancer screenings and treatment. Acadiana Region 4 has the second-highest rate of breast cancer diagnosis combined for years 2017 and 2018. A large proportion of our enrollees in Region 4 are located in Lafayette Parish (36 percent), and 55 percent of those are women. Based on our internal data and communication with community stakeholders, we have the capacity to impact mammography screenings, education, and treatment options within identified communities within this parish.

Aetna values the role of our CHWs. We have seen the benefits of CHWs with some of our most complex populations. We believe it is critical to provide our enrollees a standardized, evidence-based CHW program that is fully integrated into the current system of care and that provides our enrollees with a trusted person that shares their sociodemographic characteristics. We affirm our interest in piloting the Penn Center for Community Health Workers' IMPaCT Louisiana model in a collaborative manner that is tailored to the needs of enrollees, offers services in their home communities, and that is sensitive to our enrollees' social, cultural, and linguistic needs.

Number and Location of Louisiana-based CHWs (2.10.4.5.2)

Aetna employs four, full-time community outreach coordinators (CHWs) who are fully trained, operate statewide, and work within our Breast Cancer Screening program.

Aetna's Current CHW Program in Louisiana: Aetna has implemented a combination of the Outreach and Enrollment Agent and Community Organizer and Capacity Builder Model adopted from the Rural Health Information toolkit to design the CHW Action Plan.[1] All Aetna CHWs participate in our comprehensive training program (a full description of the training program is provided in this section). Our overarching goals are as follows:

- Promoting population health by assisting individuals in their communities to adopt healthy behaviors
- Advocating for the health needs of individuals by assisting community residents in effectively communicating with health care providers or social service agencies

[1] Rural Health Information Hub, "Community Health Workers Toolkit": accessed March 28, 2019; https://www.ruralhealthinfo.org/toolkits/community-health-workers/2/models

- Acting as liaison or advocating and implementing programs that promote, maintain, and improve individual and overall community health
- Supporting enrollees with locally based CHWs who understand the community they serve to decrease fragmentation and increase integration across providers and care settings

In Louisiana, we hire CHWs as an integral part of our Care Management team and we collaborate with community-based CHWs to maximize the opportunities available to our enrollees. Aetna CHWs' multifaceted responsibilities and skills allow them to support enrollees' needs for medical and behavioral services and social determinants. They are trained to serve individuals in a person-centered, holistic manner, in alignment with the foundational principles of our population health approach, so that if a social need is identified our CHWs have access to the complete care team to help our enrollees. We currently have four full-time CHWs and collaborate with CBOs (e.g., Louisiana Community Health Outreach Network). Our CHWs assist enrollees to navigate the health care system and provide emotional and educational support and evidence-based home visitation. In Region 4, our CHWs contribute to our Breast Cancer Screening program, focusing on reducing the burden of late-stage breast cancer for women by increasing breast cancer screenings. CHWs are key to serving our enrollees. They provide education on the signs and symptoms of breast cancer, addressing social determinant barriers that limit access to preventive services, and link women to treatment resources. The Breast Cancer Screening program supports LDH's Taking Aim at Cancer in Louisiana initiative, which aims to increase early detection and impact breast cancer survival rates in the state.

Aetna CHWs serve individuals in a variety of settings. Our current model offers services to enrollees in community-based settings, meeting them where they are. By 2020, Aetna CHWs will be providing in-home services to enrollees needing CHW supports but lacking transportation. They will assist enrollees that may not understand the public bus system or may not understand the value of preventive health screenings. Our CHWs understand the challenges of the communities where they serve and help enrollees in need. For example, CHWs collaborate with Lafayette General Medical Center and Woman's Hospital Mammography Coach (a mobile health van) to increase awareness, offer resources, and provide breast cancer screenings in the faith-based community. Though our partnership with Congregational Health Services, which serves as an arm of Lafayette General Medical Center, our CHWs have direct access to 25 regional churches reaching over 2,500 enrollees of the Lafayette community.

An Aetna CHW in our Medicaid plan in Virginia assisted an enrollee with Parkinson's disease to transition home from a facility by linking him to community-based resources to adapt his home, and identifying both a durable medical equipment provider and a neurologist close to his home.

CHW training prepares our workers to assist enrollees in care transitions including discharge from a hospital or release from the criminal justice system. In these circumstances, CHWs help enrollees with navigating the health care system, assist with care coordination, and provide health education to increase enrollees' health literacy. We will expand our program statewide, and develop collaborations with community-based CHWs and organizations to address our enrollees' whole-person needs.

CHW to Member Ratio (2.10.4.5.3)

Aetna's current CHW to enrollee ratio for our breast cancer screening program in Lafayette Parish in Region 4 is 75 enrollees per community outreach coordinator (CHW). In implementing the IMPaCT Louisiana model as a pilot program, Aetna affirms its commitment to maintaining a ratio of no higher than 100 enrollees per 1 full-time CHW as stipulated in **Section 2.6.3.2.5** of the **Model Contract**.

Main Activities of CHWs (2.10.4.5.4)

Aetna community outreach coordinators schedule, plan, and participate in community outreach events organized to increase awareness of breast cancer screenings to Aetna enrollees, providers, and the community at large. As community organizers and capacity builders, we promote community action and garner support and resources from community organizations to implement new activities, such as

community health advisor pilot project with the Louisiana Breast and Cervical Health Program (LBCHP). CHWs also educate health care providers about community needs, bridging cultural gaps between providers and communities. The specific enrollee-facing activities of community outreach coordinators in the Breast Cancer Screening program include the following:

- Participating with care managers or other members of the enrollee's interdisciplinary care team to assist with breast cancer education to address any social or cultural barriers to screening, such as interpretation needs
- Assisting enrollees with applications to Women, Infants, and Children, Supplemental Nutrition Assistance Program, and other federal programs
- Supporting enrollees to schedule and attend appointments with providers
- Arranging non-emergency medical transportation to enhance appointment attendance and access to care
- Referring enrollees to needed community-based resources
- Performing social determinants screening, using the Health Needs Assessment (HNA) and Health Care Equity Contact Assessment (described in **Section 2.10.4**) to identify food insecurity, transportation, housing, and personal safety needs; using Aunt Bertha, an online social resource tool, to locate resources
- Documenting and tracking social needs directly into our electronic care management platform. CHWs can also track social services provided by Aunt Bertha and report any gaps to our System of Care team or our Care Management team
- Coordinating care, conducting preventive care education, and assisting with care transitions
- Assisting enrollees with technology solutions, including remote monitoring tools and telehealth, to improve ready access to care

Supervision of CHWs: Aetna has a structured supervision program as well as formal training for supervisors. Our supervisor-training program includes forms to document supervision, a supervision toolkit, and policies and procedures on providing effective supervision. Each CHW is required to report directly or indirectly to an Aetna-employed CHW clinical supervisor and meet weekly for supervision meetings. The CHW supervision process offers a key feedback loop that allows cultural information from enrollees served by CHWs to be communicated and infused back into our health plan practices, and provides an opportunity to solve for problems and address questions or challenges that arise in field-based settings. This structured supervision approach improves fidelity to a defined CHW model—Aetna CHWs will have the supervision necessary to implement the IMPaCT Model.

Supporting an Enrollee Experiencing Homelessness

In our Medicaid plan in Pennsylvania, Aetna has deployed CHWs to serve enrollees with special health care needs. For example, one of our CHWs is supporting an enrollee with multiple physical, behavioral, and social determinant needs. The enrollee is legally blind and deaf, they are recovering from a broken neck, and they have a history of alcohol and opioid addiction. The enrollee is also homeless, while trying to care for a 10-month-old infant. The enrollee reported to his CHW that he often went hungry, using his resources to buy formula for his child. The enrollee struggled to find work because he did not have the proper work boots or glasses he needed. Upon their first meeting, the CHW began by connecting the enrollee to a local food bank that provided him with food to last one month, and an appointment to return for more the following month. The CHW also provided the enrollee with a voucher to purchase the work boots he needed at Walmart and assisted him to get a new pair of glasses. The CHW linked the enrollee with a CBO to help cover half of his first month's rent in a new apartment. The enrollee is now employed, has his own housing, and is about to receive new hearing aids.

CHW Training (2.10.4.5.5)

All Aetna CHWs complete our intensive core competency training, which totals 133.85 instructional hours and occurs over a 90-day period. **Table 2.10.4.5-1** presents our comprehensive CHW training curriculum. Our training program prepares CHWs to perform the core competencies established by LDH and presented in **Section 2.6.3.2.6** of the **Model Contract**. We feel this standardized approach to core competencies assists in talent and performance management as well as development of programs that are scalable and sustainable. Aetna trains CHWs in stages based on what is most important to their work and progresses them through a training plan that builds skills over time and incorporates ongoing support and education. Notably, Aetna CHWs' training includes an introduction to trauma-informed care in support of Aetna's trauma-informed transformation, and emphasizes enrollee self-management to foster independence. Our CHWs come from enrollee communities and receive training in self-care. They are delivered in a manner that is fully accessible to and culturally responsive to our CHWs. Aetna CHWs complete a capstone project at the end of their core training to assess and validate understanding of learning objectives as well as their ability to re-create the documentation of processes and/or actions in our electronic care management platform. Each CHW has access to additional resources through the Aetna online Learning Performance Library, and receives training and competency testing to understand privacy and Healthcare Insurance Portability and Accountability Act (HIPAA) requirements.

Table 2.10.4.5-1: Aetna's Comprehensive Community Health Worker Training Program

Prior to Member Contact

- CHW Core Training
- Working with Difficult People
- How Culture Impacts Communication
- Service Excellence
- Enhancing Communication with Medical Providers and Medical Terminology
- Self-Advocacy and Recovery
- The Art and Science of Communication
- Trust Building through Effective Communication
- Boundaries and Dual Relationships for Paraprofessionals
- Rapport and Relationship Building
- Soft Skills Core Class
- Introduction to Emotional Intelligence
- Time Management
- Safety in the Field
- Managing Common Physical Health
- Conditions Motivational Interviewing
- Introduction to Trauma-informed Care
- Disaster Trauma: Promoting Resilient Individuals, Organizations, and Communities
- Working in a Team
- First Aid Refresher
- Cultural Issues in Treatment
- Overview of Serious Mental Illness
- Behavioral Health 101 for Medicaid
- HIPAA Security Rule
- Professional Ethics for Substance Use Disorder Counselors
- Ethical Decision Making
- De-escalating Hostile Clients
- Crisis Management Basics
- Face-to-Face Class
- Aetna Mental Health First Aid

First 30 Days of Employment

- Enrollee Safety: Reducing Medical Errors
- Effective Communication
- Person-Centered Planning
- Emotional Intelligence: Owning Your Emotions
- Pediatric Development
- Learning to Love Groups
- Customer Services
- Learning about People–Interviewing
- Working with the Homeless
- HIPAA Privacy Rule
- HIPAA Basics
- Compliance as a Core Competency

Second 30 Days of Employment

- Integrated Care Treatment Planning
- Guidelines for Documentation
- Therapeutic Boundaries
- Navigating the Workplace with Emotional Intelligence
- Motivational Interviewing Cornerstone Workshop

Third 30 Days of Employment

- Employee Wellness – Emotional Intelligence: Feeling & Thinking
- Managing Chronic Pediatric Conditions Core Class
- Advocacy and Multicultural Care

Making Sure CHWs are Trusted by the Communities They Serve (2.10.4.5.6)

To make sure our CHWs are trusted by the communities they serve, we intentionally hire individuals that have the background, experience, and local knowledge to carry out their multifaceted functions in specific local communities. Our CHWs come from the communities where our Aetna enrollees live and match the population they serve in racial/ethnic heritage, gender, and language and culture. Aetna CHWs attend annual trainings on cultural competency and participate in quarterly cultural conversations and annual trainings with the entire Aetna health plan staff. These educational opportunities help our CHWs be more effective for the population they are serving and sensitive to enrollees' values and experiences. Enrollees who are served by a CHW have the opportunity to provide feedback to Aetna via satisfaction surveys,

which allow the Population Health team to determine what additional steps can be taken to increase CHWs' ability to relate to the communities they serve.

Data Collection and Evaluation Related to Aetna's CHW Programs (2.10.4.5.7)

CHWs document encounters with enrollees, collecting data used to measure the effectiveness of the interventions and education provided to enrollees. For example, they collect health status and social determinant data in our internet-based Health Care Equity Contact Assessment via check box and drop-down enabled forms, using 4G-enabled tables or laptops with MiFi hotspots. By 2020, Aetna CHWs will be documenting HNA information directly into our electronic care management platform.

We believe that evaluation and continuous quality improvement are keys to successful scaling and sustainability of our CHW program. Aetna collects process and outcome data for its CHW program in the Medicaid plans where they are employed as a component of our population health approach. For example, in Louisiana we collect volume of telephonic contacts and face-to-face outreach; number of care plans that CHWs assist in developing; number of referrals CHWs make to providers and CBOs; and CHW caseload ratios. Our current program has begun to look at outcomes of health using Healthcare Effectiveness Data and Information Set data, including changes in outcomes in breast cancer screening. We are developing the capability to measure other outcomes of our CHW program, including changes in enrollee knowledge; enrollee self-management; and enrollee lifestyle changes (e.g., increased exercise, tobacco cessation, etc.). We commit to a future collaboration with the Center for Healthcare Value and Equity at LSU Health Sciences Center to design and implement an evaluation of the IMPaCT model using a randomly assigned comparison group.

Collaboration with the Louisiana Breast and Cervical Health Program

Aetna collaborates with LBCHP to improve access to timely breast and cervical cancer screening and diagnostic services for low-income, uninsured, and underserved women. Grant funding and ongoing assistance from our health care equity director, manager of marketing,, and Community Development and Community Outreach staff supports the development and piloting of a community health advisor (CHA) project. To assure equitable access for these early detection services, LBCHP attempts to reach the most medically underserved women throughout pilot parishes, utilizing effective, community-based, participatory approaches. These evidence-based approaches were adapted through partnerships with existing CHA programs in Louisiana, including the American Cancer Society and Cenla Medication Access Program, as well as national programs, such as the University of Alabama's REACH model. The outputs of the CHA pilot being tracked are as follows: the number of CHAs trained; the number of women educated about breast cancer; and the number of women referred for services.

Integrating CHWs with Providers (2.10.4.5.8)

Aetna understands how to use CHWs as part of our enrollees' care team to improve enrollee experience and reduce provider burden. They educate providers about enrollees' cultural needs and the local communities and environments where enrollees live. CHWs also assist providers with identifying and accessing resources necessary to meet enrollees' non-medical needs and addressing social determinants of health, such as food insecurity, personal safety, transportation, and housing. For example, CHWs may provide technical assistance for providers on how to use Aunt Bertha. CHWs act as members of the Provider Integration team, playing an important role in understanding provider needs, and may collaborate with our population health specialists to assist providers with understanding and using health and social determinant data about the enrollees they serve.

Contact Person and Lead Team Member (2.10.4.5.9)

Contact person: Rick Born, Chief Executive Officer, Aetna Better Health of Louisiana
Lead team member: Tina Griffith, Health Care Equity Director, Aetna Better Health of Louisiana

2.10.5 Care Management

Aetna staff members are Louisianans who are engaged in our communities. The Aetna Community Outreach team participates in events to bring educational and support resources directly to the community. At the 2018 Perkins Rowe Spooktacular, the Community Outreach team gave out treats, coloring sheets, and information about the benefits the plan has to offer.

2.10.5 Care Management

Aetna has participated in Louisiana's Medicaid managed care program since 2015, collaborating with enrollees and families throughout all nine regions of the state. We are deeply invested in Louisiana's local communities, and we have demonstrated success improving the lives and health of enrollees with complex physical and behavioral health needs. Our local work throughout Louisiana parishes supports LDH's goals: we advance evidence-based practices, high-value care, and service excellence; and we decrease fragmentation and increase integration across providers and care settings, particularly for enrollees with behavioral health and social determinants of health needs. Aetna understands, acknowledges, and will comply with all requirements of the **RFP** and the **Model Contract**.

Approach to Care Management (2.10.5.1)

To achieve our collective goals, Aetna offers locally based care management activities. Our care management program is congruent with Aetna's population health management strategy, recognizing that health is more than the optimal delivery of clinical care. The Care Management department, along with the Utilization Management (UM) department, reports to the Quality Management Oversight Committee. Together, these departments and committee work for equitable health care and services that are person-centered, accessible, holistic, and evidence-based. Our enterprise-wide System of Care model supports our local integrated care management approach. The System of Care strategy positively affects the enrollee's personal journey and ultimately their healthy days, using innovative approaches, which consider the whole person's needs. The System of Care model is a collection of integrated services grounded in trauma-informed care (TIC) and trauma-informed approaches, culturally and linguistically appropriate services, and recovery principles and guides our care management service delivery model. The following response offers Aetna's strategy to serve enrollees best though health needs assessment (HNA) completion, enrollee engagement, risk stratification, care planning, and coordinating with other organizations also providing care management.

Ensuring Success in Completing the HNA (2.10.5.1.1)

Our national experience includes 30 years of implementing a variety of service delivery models to support community-based care management. We offer our HNA in English, Spanish, and Vietnamese, and in multiple formats including in-person, web-based, print, and telephonically. We obtain enrollee consent before conducting the HNA and disclose to the enrollee how we will use the information gathered in the HNA. The HNA screens for unmet social determinants of health needs, including food security, housing/utilities challenges, transportation needs, and interpersonal safety concerns. **Figure 2.10.5-1** shows the social determinants of health needs screened by Aetna's HNA.

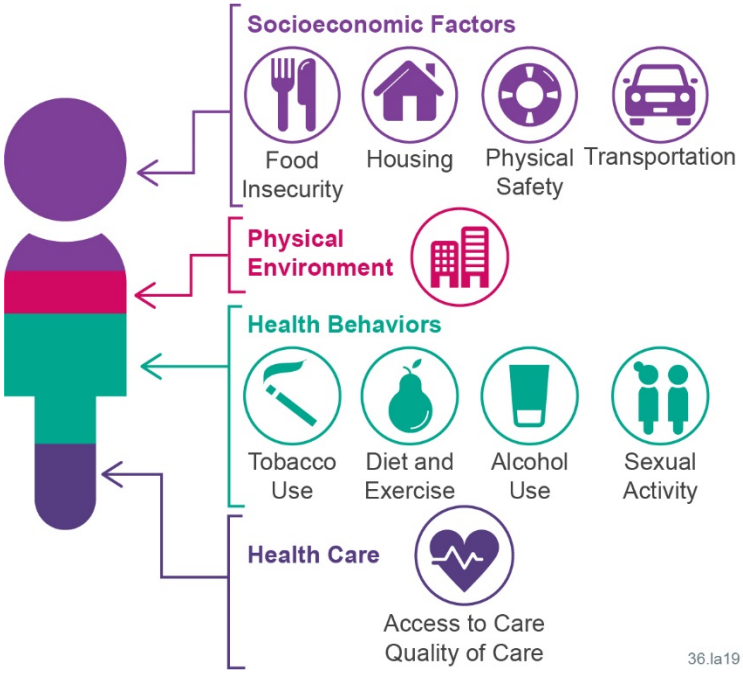

Figure 2.10.5-1: Social Determinants of Health
Aetna's HNA screens for social determinants of health needs.

Aetna agrees to use the common survey-based instrument, to be developed by LDH, as described in **Part 3: State Responsibilities**. With enrollee consent, we share all screening results with the assigned primary care provider (PCP) via the provider portal or LDH upon request. We also share HNA results with the enrollee via the enrollee portal. As described in the following response, the HNA is the first step to our care management identification and risk stratification, assessment, and individual care planning process.

Administering Screenings within Required Timelines and Results

Aetna's automated outbound HNA screening process is our first attempt to complete the HNA with the enrollee. With multiple entry points and enrollee contacts, we maximize opportunities to engage enrollees to complete screenings and conduct outreach to those missed through initial outbound screening attempts as described in the next section. Of those who complete the automated outbound screening and we identify for care management, 100 percent complete a comprehensive assessment.

Aetna contacts all enrollees to attempt to complete the screening within 30 calendar days of the enrollee's effective date of enrollment, exceeding the State requirement of 90 days and in accordance with **42 C.F.R. §438.208(b)**. We screen enrollees with special health care needs within 30 calendar days of the date of identification. In addition, Aetna's behavioral health providers conduct an assessment for eligibility based on level of care needed within 14 calendar days of referral by provider or a case manager, based on the enrollee's unique needs.

To maximize the number of enrollees completing the screening process, Aetna uses multiple telephonic and written engagement strategies as well as in-person navigation for those new enrollees discharged from an inpatient setting. Aetna makes five attempts to contact the enrollee by phone, each occurring on different days and different times to improve the probability of contact. After five attempts, Care Management staff sends a letter to the enrollee stating that the telephonic outreach attempts have been unsuccessful and invites the enrollee to contact Aetna to complete the screening. Care Management staff review the claims management system, including the call-tracking notes and enrollee records, to identify another means of reaching the enrollee. Case managers use medical, behavioral health, and pharmacy claims as well as admission, discharge, and transfer (ADT) data from the Louisiana Health Information Exchange (LaHIE) and Greater New Orleans (GNO) HIE to identify an acute inpatient admission. We also receive an exception report with enrollee contact information from CaremarkPCS Health, L.L.C., our pharmacy benefit manager, which helps us contact enrollees to complete the HNA. Staff also call the enrollee's pharmacy and review Aetna's national database to determine if a match exists.

Innovations in HNA Screening

Aetna reaches out to 100 percent of enrollees and utilizes multiple strategies to maximize the number of completed HNAs. Aetna has established several practices to increase HNA completion success with multiple points of access, including the following:

- **Face-to-face outreach:** Aetna case managers conduct face-to-face outreach for hard-to-reach enrollees. For example, Ready Responders, our community paramedic response team, recently identified an enrollee who was living in unsafe conditions and contacted Aetna's Care Management team. We had been previously unable to locate or contact the enrollee, but with Ready Responders' assistance, **the locally based case manager followed up with the enrollee face-to-face where the enrollee was living**. Together with the enrollee, we completed the HNA and a comprehensive assessment, and connected the enrollee with safe and stable housing.
- **Enrollee portal:** Enrollees may complete the HNA in the enrollee portal. Enrollee Services and Care Management staff are also available via our toll-free Enrollee Services line to aid with HNA completion if needed.
- **Population health management platform:** An alert through our population health management platform to the Enrollee Services representative will allow them to conduct a warm transfer of the call to Care Management staff for completion of the HNA.

- **Aetna mobile application:** Enrollees will be able to complete the HNA through our secure mobile application. The HNA data will feed directly into our population health management platform. This system provides the information technology to conduct care and service coordination from a single platform connecting external providers and multi-system stakeholders in near real time.
- **Integration with community health workers:** The HNA tool will be available for completion at Aetna community health events. Community health workers (CHWs) may support enrollees with form completion and connect the enrollee to resources that address social determinant of health needs.

Using HNA Data

The HNA process is one of the first ways Aetna begins to identify and engage enrollees in care management. This screening tool is especially useful in initially assessing enrollees who may have special health care needs. Once we identify an enrollee with special health care needs, we build a locally based multidisciplinary care team. The case manager, together with the enrollee, completes a comprehensive assessment to identify a course of treatment or regular care monitoring. We offer care management to all enrollees with special health care needs.

Identifying Individuals Who May Benefit from Care Management (2.10.5.1.2)

We work to understand enrollee preferences and goals, physical and behavioral health care needs, family and community supports, strengths, and any barriers impacting their ability to access appropriate care—all with the overarching objective of optimizing the enrollee's health and enabling them to maintain or achieve independence. Through a fully integrated, locally based model of care, Aetna systematically and intentionally considers the complex interactions of biological, psychological, and social factors in the delivery of health care. We identify enrollees for the appropriate level of care coordination and care management through predictive modeling, referrals, and other sources of valuable data, including the HNA. Aetna identifies and enrolls more individuals year after year. **Since 2016, we have achieved a 51 percent increase in enrollees engaged in care management**.

Aetna conducts clinical rounds with high-volume practices on a biweekly basis to coordinate care for high-risk enrollees and develop strategies to locate enrollees that may be hard to reach. Provider clinical rounds review outreach activities, identify changes in enrollee demographic information, and address any gaps in care.

Predictive Modeling

Aetna's Consolidated Outreach and Risk Evaluation (CORE™) predictive modeling tool analyzes physical, behavioral, and social determinants of health needs identified through claims, pharmacy, UM, and other data, including laboratory results, and is compliant with the requirements of the **Model Contract**. We supplement our analysis with referrals and HNA results, which helps us to stratify enrollees as Tier 3 (high risk), Tier 2 (medium risk), or Tier 1 (low risk) as described in this response.

Proprietary and evidence-based, CORE is a stratification tool that uses time-tested analytic methods honed for more than 10 years. CORE generates risk scores from internally developed algorithms based on Medicaid population data and our clinical and informatics expertise. Aetna uses several indicators other than diagnoses to identify and stratify enrollees, including CORE, the HNA, surveillance or referrals, concurrent review, and real-time utilization data. We run the model for our entire population monthly.

In addition, CORE uses pharmacy claims to identify risks related to non-adherence and other medication management issues that engagement in care management can influence. We derive approximately 40 percent of an enrollee's risk assessment from pharmacy utilization and claims. The risks identified include the following:

- The complexity and number of medications in an enrollee's drug therapy, which is a major driver of inpatient admission risk

- An enrollee's adherence to critical maintenance medications to treat conditions like asthma, diabetes, heart failure, or a behavioral health condition
- Potential overlapping therapy or drug contraindications that may impact enrollee safety
- Use of multiple pharmacies or prescribers to obtain controlled substances
- Higher enrollee costs compared to the overall population (using the Medicaid pharmacy risk adjustment methodology)

We further stratify enrollees into levels for care management and population health initiative engagement based on the information we gather from CORE and outreach activities that identify their biopsychosocial complexity and intensity of needs. Stratification is based on the enrollee's self-reported conditions and health care utilization, such as ED encounters, hospital utilization, or chronic conditions. The predictive modeling tool also identifies enrollees likely to have high utilization rates based on claims and diagnostic data. These tools determine the enrollee's potential risk level and predict that care management interventions can effectively improve the enrollee's outcome.

Predictive Model of CORE

CORE results are predictive in multiple dimensions:

- The emergency department (ED) model has a positive predictive value of 72.1 percent, meaning that 72.1 percent of the time, the predicted ED utilization occurs in the next 12 months
- Our inpatient modeling is exceptional, with a positive predictive value of 95.4 percent.

These factors, coupled with our UM and quality management surveillance strategies, enable us to assign enrollees to the most appropriate levels of care management.

Enhanced Predictive Modeling with Elli

Aetna is **leveraging our unique relationship with HMS, a leading health care technology company, to enhance our ability to analyze and use claims data through Elli**. Via artificial intelligence-based predictive models, Elli identifies healthy enrollees who are likely to develop chronic conditions. HMS' Elli identifies enrollees with high-risk factors before their utilization becomes high-cost. On average, Medicare and Medicaid populations see that the top 10 percent of the population make up to 45 percent to 55 percent of the costs. Elli uses predictive models to identify enrollees who are likely to have high-cost events due to disease progression and underlying social determinants of health.

As a first adopter of Elli in Louisiana, Aetna has access to four years of claims data collected from all managed care organizations across the state. The data will be available to us on day one of an individual's enrollment. The data analysis provides additional risk stratification that Aetna will consider in concert with our CORE predictive modeling risk stratification results. We leverage Elli, in particular, when we enroll a new individual, enabling us to engage the enrollee in the appropriate tier of care management immediately. Elli and Aetna's CORE are proven approaches to predict future cost and utilization. While these analytics are prescriptive, it is important to note a case manager always can use clinical judgment to tailor the care plan further based on information not available to either analytic platform.

Using Predictive Modeling to Support TIC

Aetna's Medicaid organization has launched a systemwide transformation initiative to address the impact of trauma among enrollees. We aim to interrupt the cycle of trauma and abuse using a custom-designed risk model identifying health plans' rising risk enrollees and creating population-based, innovative, early intervention outreach and trauma-informed practices. **Our TIC predictive model flags specific enrollees with high-risk factors who may benefit from trauma-informed approaches and practices.** The methodology works alongside the CORE predictive model. We are in the process of implementing a similar model targeting high-risk pregnant enrollees in Louisiana—we began this transformation journey by training all of our Louisiana staff on TIC. We are currently collecting high-risk, neonatal intensive care unit admission, and social determinants of health data, such as history of abuse, neglect or abandonment, involvement in the foster care system, and generational substance use. We will assign risk scores to predictive indicators leading to other traumatic health and/or socioeconomic factors for the mother and

child such as complex medical needs or substance abuse. By Quarter 3 of 2019, Aetna will initiate a provider development collaborative and training to serve our enrollees through trauma-informed practices. In addition to our predictive modeling processes, we identify enrollees who may benefit from care management from referrals from stakeholders, providers, and enrollees and their families.

Referrals

Aetna uses referrals to identify individuals that may benefit from care management services. These referral sources include the following:

- Enrollee self-referral
- Enrollee Services and Grievances staff referral and referrals resulting from historical data that we assess and trend at the enrollee level
- Providers, including primary care, behavioral health, and specialist providers
- State staff, including Medicaid, Office of Behavioral Health (OBH), Office of Aging and Adult Services, Office for Citizens with Developmental Disabilities (OCDD), Office of Public Health (OPH), and the Department of Children and Family Services (DCFS)
- UM, Quality Management, Enrollee Services, or other internal departments
- Enrollees newly eligible for home- and community-based services (HCBS) waiver services
- Health Information line (Nurse line)
- Social service organizations such as food banks and homeless shelters

Aetna works proactively with providers to encourage appropriate enrollee referral for potential engagement in care management. We include information on the referral process on our provider portal, in newsletters, and through provider education opportunities. We consider all referred enrollees for engagement in care management. In addition, we deploy population health specialists who work directly with providers to assist with our population health management platform system education, adoption, and use; the design and analysis of clinical workflows; and how to refer enrollees to care management. Once we receive a referral, a case manager who is part of the locally based care team completes a comprehensive assessment and an individualized care plan, together with the enrollee.

HNA Process

As described previously in the subsection titled **Using HNA Data** herein, Aetna use the HNA to identify enrollees who may benefit from care management services, including those with special health care needs.

Engaging Enrollees in Care Management (2.10.5.1.3)

Aetna values an enrollee's choice in how they engage with us and how they engage with care management services. We specifically designed our care management model—an enhanced locally based multidisciplinary team model—to better engage enrollees and families in care management services and improve health outcomes. We organize Care Management teams close to the enrollees they support, reducing travel time/costs for staff and promoting improved specialty knowledge of services and providers in the area.

Case managers are cross-trained in physical and behavioral health, act as a single point of contact for the enrollee, and work with other members of the multidisciplinary team (e.g., PCP, licensed clinical social workers [LCSWs], nurses, CHWs, pharmacists, and peer specialists) to engage the enrollee in services. **Aetna's integrated care management approach identifies our most biopsychosocially complex and vulnerable enrollees with whom we have an opportunity to make a significant difference.** We engage these enrollees in care management programs to remove or lessen barriers that limit their ability to manage their own health and well-being. We educate them about population health initiatives, enhance their engagement, and help them remain in the least restrictive and most integrated environment. We coordinate services based on their preferences, needs, safety, burden of illness, and availability of family

or other supports in a manner consistent with each person's personal and cultural values, beliefs, and preferences. We help individuals develop resiliency, move toward recovery, and reach their self-defined level of optimal functioning.

Through our experience, we recognize that certain enrollees will be particularly difficult to contact such as enrollees experiencing homelessness, persons in non-traditional family or residential settings, refugees, or young adults in a transition stage. Depending upon the need, the intensity of our contact efforts may vary based on enrollee information and clinical judgment. Any time we are unable to contact an enrollee, we may attempt to find them through any of the following means, as appropriate:

Our engagement efforts are successful. In 2018 we achieved the following:

- We achieved a 94**% success rate** with enrollee engagement in care management services for Quarter 4
- Our field visits **increased by 35%**
- Our volume of outreach has increased 65.5% from 2016 to 2018

- Publicly available sources such as telephone listings and online directories
- Pharmacies where an enrollee may have recently filled a prescription
- Our inpatient census tool and real-time pharmacy claims system
- Enrollee's PCP or other providers
- Emergency contacts, family, friends, property owners, or others we know to have previously been in contact with the enrollee
- Other State government agencies providing financial or service support to the enrollee
- Community-based organizations such as homeless shelters and food kitchens
- CHWs hired from within the enrollee's neighborhoods

Using Technology to Engage Enrollees

We use our best efforts to engage enrollees and close care gaps through live-person outreach to enrollees, interactive phone calls, text messaging, mailers, care management enrollee education, and web-based technology with enrollee-live access to their health care reports. We provide information to new enrollees on how to contact a case manager in the enrollee welcome packet, in the enrollee handbook, and on our website and enrollee portal. We also use reporting suites such as UM dashboards and gaps-in-care reports to identify and then engage enrollees in care management. Increasingly, technology enhances our ability to engage an enrollee in care management services. Other technology-based engagement strategies include the following:

- **Outbound texting programs:** We use a personalized mobile program that sends text messages to program enrollees on a variety of topics. These include care4life, text4kids, text4baby, text4health, and text2quit, which are no cost to the enrollee and link them to care management services.
- **Social media offerings:** In Louisiana, Aetna will offer engagement opportunities through social media platforms, such as Facebook. We want to collaborate with LDH and community-based providers on their social media offerings to offer yet another avenue for enrollee engagement.
- **Lifeline smartphone:** Aetna launched the Lifeline smartphone to link enrollees to improved phone services for better communication between the plan, their physician, and our Care Management team. The health plan now has new smartphone options for eligible enrollees. The smartphone options include a set amount of voice minutes and data and unlimited texting each month.
- **Wellpass text messaging:** Our educational text-messaging program consists of the Lifeline smartphone and targeted messages to remind enrollees to get tests and screenings done. It sends routine reminders to enrollees to support their health goals related to weight management diabetes, cervical cancer screening, opioid use, prenatal and postpartum care, well-child visits, breast cancer screening, flu shots, adult body mass index, controlling blood pressure, and chlamydia screening. We are in the process of developing an ED diversion campaign in Wellpass, which we anticipate will go live in the second quarter of 2019. **Our average rate of received messages for Wellpass is 76 percent.**

Once we receive a referral and engage the enrollee in care management services, Aetna uses all information available to identify the appropriate care management tier. The case manager conducts outreach to the enrollee, completes further assessments, and incorporates strategies based on the person's needs into the individualized care plan.

Identifying the Care Management Tier and Care Plan Development (2.10.5.1.4)

Initial stratification through CORE and Elli enables us to focus outreach to enrollees with the greatest health care needs and who may most benefit from care management services, thereby helping to ensure better health, better care, and lower costs. Other data sources we use include LDH enrollment files; ADT feeds; LaHIE and GNO HIE data; claims; lab results; HNA and care management assessment results; and publicly available community information. We run our CORE analysis monthly and perform daily reviews of prior authorization requests, census reports, and other information to determine changes in enrollee status. We use objective measures and criteria to stratify enrollees into three tiers and then use person-centered processes to develop an integrated, individualized care plan that addresses the unique needs of the enrollee.

Objective Measures and Criteria

Aetna develops, implements, and maintains criteria and protocols for determining which care management activities may benefit an enrollee. Our policies and procedures are compliant with **Section 2.7 of the Model Contract**. Aetna's systems support internal interdisciplinary activities and provide seamless solutions for the external stakeholders who support our enrollees. Our internal web-enabled care management system and our population health system provide the infrastructure for our care management activities, and it provides the flexibility necessary to integrate our data needs into the solution. Our systems connect the enrollee and their circle of supports with the entire community of the enrollee's preferred supports and allow us to assess the enrollee's care management level and service needs continually.

Using all information available, including data from CORE and Elli, Aetna stratifies enrollees into three levels; we finalize the level of care only after enrollee engagement and confirmation of needs. We may adjust the initial stratification based on the case manager's clinical judgement and information gained from the comprehensive assessment.

Tier 3: Intensive Care Management for High-risk Enrollees

Aetna provides enrollees engaged in intensive care management the most focused attention to support their clinical care and social determinants of health needs. These enrollees have the highest level of need and have complex medical and/or behavioral health conditions. We develop a plan of care in-person within 30 calendar days of identification. This process includes an assessment of the home environment and priority social determinants of health including housing, food insecurity, physical safety, and transportation. Case managers will meet with enrollees at least monthly, in person, in the enrollee's preferred setting. Case managers will update the plan of care monthly and conduct a formal in-person reassessment quarterly. **Table 2.10.5-1** describes Tier 3 criteria for enrollment and types of support Aetna offers.

Table 2.10.5-1: Tier 3 Criteria for Enrollment and Types of Support

Criteria for Enrollment	Types of Support
• Individuals with multiple complex chronic conditions, comorbidities, or co-occurring conditions • Individuals with three or more ED visits • Pregnant women with a history of substance use or who are currently using substances • Pregnant women current or historical high-risk pregnancy • Infants with neonatal abstinence syndrome	• Complex physical health, behavioral health, specialty, and durable medical equipment (DME) services • Evidence-based practices, including TIC, assertive community treatment (ACT), and medication-assisted treatment (MAT) • Opioid use or other co-occurring substance use disorder treatment and follow-up for naloxone

Criteria for Enrollment	Types of Support
• Children and adults with abuse and/or trauma histories with significant social determinant of health needs or with other complex diagnoses • Individuals in the Coordinated Re-Entry Program or incarcerated enrollees • Adults and adolescents who are homeless or have a history of residential instability (four or more residences over the past year) • Adults with serious mental illness and children with serious emotional disturbances • Transplant candidates • Individuals with HIV/AIDS, cancer, chronic renal failure, and other chronic complex conditions • Individuals in the Department of Justice (DOJ) Agreement Target Population and those transitioning from a nursing facility	training • CHW and peer specialist support • Readmission and ambulatory-sensitive admission and ED diversion • Chronic condition/disease management • Linkage to resources addressing social determinants of health • Gaps-in-care resolution • Treatment adherence support • Transitional care management • Pharmacy Medication Management Program • Pharmacy Supported Comorbid Condition Management Program

Aetna supports the State in creating an effective strategy to enhance the LDH case management program. We will work in partnership with the State to implement any approach outlined in *House Concurrent Resolution 65 of the 2018 Regular Legislative Session – Mandatory Case Management for High-Risk Enrollees* to enhance services for vulnerable enrollees and their families.

Tier 2: Care Management for Medium-risk Enrollees

Aetna offers enrollees Tier 2 support for their whole health needs. Enrollees in Tier 2 need a lower level of support that those enrollees in Tier 3, but still need significant care coordination and care management to manage chronic or complex medical and/or behavioral health conditions. Together with the enrollee, we complete the plan of care in person within 30 calendar days of identification. Case managers will meet with enrollees at least monthly and update the plan of care through a formal in-person reassessment quarterly. **Table 2.10.5-2** describes Tier 2 criteria for enrollment and types of support Aetna offers.

Table 2.10.5-2: Tier 2 Criteria for Enrollment and Types of Support

Criteria for Enrollment	Types of Support
• Individuals in the DOJ Agreement Target Population • Children under age 21 requiring foster care management • Individuals with ambulatory care sensitive conditions or a disease management condition (e.g., asthma, chronic heart failure, chronic obstructive pulmonary disease, diabetes, or depression) • Referrals from within the plan or a provider that indicates care coordination or service needs and/or readmission risks	• Evidence-based practices, including TIC, ACT, and MAT • CHW and peer specialist support • Chronic condition/disease management • Children under age 21 requiring foster care management • Naloxone training • Collaboration with care management agencies and community-based services for integrated care plan development • Collaboration with system stakeholders • Information-sharing between providers and system stakeholders • Transitional care management • Pharmacy Medication Management Program • Pharmacy Supported Comorbid Condition Management Program

Tier 1: Care Management for Low-risk Enrollees

We provide care management activities to low-risk enrollees and develop the care plan with the enrollee within 90 calendar days of identification. Tier 1 support includes an assessment of the home environment and priority social determinants of health. **Table 2.10.5-3** describes Tier 1 criteria for enrollment and types of support Aetna offers.

Table 2.10.5-3: Tier 1 Criteria for Enrollment and Types of Support

Criteria for Enrollment	Types of Support
• All enrollees with chronic conditions needing ongoing surveillance and support identified for care management and not enrolled in Tier 2 or Tier 3 • Enrollees able to self-manage condition(s) • Enrollee showing improvement who moved from Tier 2 to Tier 1	• Population health initiatives and educational material and communication • CHW support • Support with education, housing, transportation, and personal safety • Ongoing surveillance for status change • Wellness and prevention services • Semi-annual health information and reminders

Our integrated system of care uses **multidisciplinary locally based care management teams to meet all levels of care management needs of our enrollees**. Supported by Aetna's System of Care model, case managers form strategic relationships with key stakeholders (e.g., community providers, care transition networks, families, peer support services, CHWs) to address enrollee social determinants and to promote health care equity. These locally based teams are the start of the care planning process for the enrollee and are actively engaged in Transitional Care Management, described further in this response. Care Management teams are characterized by the following:

- Include case managers, CHWs, registered nurses, LCSWs, PCPs, pharmacists, peer specialists, and any other stakeholder that the enrollee identifies to effectively develop a plan of care
- Link seamlessly to a multidisciplinary team that is inclusive of professionals who have all the expertise needed to provide service coordination. Multidisciplinary teams include Aetna's employed behavioral health, substance use, UM, employment, and housing specialists.
- Serve individuals enrolled in specific waiver programs such as intellectual and/or developmental disabilities (I/DD), autism spectrum disorder, traumatic brain injury, or frail elderly and physically disabled
- Cover rural areas of the state; these teams include a mix of experts, but through our electronic service coordination support such as web-enabled tablets, we link to other experts no matter where they are located
- Include both face-to-face in-person and face-to-face virtual care coordination (through video conference) to increase engagement to enrollees in remote locations and foster the relationship between the enrollee, circle of support, and case manager
- Fully integrate the enrollee's circle of support and provide culturally relevant, person-centered, and trauma-informed physical and behavioral health services, supplementing but not supplanting natural supports
- Consider the enrollee's communication methods and functional status to support full engagement and participation by enrollees
- Are comprised of skilled staff who complete Mental Health First Aid, treatment planning philosophy, and TIC training

Aetna will support the Permanent Supportive Housing program through our locally based care teams and our housing specialist. The housing specialist will connect enrollees to appropriate housing resources. They will also work with the multidisciplinary care team to give guidance and close gaps in care for enrollees with housing instability.

In addition to ongoing care management services, Aetna offers a comprehensive Transitional Care Management program that supports an enrollee's ability to receive care in the least restrictive and most cost-effective environment.

Transitional Care Management

Transitioning from one setting to another can be unsettling and even frightening for vulnerable enrollees and their family members or caregivers. Aetna understands that effective transitions of care are paramount to maintaining and improving enrollees' quality of care, quality of outcomes, and most

importantly, quality of life. We work to promote a seamless transition of care with the aim of improving enrollees' health and recovery, effectively coordinating their care, and reducing future admissions.

We modeled our transitional care management program on the Coleman Model, pioneered by Eric Coleman, M.D., M.P.H., from the University of Colorado. Aetna uses the model's four pillars to promote high-quality transitional care management:

- **Medication self-management:** We educate the enrollee on medications and help the enrollee develop a medication management system.
- **Use of a dynamic enrollee-centered record:** Aetna works with enrollees to utilize the enrollee portal to facilitate communication and ensure continuity of care across providers and settings.
- **PCP and specialist follow-up:** Case managers support enrollees to schedule and complete follow-up visits with PCPs or specialists, and they educate enrollees on how to be an active participant in their care.
- **Knowledge of 'red flags':** We help enrollees to identify when their condition is worsening and educate them on how to seek the appropriate level of care.

Aetna successfully decreases ED and inpatient utilization year-over-year. We achieved the following in 2018 vs. 2017:

- **4.98% decrease in ED visits/1,000**
- **4.3% decrease in per member per month costs for inpatient admissions**
- **7.1% decrease in physical health admissions/1000 and a 11.1% decrease in behavioral health admissions/1,000**
- **10.5% decrease in physical health readmissions/100** and a **36.2% decrease in behavioral health readmissions/1,000**

Because enrollees are at significant risk when moving from one setting to another, effective care transitions are vital to decreasing potentially preventable events. **Our integrated care management model encompasses a strengths-based approach that empowers enrollees to achieve their optimal level of functioning**. Emphasizing continuity and coordination of care, Aetna collaborates with discharge planners at inpatient facilities to make sure each enrollee receives the highest level of service and oversight to address their unique clinical and care management needs. The enrollee, along with their family and circle of support, are the principal voices and decision-makers in the care process. We serve as their strongest advocates to coordinate care that incorporates evidence-based care and community services with a wraparound approach that addresses social determinants of health.

We routinely monitor metrics (e.g., number of face-to-face visits, adverse incidents, number of enrollees engaged in care management) to help make sure our transition of care program is impactful and to guarantee we have sufficient staff necessary to meet the specific needs of our enrollees in each of the nine regions of the state. Working in concert with our locally based multidisciplinary Care Management teams, Aetna assigns transition of care clinicians to specific hospitals and facilities to manage our enrollees' transitions from one setting to another. Discharge planning starts at the time of admission. Transition of care staff complete face-to-face visits with enrollees, which provides us with valuable access to the treating physicians and other hospital staff so that that we manage discharge orders and referrals as seamlessly as possible for our enrollee. Case managers serving enrollees in Tier 3 function as the transition case manager to provide continuity of care and maintain the single point of contact for the enrollee. We enhance this offering with support from telehealth, telemedicine, home telemonitoring services for at-risk enrollees, and post-discharge nurse visits. We will incent physical health and behavioral health providers to increase collaboration when the enrollee's care requires it.

Our care management strategy includes availability of all medical records through connection to LaHIE and GNO HIE. Aetna tracks ADT data and receives real-time notifications through LaHIE and GNO HIE. We are in the process of **contracting with the hospital-sponsored health information exchange, Louisiana Health Information Network-Encounter Notification Service, which will give us ADT feeds from most hospitals in the state**. Through these HIEs, the case manager can retrieve the enrollee's information, including primary care visits, unmet health-related resource needs, and medication and

pharmacy history to determine risk. This will enable our care providers to collaborate on creating a comprehensive, real-time data set to share across the provider continuum to promote achieving quality outcomes such as Healthcare Effectiveness Data and Information Set (HEDIS) scores and preventable readmission reduction.

Aetna case managers review all elements of the provided data and coordinate discharge activities with Aetna UM staff, which conducts concurrent reviews as enrollees' transition to new levels of care. The UM nurse coordinates with the case manager and housing specialist for all discharge needs so there is an efficient and safe discharge plan meeting the needs of the enrollee in the least restrictive setting, with all services ready for the enrollee immediately upon discharge. We provide transitional care management for enrollees to support transitions between institutional and community care settings, including transitions to/from inpatient hospitals, nursing facilities, psychiatric facilities, psychiatric residential treatment facilities (PRTFs), therapeutic group homes, permanent supportive housing, intermediate care facilities, residential substance use disorder settings, and transitions out of incarceration**. Table 2.10.5-4** highlights key components of our program.

Table 2.10.5-4: Care Transition Approaches for Facilities across the Continuum of Care

Facility	Approach
Rehabilitation services, PRTFs, and therapeutic group homes	Aetna's online referral platform allows rehabilitation providers the ability to make real-time referrals to Aetna transitional care management.
Skilled nursing facilities and residential settings	Aetna notifies skilled nursing facilities and other residential facilities when they have admitted an enrollee who is receiving transitional care management. Together, the facility care team and the dedicated local Aetna case manager identify and implement any additional needed coordination tasks.
Psychiatric hospitals	Aetna partners with Louisiana's psychiatric hospitals, which provide real-time discharge summary information to Aetna to allow for immediate transitional care management follow-up. Upon discharge, Aetna case managers connect enrollees to resources in their local community, including primary care, behavioral health, and non-medical resources.
Inpatient facilities	Transition from inpatient facilities is critical for enrollees to succeed. Aetna's case managers coordinate with discharge staff at the hospital to serve enrollees where they are—close to their homes and circle of support. Aetna will continue to coordinate with hospitals to allow for timely implementation of transitional care management.
Other transitions such as permanent supportive housing and transitions out of incarceration	Aetna's Care Management staff work closely with the housing specialist and other members of an enrollee's regional multidisciplinary team to coordinate care and implement transitional care management activities. Case managers connect with incarcerated enrollees before they are released to ensure connection to services upon release.

Pharmacy Support

Aetna has assembled a team of health professionals to manage and coordinate the transitional care of enrollees discharged from inpatient and outpatient facilities. This integrated team focuses on individual planning for each enrollee's return home and coordination of appropriate care and discharge follow-up. The care team includes a pharmacist, who conducts medication reconciliation for the enrollee. Medication reconciliation consists of comparing a list of medications used prior to admission compared to medications prescribed at discharge and resolving any conflicts in therapy. A clinical pharmacist participates in daily transitional care management rounds as appropriate. Enrollees have access to their case manager and the Aetna pharmacist for additional follow-up. In addition to the transitional care management services, our Medication Therapy Management (MTM) program tracks the enrollee's prescription claims data. Our MTM services mitigate adverse medical events, enrich enrollees understanding of medication use, and improve therapeutic outcomes by enhancing medication

adherence. In 2018, Aetna's MTM program, administered by CaremarkPCS, had a program comprehensive medication review (CMR) completion rate for 6,883 eligible enrollees of 23.6 percent (1,627 CMRs). Pharmacists completed 5,155 therapy interventions with prescribers and enrollees with a 70 percent success rate in changing therapy. We conduct medication reviews between the enrollee, the prescriber, and the pharmacist at their usual community pharmacy with interactive consultation to provide follow-up interventions as necessary.

Our Pharmacy Medication Management Program's clinical pharmacists analyze pharmacy data and program outcomes, coordinate the distribution of clinical drug information through education, and engage clinical staff and providers. The clinical pharmacist also supports multidisciplinary teams with care planning to improve enrollee access to the right medication at the right time.

Individuals in the DOJ Agreement Target Population

Aetna acknowledges, understands, and will comply with all care management requirements in **Section 2.7.7 and 2.7.8 of the Model Contract**. Enrollees identified for transition from a nursing facility to the community as part of the DOJ Agreement Target Population will receive transitional care management services prior to release from the nursing facility as part of their discharge planning process. Aetna supports the LDH transition team in the development of the transition plan required as part of the DOJ Agreement. These enrollees receive transitional care management services at the Tier 2 or Tier 3 level for a minimum of 12 months post-transition and receive face-to-face care management as identified in their individual plan of care.

Independent Evaluations for PASRR Level II

Aetna conducts Preadmission Screening and Resident Review (PASRR) Level II evaluations of enrollees upon referral from LDH. Referrals are based upon an independent evaluation to determine the need for nursing facility services and/or the need for specialized services to address mental health issues while the enrollee is in a nursing facility. Aetna complies with **42 C.F.R. Part 483, Subpart C** and uses the PASRR Level II standardized evaluation form provided by LDH. Aetna tracks enrollees in a nursing facility who went through the PASRR process, those identified with serious mental illness, and those receiving specialized services as per **42 C.F.R. §483.130** in the population health system. Aetna will continue to report quarterly to LDH the delivery of all PASRR specialized behavioral health services. Aetna collaborates with our provider, Merakey, to complete the PASRR within the mandated four-day timeframe.

Individual Plan of Care Planning Process

Our integrated system of care uses **multidisciplinary, locally based Care Management teams to meet all levels of care management needs for our enrollees**. These locally based teams are the start of the care planning process for the enrollee. Our processes are compliant with **Section 2.7.10 of the Model Contract**.

Trauma-informed Approach to Care Planning

The Aetna Medicaid organization is the first and only managed care organization to collaborate with the National Council for Behavioral Health to implement an enterprise-wide TIC initiative.

All Aetna case managers complete training in TIC, resiliency, and adverse childhood experiences (ACEs) in alignment with Louisiana's TIC Transformation. We understand the impact of the experience of trauma, the importance of creating a safe environment, and the steps necessary to help someone successfully develop coping skills. Aetna also addresses root causes that are frequently related to past trauma experiences, ACEs, and social determinants of health. We use the National Council for Behavioral Health's *Organizational Self-Assessment: Adoption of TIC Practice* to improve our policies, procedures, practices, and social and physical environment to reflect the core principles and values of a TIC organization. We understand the steps necessary and the tools needed to support enrollees locally by using trauma-informed practices, driving care to community-based organizations, and providing wraparound support. This trauma-informed foundation supports our overall plan of care planning process.

Using Assessments in Care Planning

Dedicated local case managers who reside in the region of their assigned enrollees conduct comprehensive assessments with the enrollee and caregiver and/or involved social services stakeholder. HNA results, predictive modeling, and referral information trigger need for completion of the comprehensive assessment. We conduct comprehensive assessments in a location and setting dictated by convenience for the enrollee, whether it is in the home, with the PCP, or another identified private location. Through the comprehensive assessment, case managers gain an understanding of the enrollee's health and conditions across all physical, behavioral, and cognitive systems. The comprehensive assessment is extensive in its evaluation of social determinants of health, trauma, access to and historical utilization of services, health behaviors (inclusive of substance use, physical activity, and nutrition), and medications. The assessment also includes discussion of social supports and caregiver resources. **Aetna's care management and care planning strategies are highly effective: Aetna ranked #1 compared to other health plans for the following HEDIS measures: Diabetes Screening for People with Schizophrenia or Bipolar Disorder and Well-child Visits in the First 15 Months of Life.**

We conduct additional assessments customized to a variety of populations, including age- and gender-specific preventive screening questions and assessments specific to disease or priority populations. For example, we assess pregnant women using internally developed and evidence-based validated tools to evaluate further conditions of the pregnancy, obstetrical history, family supports, and psychosocial issues, including the Edinburgh Postnatal Depression Scale. Children with special health care needs also receive specialized assessments, including the Survey for the Well-Being of Young Children. Additional assessments informing care planning include the UNCOPE and PHQ-9, as well as assessments of anxiety, pain, and weight management.

Enrollee-directed Care Planning

The dedicated locally based case manager develops the care plan with the enrollee, their PCP, and their multidisciplinary care team within 30 days of completion of the initial comprehensive assessment. All participants invited/permitted by the enrollee to the multi-disciplinary care team are collaborators with the enrollee in the development of the care plan. Therefore, the process is enrollee-driven and provider-informed. **Figure 2.10.5-2** illustrates how our care planning process meets enrollees' unique needs. In addition to primary physical health and behavioral health providers, members of the care team may include the housing specialist, employment specialists, transition specialists, nutritionists, CHWs, pharmacy representatives, dental providers, peer/family support specialists, school representatives, and pharmacists. Goals, objectives, and services identified during care planning address all factors that affect health to foster improved health outcomes. **The care planning process focuses on closing care gaps and ensuring continuity of care, particularly for enrollees with special health care needs, pregnant women, and enrollees needing or using DME.** We identify needed pharmacy services, specialist services, or resources addressing social determinants of health in compliance with **Section 2.8 of the Model Contract**.

Figure 2.10.5-2: Enrollee-directed Care Planning

Aetna's care planning process meets enrollees' unique needs.

Aetna supports the enrollee as the lead voice in the care planning process and the principles of self-determination and recovery. Case managers periodically review the list of participants permitted by the enrollee to participate to verify the ongoing invitation to remain on the team. Case managers trained in motivational interviewing, recovery, and resiliency, as well as TIC, actively engage the enrollee and the enrollee's family, advocates, caregivers, and/or legal guardians to support continued active involvement and feedback in the care planning process. **Our case managers also have specialized certifications in the Diabetes Education Empowerment Program (DEEP™) and HIV care management.**

The assessment and care planning process produces an individualized care plan, which includes an enrollee action plan and referrals to community-based organizations and other programs that can provide needed services. These services include tobacco cessation and problem gaming programs, Well-Ahead Louisiana, Louisiana's Tobacco Quitline, the Special Supplemental Nutrition Program for Women, Infants, and Children, and permanent supportive housing. We also refer enrollees to internal specialty care management programs like our hepatitis-C care management program and CaremarkPCS Health's Accordant Care. Accordant Care is an extension of our care management program that utilizes real-time pharmacy and medical claims data, electronic health records, and health plan and specialty pharmacy referrals to identify enrollees with complex conditions earlier and proactively provide support to better manage their whole condition. Accordant Care is an NCQA-accredited disease and care management program

The action plan includes the enrollee's own language with respect to their personal goals and self-management objectives. The enrollee and/or guardian must approve the care plan and will have ongoing real-time access to current care plans via the enrollee portal. Aetna's care plan meets health literacy guidelines and includes all elements outlined in **Section 2.7.10.5 of the Model Contract**. We store copies of the current and prior care plans in the population health system. Care plans are also accessible by care team members via the provider portal.

Ethan's Individualized Care Plan

Ethan, an 8-year-old enrollee living in East Baton Rouge Parish, has multiple medical diagnoses including a seizure disorder, autism spectrum disorder, mitochondrial disorder, feeding intolerance, gastrostomy tube dependence, and severe development and speech delays. Ethan's family of five lost their home, vehicles, all personal belongings, and medical equipment due to recent flooding. The enrollee's family is currently living with friends. The family has trouble managing their and Ethan's significant and complex needs, including a complex medication regimen; limited transportation; and supporting another medically complex sibling. Ethan's mother is also living with a disability and is very reluctant to engage with the case manager. Ethan's local case manager, Cassie, developed with the family an individualized care plan for Ethan. She worked to get Ethan and his sibling actively enrolled in care management services. Cassie met with the family to gather a list of immediate needs; found the family permanent housing; secured a wheelchair for Ethan with support of Aetna's UM team; connected the family to a Families Helping Families autism advocate to support the family with needs related to Ethan's diagnosis of autism; and connected the family to medication management support. Because Ethan's autism causes him to wander, and at his parent's request, Cassie worked with the East Baton Rouge Parish Sheriff's Office and Project Lifesaver to obtain a personal locator system for Ethan and secured a six-month sponsorship to pay for the device. As a result of these interventions and wraparound services, Ethan and his family are finding stability and increasing Ethan's independence and quality of life.

Care Plan Updates

Ongoing multidisciplinary team communications allow for continual review of progress toward care plan goals and objectives. Assessment for progress toward overcoming barriers, functional needs, meeting goals and compliance with the care plan, as well as identifying further needs occurs at a frequency based on the enrollee's care management tier. Aetna's population health management platform has a trigger to alert case managers when annual assessment and care plan updates are due. We also update care plans

when an enrollee's circumstances or needs change significantly; at the request of the enrollee, their legal guardian, or a member of the multidisciplinary care team; and when reassessment occurs.

Care Planning with Enrollees with Behavioral Health Needs

Individualized care planning focuses on coordination and integration between physical and behavioral health services provided in the enrollee's community. When an enrollee receives services requiring a plan of care from LDH, such as HCBS or services through OPH, case managers collaborate and coordinate among the agencies. Enrollees with behavioral health needs may also receive referrals to telepsychiatry as needed; coordination with an ACT team prior to discharge from an inpatient facility, if eligible for ACT services; and biweekly rounds that address enrollees with high utilization rates. We also ensure connection to specialized substance use disorder treatment. Since its launch in 2017, Aetna's Enterprise Wide Opioid Taskforce has supported the advancement of Aetna's clinical strategy to combat the opioid overdose crisis. Fueled by cross-functional collaborations and insights, Aetna's opioid initiatives have yielded meaningful results. In the first year since announcing our five-year enterprise goals, **we have seen nearly a 30 percent increase in the rate of MAT or other evidence-based treatments utilized by enrollees with opioid use disorder**.

Peer Support Services

Aetna collaborates with community-based organizations offering peer support services to enrollees with behavioral health needs. **This value-added service leverages peers' expertise to engage enrollees** in care management services through identifying goals, assisting with treatment planning, life skills coaching, resource referral, conducting recovery groups, and assisting with discharge planning. Aetna enrollees receive peer support services through ACT and permanent supportive housing program teams; HIV/AIDS Alliance for Region Two, Inc.; the Extra Mile of Monroe; Mental Health Association of Greater Baton Rouge; National Alliance on Mental Illness New Orleans; and the Metropolitan Human Services District.

Coordinating with Providers that also Provide Care Management (2.10.5.1.5)

Aetna is responsible for the coordination and continuity of care of health care services for all enrollees consistent with **42 C.F.R. §438.208**. We coordinate services with traditional and non-traditional providers and across all funding sources with a focus on eliminating duplication of services, improving continuity of care, and facilitating the coordination of benefits. We avoid duplication of services with federally qualified health centers through biweekly rounds. We coordinate with the OCDD for the behavioral health needs of the I/DD co-occurring population. For example, Aetna case managers work together through the multidisciplinary care team process to create a single individualized plan of care. Aetna defers to the other organization's case manager and sets in place wraparound supports to enhance the care plan. We confirm the enrollee has a single point of contact to decrease confusion and enhance continuity of care. In addition, we make sure of the following:

- Train Aetna case managers on the unique needs and services of individuals with I/DD
- Deploy population health specialists to assist organizations in preventing duplication of efforts
- Engage in formal council meetings, as invited, to facilitate ongoing coordination

Aetna also coordinates care for enrollees receiving services from other State agencies or organizations. We do not duplicate services; instead, we coordinate benefits and provide medically necessary wraparound supports. Agencies we regularly coordinate with include CrescentCare (a Ryan White provider), Urban League of Louisiana, Second Harvest Food Bank, and State systems such as DCFS, Office of Juvenile Justice, the Bureau of Family Health, and the OBH.

2.10.6 Case Scenarios

Aetna support's Louisiana's health priority of promoting healthy living. The Aetna Community Outreach team hosts regular cooking and nutrition classes in our communities. We were pleased to have local chef Jay Ducote help us learn how to make delicious and healthy traditional Louisiana cuisine alongside Ted E. Bear, M.D. During all of our cooking sessions participants have an opportunity to learn how to use ingredients they may already have in their pantry to create a healthy meal. They also leave with nutrition resources and recipe cards on how to make the dishes they were taught at the event.

2.10.6.1 Case 1

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2.10.6 Case Scenarios

2.10.6.1 Case 1

Aetna will provide our enrollee in this scenario, Tracy, with comprehensive case management, ensuring our full understanding of her unique circumstances, connection to services to address her goals, provision of ongoing support, and leveraging of our infrastructure and resources to maximize her health.

Expanded View of Tracy's Circumstances

Tracy is a 38-year-old African-American single mother who lives in an apartment in Greensburg, located in St. Helena Parish. She works part time at the local library. She and her three young children (who live with her) enrolled with Aetna one week ago. They were previously enrolled with, and they received case management from, another managed care organization. Within three days of her transition to Aetna, we contacted Tracy by phone to conduct the welcome call and the initial Health Needs Assessment (HNA). During the initial HNA, Tracy responded positively to questions regarding having several chronic conditions and social determinants of health (SDOH), particularly related to transportation needs. As a result, we conducted a warm transfer to Linda, who conducted further care management triage. Linda is a seasoned care manager (CM) who has worked in St. Helena Parish for several years and is familiar with the services in the rural area of Greensburg. Linda is a registered nurse with extensive background in high-risk Maternal Child Care Management. Linda is also a certified diabetes peer educator and board-certified case manager with experience in delivering integrated case management to individuals with complex medical and comorbid mental health or substance use issues. She has participated in training on trauma-informed care (TIC), motivational interviewing, and Mental Health First Aid. Linda's qualifications and expertise will be a good fit to work with Tracy on her particular needs; therefore, she will be assigned as Tracy's CM.

During the care management triage call, Linda interpreted the HNA and asked Tracy follow-up questions. Linda also completed a specialized pain assessment tool with Tracy. Tracy is not currently pregnant, but she has a history of complicated pregnancies related to hypertensive disease and remains hypertensive postpartum. In addition, Tracy has been diagnosed with hepatitis-C and diabetes, and experiences chronic back pain. Findings from a previous magnetic resonance imaging resulted in the diagnosis of lumbar stenosis (M99.33). Tracy is not currently sexually active or in a relationship, and her children's father is deceased. She does attend annual Well Woman exams and regular dental checkups. Linda also reviewed Elli claims data, which contains several years of Tracy's history and is considered in risk stratification. Linda reviewed the records the former health plan provided during the transition process with Tracy and notes that Tracy's primary care provider (PCP), Dr. Hays, has been prescribing Norco-hydrocodone-acetaminophen (10/325 PO every 4-6 hours as needed) for 2 years (dosage increased to this level over that time). Dr. Hays reported this approach is no longer effective (citing her numerous emergency department [ED] visits) and is now recommending that she see an orthopedic doctor to assess the possible need for back surgery (Lumbar discectomy, foramenectomy, laminectomy).

The online Cares Network Indicators Report notes that the percentage of people diagnosed with diabetes in St. Helena Parish is 12.5%, higher than both the statewide percentage (11.21%) and the national percentage (9.28%).

In the introductory call, Linda and Tracy discussed opioids and the concern that Tracy may be opioid dependent, as evidenced by reports of prolonged opioid prescription use, escalating dosages that are no longer effective, and frequent visits to the ED for pain. Tracy's history of hepatitis-C (suggesting possible history of illegal drug use), several complicated pregnancies, diabetes, and hypertension add to the complexity of her treatment needs. Utilizing Aetna's proprietary risk

According to the Prescription Behavior Surveillance System, there were 115 opioid prescriptions (per 100 residents) for women in Louisiana in 2017.

stratification tool, Linda establishes a preliminary risk stratification based upon based on the results of the HNA, Elli claims data, information from Tracy's former plan and PCP, and her follow-up conversation with Tracy. She assigns Tracy to our most intensive level of case management (Tier 3). Linda asks Tracy to begin thinking about the main health care issues she will want to focus on, explained that she would lead Tracy's care team, and provided her with 24/7/365 phone numbers for the crisis hotline and Health Information line (Nurse line).

Ensuring Access to Services to Address Tracy's Primary Presenting Issue

Linda will initially engage Tracy in comprehensive assessment and care planning, followed by assisting in connecting her to services. **Figure 2.10.6.1-1** summarizes our approach with Tracy.

Comprehensive Assessment and Initial Individual Plan of Care

Linda and Tracy scheduled an in-home comprehensive assessment to occur in one week. Linda conducts the assessment to understand all biopsychosocial conditions relevant for Tracy's care and inquires about health care needs for her children. Linda assesses Tracy's access to and historical utilization of services, and any associated barriers to care. She asks Tracy about her pain, her medications, and her diet and exercise patterns. Linda asks what Tracy has tried for her pain and what, if anything, has worked. Tracy explains that things have been very tough lately and when she gets stressed, her pain meds are one of the few things that make her temporarily feel better and reduce the pain. Tracy told Linda she has tried acupuncture and was only able to get her and the kids there one time. Her transportation does not allow her to ride with the three kids and she does not have anyone to watch the children for two or three hours. She does not exercise but the kids keep her active. Tracy is not sure her diet is good for her diabetes, but says she eats whatever she makes for the kids.

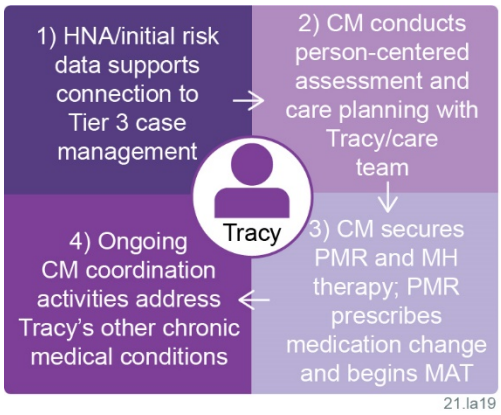

Figure 2.10.6.1-1: Approach to Assisting Tracy
Case management services will address Tracy's immediate and long-term goals.

Linda and Tracy examine why Tracy goes to the ED to address pain issues and discuss the frequency and efficacy of these visits. Linda inquires whether Tracy interfaces with a particular pharmacist at her local pharmacy, and what those interactions are like. She asks Tracy if her pain medicine is effective and if she is taking any other medications or herbal remedies (prescribed or over the counter) for pain. Tracy reports she is not taking any other pain medicine or herbal remedies, nor does she report use of benzodiazepines or muscle relaxers. Linda checks our prescription history website to verify this. Tracy reports her back pain sometimes affects her ability to engage in physical activities with her kids or function at work at the library. Tracy said that she does not always get relief and that when it feels better, she has to lift the kids, and then it starts hurting again. She mentions that when she has run out of her pain medicine before, she experienced withdrawal symptoms such as nausea and muscle cramps. Tracy is concerned about her back and worried that the next step seems to be surgery and she is not sure she can coordinate something like that. Linda assesses Tracy's historical use of elicit or prescribed substances and whether there is a family history of substance use disorders. Tracy acknowledges her hepatitis-C diagnosis was related to previous intravenous (IV) substance use in her late 20s and early 30s. She quit using on her own and she says she has been clean since age 34. Linda asks Tracy if she thinks she may be dependent on her pain medication in the same way she used to be dependent on IV drugs. Tracy says she is not sure, but admits this could be an issue. Dr. Hays prescribed her medications in conjunction with her agreement to a pain medicine contract.

As required by the **Louisiana Medicaid Managed Care Organization Model Contract**, Linda screens Tracy for problem gaming and tobacco usage, neither of which are an issue for her. Linda obtains information about Tracy's ability to manage her activities of daily living and instrumental activities of daily living. Throughout the assessment process, Linda utilizes motivational interviewing techniques to seek Tracy's perspective of her situation and to understand her values and what motivates her with respect to health behaviors. Linda interacts with Tracy through a trauma-informed lens with sensitivity to any traumatic experiences that play a role in Tracy's overall health. After building rapport, Linda asks Tracy if she has experienced physical or emotional trauma and evaluates Tracy and her children's physical safety in the home. She determines that Tracy is properly storing her medications, out of the children's reach. Linda still offers Tracy Aetna's Opioid Lockbox program. Linda talks with Tracy regarding other SDOH and socioeconomic factors and asks about any barriers with respect to her housing, access to transportation, and access to healthy foods. Tracy reports the nearest grocery store with fresh fruits and vegetables is 15 miles away. The assessment includes discussion of Tracy's social supports and caregiver resources and a review of available core benefits and other value-added benefits available to Tracy. Linda spends some time talking with Tracy regarding her children and State-supported services received such as Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP). Linda asks Tracy if any of her children have significant medical conditions or behavioral health issues to determine if they will need case management. Tracy reports her children are healthy and stable at this time and Linda talks with Tracy regarding scheduling their well-check appointments. Linda's person-centered approach effectively engages Tracy to discover her strengths, cultural background, and current coping and health improvement skills. Linda finds that Tracy is a loving mother. She has a group of positive friends from church and is being highly productive in her work at the library.

Following the initial in-home comprehensive assessment, Linda discusses Tracy's issues in rounds with her medical director and CM team. **Linda schedules a subsequent individual care planning session** to occur in two weeks with a multi-disciplinary care team (MDCT). Tracy asks that Linda include her friend, Karen, (whom she says is "like a sister") as well as her PCP, Dr. Hays, his medical assistant, and local independent pharmacist on the MDCT invitation. Linda mentions the types of services a community health worker (CHW) can provide and Tracy agrees that the local CHW should be invited to the meeting. Tracy, Linda, the local CHW, and Karen attend the MDCT meeting in person at Tracy's home. Dr. Hays, his medical assistant, and Tracy's pharmacist participate by phone. The care planning session is a collaborative process in which Linda does the following:

- Provides a summary of her comprehensive assessment findings to the team
- Empowers Tracy to identify and prioritize goals in her own words, to be documented in the care plan
- Collaborates with Tracy and the team to document Tracy's strengths and needs in the care plan
- Provides education regarding available covered services
- Elicits feedback from team members regarding potential benefits of various treatment options
- Supports Tracy's voice and choice as specific services/providers are included in the care plan

Tracy says she is fatigued by chronic pain and that ED visits are costly in terms of time and money for a sitter, interfere with her parenting, and do not result in long-term relief. **Tracy states her immediate goal is to experience less pain and to identify alternative solutions to address her pain other than going to the ED.** Dr. Hays reiterates the medication he has been prescribing for pain management is no longer effective, and believes an orthopedic doctor should evaluate Tracy for possible back surgery. Dr. Hays acknowledges that, aside from pain management medication and one acupuncture visit, no other treatment options have been attempted to address Tracy's back pain. Tracy previously declined epidural injections and they could not find a physical therapy (PT) provider in the area either. Tracy states she would like to look at other solutions besides surgery. Linda reports the Aetna case management team believes PT would be beneficial, but acknowledges there are no PT providers nearby. Dr. Hays, the pharmacist, and Linda also talk with Tracy about her apparent dependence on pain medicine and Tracy agrees to consider alternative means to address her pain and eliminate potential dependence on narcotics. They speak to Tracy about medication-assisted treatment (MAT) and the

opportunity to come off the pain meds and not feel badly as she had described. **Tracy discusses and considers the following treatment options with her MDCT**:

- Although pain specialist services are not a covered benefit, the team discusses incorporation of a physical medicine and rehabilitation specialist (PMR) to evaluate Tracy further for indicators of dependence and/or misuse of prescriptions and to suggest other options to control pain. The PMR can identify and recommend alternative non-narcotic prescription options for pain such as antidepressants or for antiepileptic drugs in lieu of narcotics and might be able to provide MAT to address opioid use disorder (OUD), if that diagnosis is made.
- PT for back pain (available in another parish, transportation could be provided)
- Other non-pharmacological value-added services such as chiropractic services or acupuncture for pain
- Mental health therapy to develop coping/meditation skills related to pain and to evaluate (and treat if indicated) for OUD (in collaboration with the PMR)
- Epidural or facet injections for pain

Tracy says that she wants to pursue follow up with a PMR and mental health therapy. Tracy's PCP, Dr. Hays, is in network with Aetna and he will remain Tracy's PCP. He will continue Tracy's current treatment of pain until PMR and mental health services begin. Dr. Hays reviews the State Prescription Monitoring program (PMP) to verify that he is the only prescriber of pain medications and other controlled substances for Tracy. Linda suggests that he prescribe Narcan for Tracy (consistent with Centers for Disease Control and Prevention recommendations) in case of an emergency. Linda will educate Tracy and her friend Karen regarding how this is used. Linda also asks that the PCP order random urine drug screens (UDS) to rule out the possibility that Tracy is taking other drugs that may be dangerous in combination with her narcotic pain medication, and to verify she is taking her prescribed medication. Linda tells Dr. Hays how to find Aetna's provider website, which includes a link to LDH's resources on OUD treatment. Linda will also refer Tracy to our member restriction program, which will limit her to using one pharmacy (of her choice) for one year. Tracy and the team agree that if she does not report marked reduction of back pain and improved daily functioning in two months as a result of PMR interventions and therapy, they will re-examine back surgery and/or other options. Tracy receives a copy of her care plan and the MDCT is reminded that this information is also accessible on the provider portal.

Securing Services Identified in the Plan of Care to Address Tracy's Primary Concern

Linda contacts a PMR who works in St. Helena Parish, who is trained in evaluation of OUD, and who is a certified provider of Suboxone induction and follow-up MAT care. The PMR's evaluation with Tracy is set to occur in four days at a convenient time for Tracy. The CHW arranges transportation for Tracy to attend this appointment. Linda also connects Tracy to a tele-mental health provider of counseling services, who schedules an initial session to occur in five days. This licensed mental health professional (LMHP) is trained in TIC and will address Tracy's pain experience and conduct further thorough assessment and treatment of mental health and opioid use/substance use. Linda verifies with Tracy that she has an internet connection and knows how to use the telehealth software to connect with the LMHP. As a result of further evaluation with Tracy, the PMR diagnoses her with OUD and suggests a multipronged approach to treatment of her pain and OUD. The PMR determines that Tracy would benefit from transitioning to a non-narcotic medication to address her pain. The PMR also recommends a home stretching/strengthening program. The PMR suggests MAT services for Tracy for OUD. The PMR takes time to explain these interventions, their benefits, and potential risks to Tracy before obtaining Tracy's consent. The PMR speaks with Tracy's PCP, Dr. Hays, as well before implementing these treatment changes, so that Dr. Hays' discontinuation of Tracy's Norco-hydrocodone-acetaminophen can be coordinated carefully with the PMR's new interventions. Following this coordination, the PMR prescribes Neurontin and Cymbalta for Tracy as a non-narcotic option to address her pain. The PMR also begins Suboxone induction with Tracy and will conduct biweekly (and later monthly) follow-up as she continues in MAT services. Tracy tells the PMR that once her pain reduces slightly, she would be interested in seeing a chiropractor. The PMR and LMHP will become part of Tracy's MDCT going forward. The PMR will follow

up with Tracy and the team at the next MDCT meeting regarding whether/when to begin chiropractic services and to ensure the care plan is updated with the new treatment interventions the PMR began. The PMR will follow up with the PCP and therapist on a monthly basis regarding ongoing UDS results and PMP monitoring.

Ongoing Support through Case Management Interventions and Other Activities

Tracy also has a history of complicated pregnancies and several chronic health conditions. Tracy told the MDCT she has difficulty with follow-through on treatment recommendations for hepatitis-C, hypertension, and diabetes related to her medication regimen and dietary decisions. The care plan also includes interventions to address these concerns and conditions as described in **Table 2.10.6.1-1**:

Table 2.10.6.1-1: Ongoing Support and Case Management to Address Tracy's Other Health Conditions

Condition or Concern	Identified Intervention
General	• Linda to conduct in-home visits to provide disease, family planning/maternal health, and sexual health education, support medication compliance, and counsel positive nutrition/exercise • CHW to review Aetna's online self-management and mobile app tools with Tracy • Linda to talk with Tracy regarding alternatives to handle acute pain as opposed to going to ED • Linda to facilitate ongoing reassessment and care plan update activities in accordance to Tier 3 requirements; Linda to conduct ongoing coordination of care in between team meetings with all members of the MDCT as clinically indicated with regard to Tracy's progress • Pharmacist to perform medication reconciliation and communication with MDCT regarding Prescription Drug Monitoring Program • CHW to verify Tracy is signed up for all benefits for which she may be eligible (SNAP, WIC, etc.); identify services for Tracy's children such as Early Head Start, daycare, or afterschool programs; support Tracy in identifying and removing any barriers to taking children to well-check visits
Diabetes and Hypertension	• Linda to evaluate need (and arrange if applicable) for durable medical equipment to actively treat Tracy's diabetes and hypertension; pharmacy can conduct blood pressure checks • Care Innovations to conduct remote patient monitoring and communicate key biometric data (blood sugars, blood pressure, hemoglobin A1C, weight, etc.) to members of Tracy's care team; CHW to help Tracy set up IPad to access biometric components • Linda to continually monitor Tracy's Healthcare Effectiveness Data and Information Set measures (such as ED utilization, comprehensive A1C hemoglobin , neuropathy, retinopathy screening, controlling blood pressure measure) and contacts PCP to close care gaps • If hemoglobin A1C is uncontrolled, PCP to connect Tracy to endocrinologist
Hepatitis C	• PCP to consult with hepatologist; if Tracy meets criteria, enroll her in Aetna's CM Adherence Program for hepatitis-C (focuses on completing the drug regimen, removing barriers to success)
Social Determinants of Health	• CHW to connect Tracy to the Well-Ahead Louisiana program to address health equity concerns related to access to healthy food and general education regarding diet and exercise • CHW to arrange transportation to services through Logisticare if indicated/needed

As we continue with Tracy on her journey to maximized health, Linda's priority is Tracy's and her family's health and well-being. As Tracy makes progress toward her goals, additional evaluation and care plan review may result in re-tiering to less intensive case management. Linda talks with Aetna's Network team about developing PT capacity in Greensburg.

Aetna Infrastructure and Other Resources to Support Tracy's Success

Our case management infrastructure supports enrollees with dedicated, local case managers and MDCTs that include members chosen by the enrollee as part of their circle of support. CMs conduct face-to-face MDCT team meetings and use telecommunication and online tools as needed. Aetna's Pharmacy team is experienced in supporting members with substance use disorder. Aetna has specialized networks to provide local, simple, personable relationships with pharmacists to assist with medication reconciliation and notes on prescription bag tags to remember primary visits.

2.10.6.2 Case 2

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2.10.6 Case Scenarios

2.10.6.2 Case 2

Aetna will provide our enrollee in this scenario, Toby, with case management tailored for children with special health care needs including assessment, integrated care planning, ongoing case management to foster positive health outcomes, and infrastructure and other resources to deliver exceptional care.

Expanded View of Toby's Circumstances

Toby is an 11-year-old Caucasian male with special health care needs living in Shreveport. He has extensive history of childhood trauma including sexual and physical abuse perpetrated by his uncle, and his outpatient child psychiatrist has diagnosed him with post-traumatic stress disorder (PTSD). Although he is not a Chisholm Class Member, he is involved with the Office for Citizens with Developmental Disabilities (OCDD) related to mild autism spectrum disorder (ASD) but demonstrates low to normal intelligence and good language skills. He currently lives with his father, Mark, and his stepmother Allison, both of whom have been treated previously for anxiety and depression (now in remission). Toby is currently in the emergency department (ED) for the third time in a few weeks. Inpatient psychiatric hospitalization was recommended at the first of these ED visits following Toby's engagement in self-injurious behavior, but Toby was discharged home after spending several days waiting in the ED for a psychiatric bed in the community. In Toby's two most recent visits to the ED (and the current presentation), he and his parents continue to describe that Toby is experiencing extreme levels of anxiety every day, as well as nightmares and dissociative periods associated with memories of his traumatic history. He continues to attempt self-injurious behavior and he has attempted to induce vomiting. His parents feel overwhelmed and unable to help Toby maintain his safety at home. It is beginning to affect their own mental health as evidenced by their reports of increased anxiety and difficulty sleeping.

Toby's child psychiatrist referred him for Aetna case management in November 2018 for the purpose of enhanced care coordination. Based upon the most recent health needs assessment and predictive modeling information available at that time, Aetna connected him with Tier 2 case management, a level for medium-risk individuals. Since then, and up until present, his case manager has delivered case management services including updated assessments and treatment planning with Toby's multi-disciplinary care team (MDCT), according to LDH requirements for Tier 2 case management. His care manager (CM), David, a licensed professional counselor, was selected for Toby because of his training and experience in trauma-informed care (TIC), mental health first aid, motivational interviewing, and functional family therapy. David also has previous experience as a service line tech working under the direction of a board-certified behavioral health specialist at an Applied Behavioral Analysis (ABA) facility. David is now part of an Aetna regional case management team in Shreveport. He works in the community where Toby lives and has relationships with providers there.

Toby's two previous presentations at the ED occurred on weekends and ED staff was not aware that David was Toby's CM; therefore, they did not outreach him to coordinate care or discuss inpatient psychiatric services. When David noted the ED service on the admission, discharge, and transfer (ADT) feed the next business day following Toby's first ED visit, he telephoned Toby's parents three times over the next two days to attempt to schedule an in-home visit. He was not able to make contact with the family, but left voicemail messages and sent them a letter, offering assistance and requesting that they call him back. David left messages with Toby's teacher and ABA provider regarding the situation, explaining he was trying to reach the family. When Toby presented at the ED a second time David again attempted to contact Toby's parents, but again had to leave them a message. David went to Toby's home in the evening, but there was no answer at the door. He also called the hospital to ask that he, as Toby's CM, be contacted if he presents there again. David reviewed documentation from Toby's last MDCT meeting three-and-a-half weeks ago to refresh his memory regarding Toby's situation at the time. Toby and his

parents had reported Toby was having some difficulty managing his feelings of anxiety and the intrusive memories of his past trauma. However, he was not engaging in self-injurious behavior at the time, nor was he experiencing nightmares or dissociative episodes. He was not engaging in tobacco or substance use, nor was he sexually active or participating in problem gaming. He had been receiving community psychiatric support and treatment (CPST) and psychosocial rehabilitation services (PSR) for the last six months to help him develop coping skills related to his trauma and anxiety. Toby had completed a comprehensive diagnostic evaluation, which identified Toby's ASD diagnosis and noted behavioral deficits that affected Toby's interactions at home and in the community. As a result, he was connected with and began ABA services with Behavioral Specialists of Louisiana (BSL). David had coordinated care with school staff regarding school-based services identified in Toby's individualized education program (IEP). David had led case management activities with the agreed-to participants with Toby's parents, which includes Toby's pediatrician, Dr. Sparks, his child psychiatrist, CPST/PSR and ABA providers, OCDD support coordinator, and teacher. In the last MDCT meeting, the family and MDCT acknowledged that Toby was making some progress and would continue with the services indicated in his plan of care, with ongoing monitoring and planning around his safety and sense of security.

Ensuring Access to Services to Address Toby's Primary Presenting Issue

Toby's third visit to the ED occurs on a Tuesday and David is notified in near real time via ADT feeds. **Based on recent escalation of Toby's situation and third visit to the ED, he will now receive Tier 3 case management services (our most intensive level).** David will respond to Toby in the ED to conduct an assessment with Toby and his family and establish an interim plan of care to address Toby's current needs. **Figure 2.10.6.2-1** summarizes our approach with Toby.

Assessment and Plan of Care for Toby's Immediate Situation

David immediately contacts the ED to inform them he is Toby's CM and to coordinate for the Northwest Louisiana Human Services District mobile crisis team to meet with Toby and his parents at the ED. Additionally, David proceeds to the ED to meet with the family. Upon arrival at the ED, David speaks with the mobile crisis team, which has completed their evaluation of Toby. They report that this morning he began throwing things in his room, banging his head on the floor, and attempted to make himself vomit. His father intervened and he and his wife brought Toby to the ED, not only out of concern for the circumstances underlying the behavior, but also due to worry that he may have injured his head and might hurt himself further. The crisis team states that the parents have difficulty applying coping and parenting skills during the height of a crisis and do not appear equipped at present to maintain his safety at home. David inquires with the crisis team and ED medical staff as to whether, from a medical standpoint, Toby showed any signs or gave any reports of abuse. Since his medical history includes the self-induction of vomiting, David asks about lab results to determine if an electrolyte imbalance appears to be an issue. Hyponatremia (low sodium) can compound a psychiatric crisis by exacerbating mood changes, or it can be misdiagnosed as a psychiatric crisis. The crisis staff and ED medical staff do not report any signs of abuse that would require a call to Department of Children and Family Services (DCFS), nor does electrolyte imbalance appear to be a factor. The X-rays of Toby's head showed no signs of trauma and a CT is not ordered. Toby's urine drug screen (UDS) is negative. The ED physician declares that Toby is medically cleared but will need an evaluation for his psychiatric concerns. Based on Toby's recent

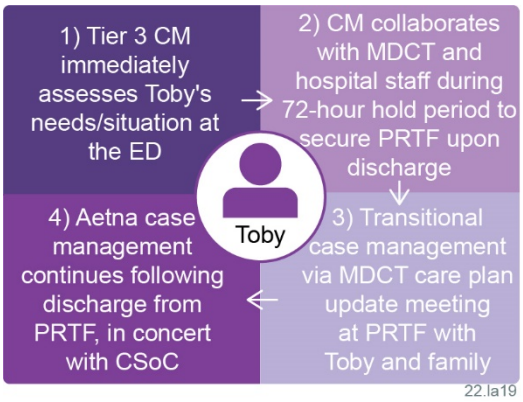

Figure 2.10.6.2-1: Approach to Assisting Toby
Toby's CM will support Toby as he transitions from the hospital, to PRTF, and to home.

escalating symptoms, unsafe behavior, and the fact that his parents are struggling to maintain his safety in the home, the ED physician does not believe Toby can be safely monitored and treated on an outpatient basis at this time. There is currently no inpatient psychiatric or Institutions for Mental Disease bed available. The ED physician completes a physician emergency certificate (PEC) to admit Toby for a 72-hour hold with a 1:1 monitor to ensure his immediate safety and further evaluation by a psychiatrist.

While waiting for Toby's transfer (under the PEC) to the hospital floor to occur, David meets with Toby and his family in the ED. David uses motivational interviewing strategies to conduct a brief assessment of the current situation. David's training and experience in TIC guide his approach as he investigates what led to Toby's escalating symptoms and resulting visits to the ED. His parents report that although Toby does not have any contact with his uncle, he saw him at a shopping mall in Shreveport two-and-a-half weeks ago. Toby and his parents attempted to avoid eye contact and evade him but Toby's uncle approached him and tried to give him a hug. Since then, Toby has been inconsistent with taking his medications, has begun to have nightmares, and has experienced dissociative periods. He has also reported several instances of severe nausea. Mark and Allison report the CPST and PSR services are not helping to address this spike in upsetting symptoms. David talks further with Toby, who states he feels scared, sad, angry, and out of control and is worried that he is making things harder on his parents. He reports he has been much more anxious. Toby says he has been trying to use the skills he learned with PSR, but it has not been working. David describes to Toby and his parents that while he is on the hospital floor on the PEC hold, the family will speak with a child psychiatrist who will conduct further evaluation. This psychiatrist will also be consulting with Toby's outpatient psychiatrist as well as with Toby's pediatrician, Dr. Sparks. David assures the family that he will remain the primary point of contact for the family and members of Toby's MDCT, as needed, to coordinate services recommended by the psychiatrists. David will provide updates to the family regarding the psychiatrists' recommendations and will resolve information gaps through bidirectional communication between the family and all providers. David confirms the family's agreement with the plan of care. David also asks that if, in the future, they bring Toby to the ED, they notify him immediately. He also states he is going to ask the medical social worker to note in Toby's record that David is his case manager and should be contacted if he arrives at the ED again in the future. Mark and Allison apologize for not returning David's calls over the last week.

Over the next 48 hours, David speaks to Toby's parents and hospital staff to see how Toby is doing. David also speaks with Dr. Sparks, Toby's teacher, and ABA provider to offer updates as to Toby's status. David also has also notified DCFS of Toby's recent interaction with his uncle. Over the past 48 hours while admitted under the PEC, Toby has begun taking his medications consistently and has not engaged in any self-injurious behavior. David consults with his internal Aetna medical director and communicates with the hospital's psychiatrist who evaluated Toby, as well as Toby's outpatient psychiatrist. The psychiatrists inform David that Toby has contracted for safety, his behaviors have de-escalated, and they are no longer concerned that he may be a danger to himself or others. The psychiatrists have determined that a psychiatric residential treatment facility (PRTF) is the appropriate next level of care for Toby. David discusses this option with the family, who agrees with this plan.

Securing Services Identified in the Plan of Care to Address Toby's Immediate Needs

David identifies the Louisiana Methodist Children's Home (LMCH) as a well-matched PRTF provider for Toby due to their specialization in TIC. LMCH also has marriage and family therapists that can facilitate family sessions while Toby is in their care. Additionally, there is some family housing onsite. LMCH is equipped to help de-escalate Toby's self-injurious behavior, should that occur. Toby will be able to continue his ABA services with BSL while in care with LMCH. LMCH and David will actively coordinate care with Toby's outpatient psychiatrist regarding medication changes (if applicable) while he is there. David coordinates with Toby's MDCT and the Aetna Utilization Management (UM) department to complete PRTF screening, referral, prior authorization, and Certification of Need requirements for

admission to PRTF. The UM team initially approves two weeks of PRTF and will conduct daily concurrent review to assess Toby's unique needs and whether continued stay addresses these. LMCH does have a bed available and accepts Toby. David ensures that LMCH has all relevant information regarding the events preceding Toby's admission and discusses with LMCH and Toby's family the initial goals of treatment at PRTF (maintaining Toby's safety and ensuring medication compliance) until a formal care plan update can occur. Toby's parents take him to the residential facility that evening for admission following the completion of his 72-hour PEC hold.

Providing Ongoing Support through Case Management Interventions

Following Toby's admission to the PRTF, David continues transitional case management (at Tier 3 level). **He contacts the approved/permitted members of Toby's MDCT to schedule a care plan update meeting, to occur onsite at the residential facility in two days.** Toby's CPST/PSR and ABA providers and the OCDD support coordinator participate with Toby, Toby's parents, PRTF staff, and David in-person for this meeting. Toby's outpatient child psychiatrist and a medical assistant from Dr. Sparks' office participate by phone. His special needs teacher from school was invited, but was unable to attend. David obtained her input prior to the meeting and will share the resulting care plan update details with her afterward.

During the care plan update meeting at the PRTF, David asks Toby and his parents to summarize the events leading up to his recent ED visits and subsequent admission to the PRTF. As David facilitates discussion, he is careful to seek input from Toby about his goals for greater stability and reduction of symptoms going forward. Likewise, David asks Toby's parents to share their perspective. His approach maintains a person-centered focus, factoring in the unique culture and values within Toby's family. All team participants aid in identifying Toby's strengths and interests, including his kind nature, ability to complete some chores, and his interest in art and drawing. His father and stepmother are supportive and loving but indicate they need extra education regarding how to help Toby when he is in a crisis. They explain that the CPST and PSR services were no longer helping Toby with his PTSD symptoms. At this time, David also evaluates whether there have been any changes in Toby's housing stability, access to healthy foods, transportation needs, and/or physical safety, or whether Toby is smoking or engaging in problem gaming. The family reports no problems in these areas at this time. Toby and his family say that once Toby returns home from the PRTF, they will need more support to help Toby with self-care and to address his trauma experience. **David explains transitional case management activities will continue while he is in the PRTF and that case management will continue at the Tier 3 level upon discharge from PRTF with enhanced services to better address PTSD symptoms.** The team collaborates with Toby and his parents to establish three goals to achieve while in the residential program:

- Toby wants to control his behavior when he is upset, instead of doing things that are harmful to him
- Toby wants three nights in a row of no nightmares
- Toby wants anxious episodes only three times a week as opposed to daily

Toby, his parents, and his team also identify the following post-discharge goals:

- Maintenance of or improvement upon goals established for residential treatment (above)
- Reduction of dissociative episodes, which Toby described as feeling "confused" or "not like me"
- Increase in Toby and his parents' ability to proactively intervene or prevent or crises and to access crisis service alternatives if needed in lieu of visiting the ED

During the care plan update meeting at the PRTF, David facilitates discussion around what types of services Toby will need to achieve his post-discharge goals. Toby and his family mentioned during the assessment that CPST/PSR is no longer helping Toby manage his symptoms, and they want to discontinue these services. David discusses that if these services are discontinued, it is important to identify effective alternatives to address Toby's PTSD symptoms, which leads to discussion about the benefits of a community health worker (CHW), Coordinated System of Care (CSoC) services, and the importance of continuing ABA services. David is careful to verify there is no duplication of services

given the many treatment team partners involved. David explains he is the point of contact for the family and is responsible for follow-through to ensure the care plan is implemented. **Table 2.10.6.2-1** describes interventions/services Toby and the MDCT documented in his updated care plan:

Table 2.10.6.2-1: Toby's Individual Plan of Care (Post-discharge from PRTF)

Responsible Party	Intervention/Service
David (CM)	Conduct in-home evaluation of environmental safety and social determinants of health
Toby/Family	Continue seeing outpatient child psychiatrist; continue ABA services for ASD with BSL
Toby's Pharmacist	Invite Toby's pharmacist to the MDCT; pharmacist to provide medication reconciliation and education regarding side effects; pharmacist to rule out duplications when medication is changed
David (CM)	Implement a crisis plan with Toby's family to identify potential crisis triggers; learn crisis de-escalation skills; educate regarding crisis service alternatives (crisis hotline); discuss how to help Toby feel safe and process feelings if he should run into his uncle again
David (CM)	Request a child and adolescent needs and strengths assessment and make referral to the CSoC 30 days prior to discharge; CSoC services to include youth/family peer support
CHW	Local CHW to join MDCT; CHW will help with appointment scheduling/reminders, attend office visits with Toby and his family (if requested), and teach Toby self-management skills;
David (CM)	Refer for oral health evaluation of potential damage caused from self-induced vomiting
David (CM)	Verify that school-based resources are in place (IEP, 504 plan, in-school supports,) and school staff to continue participation in MDCT; ensure that IEP calls for trauma therapy as a required component
David (CM)	Coordinate with Toby's pediatrician to ensure immunizations and Early and Periodic Screening, Diagnostic and Treatment (evaluations are completed, in alignment with Healthy Kids population health approach; UDS reassessment if/when warranted
David (CM)	Speak with Toby's parents regarding their health care services/benefits; coordinate with their service providers (with their permission) to ensure they are getting necessary mental health services/support
David (CM)	Foster Toby's interest in drawing/peer socialization via connection to Boys & Girls Clubs art program
David (CM)	Connect family to National Alliance on Mental Illness Northwest Louisiana branch

David follows up with the family at home the day after Toby's discharge from PRTF to see how the whole family is adjusting to his return and to confirm care plan recommendations are being implemented or were completed before Toby left the PRTF. **David explains that Toby has been accepted for CSoC services** and that going forward David will follow the lead of the CSoC facilitator as they take a more prominent role in care planning and case management. Rather than duplicating services for Toby, David's activities will complement those of the CSoC facilitator. When the family reports significant progress or achievement of Toby's goals, they will talk with the MDCT about whether to decrease the intensity of his case management tier level. David will conduct another formal reassessment in three months.

Aetna Infrastructure and Resources to Support Toby's Success

Building Bridges Initiative (BBI): Toby was admitted to LMCH, partly for its value in adhering to principles of the BBI, to which LMCH is a signatory. The BBI's mission is to identify and promote best practices with youth, their families, their communities, and residential treatment providers. Aetna has been involved with activities to develop BBI in Louisiana from the outset and presented BBI principles to LMCH staff at their site several years ago.

Aetna's Trauma-informed Organizational Transformation and Thrive Collaborative: Aetna has collaborated with the National Council for Behavioral Health to transform the way we deliver care. Aetna trains 100 percent of its staff in trauma-informed principles. Through our Thrive Collaborative, we work with Juvenile Justice, DCFS, and schools throughout Louisiana to support system partners in becoming trauma-informed. We also help send teachers to TIC training and educate parents on the topic.

2.10.6.3 Case 3

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2.10.6 Case Scenarios

2.10.6.3 Case 3

Our enrollee in this scenario, Ray, will benefit from Aetna's more than 30 years of experience managing Medicaid services through case management, which ensures a thorough assessment of Ray, comprehensive care planning, and coordination across complex benefit structures.

Expanded View of Ray's Circumstances

Ray is a 65-year-old Caucasian male who lives in a nursing home in Jefferson Parish. He was admitted three months ago with a diagnosis of failure to thrive (R62.7) after his primary care provider (PCP) saw him and noted he had lost 25 percent of his body weight and appeared frail and weak. Ray has been diagnosed with schizoaffective disorder (bipolar sub-type), high blood pressure, and experiences chronic pain due to unspecified neuropathy. His pain and weakened state limit his ability to ambulate on his own. He also has difficulty performing tasks that include making meals, getting dressed, general housework, and using public transportation. The majority of his functional deficits are due to anxiety in performing tasks and/or not having proficiency in completing tasks independently. Additionally, Ray has difficulty following his prescribed medication regimen. He has also attempted suicide several times, resulting in multiple inpatient psychiatric hospitalizations, the most recent occurring a few months ago. He has frequently visited the emergency department (ED) to address both physical and behavioral health symptoms. A recent functional evaluation by the State deemed he no longer meets criteria for a nursing home. Unfortunately, Ray had been evicted from his apartment while at the nursing home. He would like to return there (or to another apartment) if possible. He is estranged from his family and he lacks a support system.

Ray is enrolled in Aetna's Dual-Eligible Special Needs Plan (D-SNP) with Aetna Medicare and has Specialized Behavioral Health benefits with Aetna Medicaid. Prior to his admission to the nursing home, Ray was assigned to a primary Aetna Medicaid organization case manager (CM), Jim, who works in Jefferson Parish. Jim is a licensed clinical social worker, trained in trauma-informed care, motivational interviewing, and mental health first aid. Jim coordinates Ray's benefits and care with Ray's Medicare case manager. As a previous member of a D-SNP care management team, Jim has several years' experience working with the older adult/geriatric population and has had specialized training in this area. Ray was placed in Tier 3 care management with Jim (secondary to his complex biopsychosocial health history) to support Ray's clinical care and social determinants of health needs.

Prior to Ray's admission to the nursing home, Jim collaborated with Ray's psychiatrist, who requested authorization for assertive community treatment (ACT) based on Ray's diagnosis of schizoaffective disorder (bipolar sub-type), which qualifies as a serious mental illness (SMI). Ray met criteria for ACT and was approved for services with the Jefferson Parish Human Services Authority. Jim explained to Ray at that time that while ACT services are delivered, he would remain the primary coordinator for his care. Jim provided Ray with his direct telephone number as well as the Aetna Behavioral Health After Hours call line for 24-hour crisis intervention coverage.

Ray meets the following Tier 3 case management criteria:

- Biopsychosocial complexity
- Individuals with 3 or more ED visits
- Adults with SMI
- Individuals in Department of Justice Agreement and those transitioning from a nursing home

Jim has received a call from Ray's LDH transition coordinator, who stated Ray no longer meets eligibility for the nursing home. Jim completes the Preadmission Screening and Resident Review (PASRR) Level II. The PASRR II evaluation concurs with the State's functional evaluation that the nursing home is no longer the least restrictive environment for Ray.

Ensuring Access to Services to Address Ray's Primary Presenting Issue

Transitional case management services are provided by Jim to complete an updated assessment and care plan to facilitate Ray's move into to the community. **Figure 2.10.6.3-1** summarizes the approach.

Comprehensive Assessment and Updating the Individual Plan of Care

Jim calls Ray to discuss his transition from the nursing home and ensure that Ray understands his options consistent with My Choice Louisiana, including care in a home- or community-based setting. Jim and Ray agree to schedule a care plan update meeting with Ray's multi-disciplinary care team (MDCT) to occur in two days at the nursing home. Jim confirms with Ray's PCP, Dr. Adams, that she or her representative is available to attend either in-person or by phone. Jim also invites nursing home staff, the D-SNP Medicare case manager, Ray's psychiatrist, the Aetna and ACT housing specialists, the ACT peer support specialist, and Ray's pharmacist to the meeting. Each has previously been approved by Ray as members of his MDCT. Jim explains to Ray the role a community health worker (CHW) can play in helping him navigate independent living and obtains Ray's permission to invite the local CHW to the MDCT meeting as well. Jim schedules extra time directly with Ray for approximately one hour prior to the care plan meeting, to conduct an updated comprehensive assessment with Ray. Jim reviews the documentation of Ray's last assessment and care plan before the meeting.

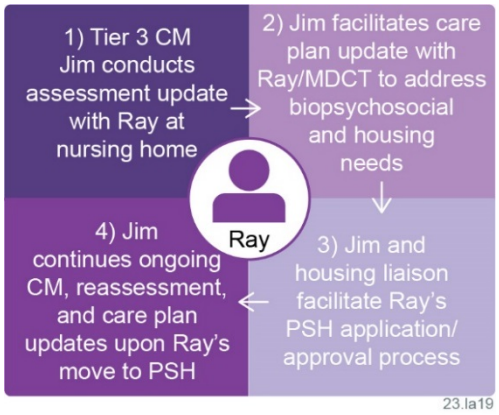

Figure 2.10.6.3-1: Approach to Assisting Ray
Ray's CM delivers transitional case management to address his discharge from nursing home and transition to the community.

On the day of the meeting, Jim uses a person-centered approach to conduct an **assessment update**, asking Ray to tell him how he has been feeling both from a physical and mental health standpoint.

On a positive note, Ray's weight has improved and it is now stabilized. Ray reports some ongoing pain related to his unspecified neuropathy. Ray rates this pain as a 3 on a scale of 1–10, 10 being the highest. He states that he feels "mostly alone," save for the support he receives from Jim, nursing home staff, and other members of his MDCT. Jim inquires further about Ray's sense of isolation and Ray voices concern that when he returns to the community, he does not have any friends with which to socialize. He has gotten used to the nursing home setting where he is able to participate in some social activities (such as Bingo and trivia game night) with other patients and interacts regularly with staff. He says sometimes he leads the games and this makes him feel useful. Ray is worried about losing these connections when he lives on his own. Ray says he does feel anxious most days and occasionally sad, but he does not have any thoughts (or plans) to attempt suicide at this time. Jim notes during the comprehensive assessment that Ray reports neither feeling lost nor seeing things, nor having trouble thinking or speaking. As part of this assessment update, Jim asks Ray about whether he engages in tobacco use, problem gaming, and alcohol and/or substance use, none of which are an issue for him.

Jim uses motivational interviewing techniques to help understand Ray's challenges. Jim asks Ray if he has been able to manage his personal hygiene and other activities of daily living (ADL) while in the nursing home. Ray tells Jim he can do these activities, but he feels anxious about the process. He sometimes needs reminders and help from nursing home staff to complete tasks such as dressing himself and taking his medication. Ray reports he is anxious that about not being able to care for himself outside the nursing home. Jim reviews with Ray all of his medications and informs Ray that some of his medications may be available through an injection to reduce the number of pills he has to take. Ray indicates this sounds like something that might help him. Jim informs Ray that this will be something to

discuss in the care-planning meeting with the MDCT. During this reassessment, Jim talks with Ray about factors to consider when he is living independently related to accessing healthy food in the community, as well as what transportation supports he might need. Jim also reassures him that his MDCT will help identify and obtain services to make the transition back into the community successful. Jim encourages Ray to recall the positive aspects of living in the community prior to his stay at the nursing home and asks what he liked about his previous apartment setting. Jim also talks with Ray about his strengths, which include knowing how to contact Jim when he needs help, and how to lead people, as Ray does during the Bingo and trivia games at the nursing home. Jim educates Ray regarding the goals of the care-planning meeting (which is set to occur after this reassessment conversation) and who will be there. They talk about how he can be assertive in stating his needs during that care plan meeting.

Following the reassessment time with Ray, Jim facilitates the MDCT care plan update meeting. Ray's PCP, psychiatrist, and pharmacist participate by phone. The nursing home staff, Aetna D-SNP case manager, Aetna and ACT housing specialists, local CHW, and ACT peer support specialist attend in-person at the nursing home. Jim summarizes what Ray has shared in their reassessment discussion regarding his status and concerns about the transition out of the nursing home. Jim asks Ray to elaborate in his own words with the team and empowers him to share what he wants to see happen with his care.

During the care plan update meeting, Ray clearly expresses his desire to return to his previous apartment, make some friends, take fewer pills, and reduce his anxiety. He is very concerned about his ability to walk even short distances due to pain. Jim and the MDCT develop his care plan prioritizing coordination for permanent supportive housing (PSH) and arrangement of tenancy supports. Dr. Adams, Ray's PCP, discusses management of his hypertension, pain associated with neuropathy, and age-appropriate preventive health services (pneumonia and flu vaccine, blood pressure monitoring). All agree that keeping Ray with his established ACT team upon discharge will provide continuity of care. Jim reviews core benefits and value-added services available. In addition to identifying the need to secure housing through the PSH program, Ray identifies (with support and input from the MDCT) the following goals:

- Decreased pain (from Level 3 to Level 1)
- Taking all medications as prescribed and maintaining a healthy weight
- Self-management of daily hygiene tasks and general housework tasks
- Improved mood; decreased sense of sadness, anxiety, and loneliness
- Making two new friends and identifying available social activities
- Learning how to use the bus system

As a result of this collaborative discussion, Jim and the team help Ray identify interventions he will need to address his pain and medication adherence. These can be conducted while Ray is still in the nursing home. Relevant services and interventions documented in the updated care plan include the following:

- Dr. Adams will connect Ray with a physical medicine and rehabilitation specialist (PMR) specialist who can further evaluate the source of Ray's neuropathy to develop a plan to address his pain and provide appropriate durable medical equipment (DME)—i.e., cane, walker, bedside commode, etc.
- Ray's psychiatrist, PCP, and pharmacist will talk with Ray regarding options for administering behavioral health medication injections to assist with adherence to medications
- Ray's pharmacist will conduct medication reconciliation activities that are consistent with his Medicare Part D plan and ensure pharmacy wrap drug coverage; dispensing devices and pill packs

Jim and Ray also document in the care plan the interventions/services to be implemented as he discharges to the community. The following interventions will address Ray's goals related to skills training, improved mood and decreased isolation and anxiety, increased social activities, and navigating the transportation system:

- Jim and the ACT team will develop a behavioral health crisis plan with Ray to include guidance regarding recognizing crisis triggers and symptoms, coping skills Ray finds effective, and the availability of his ACT team and/or crisis services to utilize if suicidal thoughts or plans return
- Ray's peer support specialist will help teach (and work with Ray to practice) anxiety management and coping skills, and how to use the local transportation system
- The CHW will provide skills training and development for Ray to teach him how to take care of personal hygiene, general housework, and other ADLs
- Jim will go with Ray to his first visit to the Jefferson Council on Aging (JCOA) senior center in his new neighborhood and will provide coaching and support as Ray gets oriented to the center and meets new people; they will look for opportunities for Ray to lead social events there, as permitted
- The ACT therapist and Ray's psychiatrist will meet with Ray to discuss his feelings of isolation and depression and to arrange for ongoing counseling sessions as needed
- The employment specialist on Ray's team will help him identify meaningful life activities/hobbies
- Jim and Ray will work on daily routine planning (i.e., bed times/meal planning) for independent living

At the end of the session, Ray indicates he is looking forward to implementing the agreed upon care plan.

Securing Access to PSH Services as Identified in the Updated Plan of Care

The need to secure PSH was identified as a critical priority for Ray during the MDCT meeting. With Ray's informed consent and approval, Jim works with Aetna's permanent supportive housing liaison to complete all steps (as described in the **Model Contract, section 2.7.15.2**) of Ray's application for PSH. Jim, Ray, and the PSH housing liaison work together to identify a housing option for Ray in Jefferson Parish that offers a safe environment with easy access to transportation services, a JCOA senior center, pharmacy, and grocery stores with healthy, fresh food. Jim attends Ray's PSH interview with the property owner to provide assistance and help minimize any anxiety Ray has about this step.

A PSH placement is secured with the new apartment complex and Jim notifies Ray that his housing application was approved. The apartment has been evaluated to ensure compliance with the Americans with Disabilities Act and to mitigate fall risk. Jim coordinates with the nursing home and apartment complex to schedule the move-in date in 30 days, at the time of Ray' discharge from the nursing home. Jim takes time to talk with Ray about the new apartment location and any concerns or worries he might have. Jim and the housing specialist ensure that all needed tenancy supports are scheduled to begin once he moves in. These include ongoing support from the housing specialist and in-home peer support services.

Ongoing Support through Additional Case Management Interventions

Jim, the CHW, and the housing specialist meet with Ray at his new apartment on his move-in date to ensure he is settled in and has his medication, DME, contact phone numbers, and food in the refrigerator. Ray expresses interest in the possibility of getting a dog to offer emotional support and companionship. Jim schedules a follow-up transitional case management meeting to occur later that week with Ray and the MDCT at his office. Ray has selected this location. Jim will arrange for non-emergency transportation provider LogistiCare Solutions to transport Ray to the meeting. This meeting will serve as an opportunity for the MDCT to check in with Ray regarding his new housing, how he is doing (from both physical and mental health standpoints), and to verify that all tenancy supports and intervention/services identified during the care plan update meeting at the nursing home have occurred or have been scheduled.

On a go-forward basis, Jim and the MDCT will provide (or coordinate for) the following additional services and supports to help Ray achieve and maintain his goals:

- Jim will coordinate with Ray's psychiatrist to provide documentation supporting the mental health need for an emotional support animal of Ray's choice
- Jim to share information with Ray regarding the CVS MinuteClinic in Metairie, as an alternative for him to address non-emergent acute illness and injury (as opposed to the ED)

- CHW will support Ray with education regarding making healthy lifestyle choices while on a limited budget; ensure follow-up on dental health services; assess need for sexual health education; CHW will ensure Ray has a pill counter for non-injection meds, and will educate Ray to help make sure this is filled correctly
- Connect Ray to Meals on Wheels and Supplemental Nutrition Assistance Program for food assistance
- Connect Ray to social activities programs geared to support individuals with SMI
- Assist Ray with completion of Office of Aging and Adult Services application for the Program for All Inclusive Care for the Elderly and long-term personal care services
- Jim to coordinate care (as needed between formal case management meetings) with Ray, his Medicare case manager, PCP, and PMR around treatment of Ray's medical conditions, to discuss the following:
  - Ray's adherence to medication regimen associated with physical health conditions and
  - whether resources such as home delivery of medications, occupational therapy, LifeAlert, and personal care services are needed are being considered
  - monitoring of maintenance of healthy weight
  - Medicare CM's scheduling of wellness appointments with Ray
- Connect Ray with the Wellpass text messaging program, which will send Ray targeted reminders about needed tests or screenings and information regarding appointments and general wellness, using phone provided by Aetna;
- Connect Ray with the local branch National Alliance on Mental Illness

Jim will facilitate transitional case management activities for a minimum of 12 months following Ray's discharge from the nursing home. Jim will sustain the person-centered focus of interventions with Ray and will continue to facilitate monthly (at minimum) MDCT meetings and service delivery in accordance to Tier 3 and transitional care management **Model Contract** requirements. Ray continues to meet with his therapist and psychiatrist to discuss his anxiety, depression, and loneliness. He has agreed to receiving injections of his antipsychotic medication. He is learning coping skills to address his anxiety and enjoys time at the senior center. Ray is actively following up with his PCP and PMR to address his pain and hypertension. Jim went with Ray to the Society for the Prevention of Cruelty to Animals to pick up his dog Gumbo. If/when Ray indicates he has made significant progress toward his goals, he will talk with his MDCT about transition to lower intensity of case management. He will continue to remain eligible for CHW services.

Aetna Infrastructure and Resources to Support Ray's Success

ACT services represent an intensive, evidence-based practice (EBP) for individuals with SMI. ACT fidelity monitoring is conducted semiannually for Aetna through an agreement with the Center for Evidence-Based Practices at Case Western Reserve University. Aetna receives their fidelity reports on over 20 ACT teams within our provider network, including results for multiple ACT teams located in Jefferson Parish. As a result, Ray has a choice of local providers for this EBP service.

Aetna is aware that some enrollees (like Ray in this case) frequently visit the ED. Aetna utilizes real-time ADT feeds to identify and intervene with individual enrollees when this occurs. As described in Ray's scenario, case managers respond by developing crisis plans, which target root causes of ED visits, and discuss alternative service options with members to help prevent avoidable ED visits. Services available to address avoidable ED visits might include utilization of CVS MinuteClinics, behavioral health crisis services, or telehealth services.

Ray, as a member of a unique D-SNP population, will benefit from Aetna's integrated model of case management, which promotes the seamless coordination of care across complex service delivery systems and lines of business. The provider and member portals store Ray's assessment and care plan information, which are accessible by permitted members of the MDCT. Additionally, Aetna case managers are skilled in coordinating and delivering services to address members' biopsychosocial factors in a manner that is person centered and fosters self-management.

2.10.7 Provider Network

Aetna recognizes that chronic illness such as diabetes has an enormous impact on Louisiana communities. Aetna participates in the Dragon Boat Festival each year in Monroe to promote health and physical activity, contributing to a healthier mind, body, and spirit.

2.10.7 Provider Network

Pursuant to the requirements of **RFP Section 2.10.7**, the Provider Network Listing Response Template and the Provider Network Capacity Response Template can be found in a folder titled **2.10.7 Provider Network** on the USB provided to the State.

The folder titled 2.10.7 Provider Network has been removed from the USB as it contains data identified as confidential information and has been redacted in its entirety.

2.10.8 Network Management

Following the state's priorities to address obesity and unhealthy eating through the elimination of food deserts, Aetna provides the resources for the creation of community gardens and offers healthy eating options in local schools, community centers, and places of worship. We celebrate the collaboration and coordination to create community gardens in public spaces in low-income neighborhoods.

2.10.8 Network Management

Aetna has participated in Louisiana's Medicaid managed care program since 2015. Our strong community relationships, integrated network analysis and recruitment processes, and high-touch model of network management assist us in ensuring a network sufficient to meet the needs of Louisiana residents. Through our network management strategies and processes, we continue to ensure timely access to culturally competent primary and specialty care services necessary to promote LDH's goals. Our provider network, which meets LDH's expectations and requirements, includes all provider types, including primary care providers (PCPs), pediatricians, community mental health centers, federally qualified health centers (FQHCs), rural health clinics (RHCs), obstetricians/gynecologists (OB/GYNs), behavioral health providers, specialists, hospitals, ancillary providers, and pharmacies that provide the highest quality of care to our enrollees. We acknowledge, understand, and will comply with all of the requirements of the **RFP**, the **Model Contract, and the MCO Manual**.

In support of our commitment to quality, ready access, and innovation to maximize enrollee health, advance health equity, and address social determinants of health within a flexible value-based approach, we have developed, and we continue to develop, a robust statewide provider network capable of meeting the health care needs of Louisiana Medicaid enrollees in an accessible, timely, and convenient manner.

Currently, Aetna has contracts with over 23,000 providers, including more than 5,000 primary care providers, 18,000 specialty physicians, 4,900 behavioral health specialists, 251 behavioral health and physical health hospitals, and 100 percent of the FQHCs and RHCs across the state. Network development efforts are ongoing as we work toward the goal of 100 percent adequacy. In cases where an enrollee's current provider is not contracted or when one does not exist, we will authorize services through single case agreements (SCAs) and provide transportation through the transition period to preserve continuity of care and access. **Table 2.10.8-1** demonstrates our network adequacy for the provider types referenced in this section.

Aetna far exceeds LDH's provider network access standards for adult PCPs in rural and urban parishes. The current standard is 90%, and to date we have **98% coverage** across Louisiana. Additionally, **90% of our PCP network has open and accessible panels for new enrollees.**

Our network for the Medicaid program also includes 100 percent of FQHCs and RHCs providers for increased rural access to health services for enrollees. Aetna has offered contracts to Opioid Treatment Centers in Louisiana and will continue contracting efforts to ensure an adequate network.

Table 2.10.8-1: Aetna Provider Network Adequacy and Accessibility

Provider Type	Rural Accessibility %	Urban Accessibility %
Cardiologists	99.9%	99.9%
Dermatologists	92.2%	92.2%
Endocrinologists (Pediatric)	98.2%	98.2%
Endocrinologists (Adult)	97.5%	97.5%
Licensed mental health specialists (Pediatric) Access to 1	98.7%	96.5%
Licensed mental health specialists (Pediatric) Access to 2	96.5%	94.9%
Licensed mental health specialists (Adult) Access to 1	98.5%	96.6%
Licensed mental health specialists (Adult) Access to 2	96.2%	94.9%
Neurologists (Pediatric and Adult)	99.9%	99.9%
OB/GYNs (Adult)	95.8%	93.4%
Orthopedists (Pediatric)	99.9%	99.9%
Primary care providers (Pediatric) Access to 1	99.9%	96.3%

Provider Type	Rural Accessibility %	Urban Accessibility %
Primary care providers (Pediatric) Access to 2	99.9%	95.6%
Primary care providers (Adult) Access to 1	99.9%	96.1%
Primary care providers (Adult) Access to 2	99.9%	95.4%
Psychiatrists (Pediatric) Access to 1	98.7%	93.2%
Psychiatrists (Pediatric) Access to 2	96.5%	92.4%
Psychiatrists (Adult) Access to 1	98.6%	93.4%
Psychiatrists (Adult) Access to 2	96.4%	92.7%
Pulmonologists (Pediatric and Adult)	99.7%	99.7%

We are prepared, upon award and in collaboration with the State, to expand MinuteClinic access in at least one existing CVS store and as many as three existing CVS stores. We will assess the regions of the state where there are a high number of potentially preventable emergency room visits, feasibility of Clinic placement and overall timing, and staging for the new clinic(s).

Identification of Current Network Gaps (2.10.8.1)

To maintain network adequacy and identify gaps in network access or where gaps are likely to occur, Aetna conducts both enrollee density and network GeoAccess® analysis to determine areas within the state, parishes, and cities where network adequacy and provider accessibility can be enhanced. Aetna uses assessment and measurement programs as the primary means of determining network adequacy and our level of compliance with Louisiana access standards. These assessments analyze compliance with travel distance standards, appointment availability, after-hours access, open panel status, and cultural competency for key provider types.

If an enrollee cannot access a pharmacy, hospital, PCP, or other specialist, then the network is not adequate (useable) for that enrollee, regardless of whether our network technically meets LDH's definition of adequate. We monitor our network to make certain that every enrollee has access to services and supports the need to achieve their health ambitions. Our goal is to exceed LDH requirements by providing access and choice of providers to 100 percent of enrollees within the required time and distance standards. While the provider counts in this section reflect our current network, we continue to build network capacity to eliminate identified access challenges or deficiencies. Louisiana has known areas of provider shortages. Based on our analysis, we identified the access challenges presented in **Table 2.10.8-2.**

Table 2.10.8-2: Identified Access Challenges

Region	Identified Access Challenges
Region 1	Although this region is categorized as an urban parish, its geography is more like a rural parish. There is currently not a sufficient amount of providers in the parish to meet the urban time/distance standard. Similarly, Jefferson Parish includes parts of Grand Isle that contribute to exceeding the time/distance standard. This region's primary access challenges exist in Plaquemines Parish. The geography naturally lends itself to restrictive travel patterns. Coupled with a shortage of physicians and practitioners post-Hurricane Katrina and the BP oil spill, Medicaid enrollees face difficulty accessing quality care. Further, combined with the geography, the local culture has an isolationist nature whereby people living outside the region's more urban areas often will not come into town for care. We have opportunities to address these challenges by continuing to contract with all available local physicians/practitioners as well as provide additional enrollee education on telemedicine and remote patient monitoring (RPM) opportunities. Aetna's approach to ensuring access in this region includes providing mobile clinics during community events and enrollee education. Utilization data suggests that our enrollees' pattern of care is utilization in Orleans Parish, where we have a very strong network. Our non-emergency medical transportation (NEMT) value-added service will provide enrollees with enhanced transportation services to access services in neighboring parishes.

Region	Identified Access Challenges
Region 2	Although the total number of providers in Region 2 is stronger than other regions, enrollees face similar challenges related to access to care. Some of the key challenges for enrollees accessing care in Region 2 are providers not accepting Medicaid due to reimbursement rates, lack of transportation and housing, and a lack of health education for Medicaid enrollees. Recently, Aetna signed a letter of intent for a value-based payment (VBP) arrangement with Franciscan Missionaries of Our Lady Health System (FMOLHS) Accountable Care Organization (Health Leaders Network) that should expand access to care, especially in the area of psychiatry, across all specialties aligning our mutual goals to the Triple Aim. Practice patterns suggest that more common diagnoses such as attention-deficit/hyperactivity disorder, diabetes, and some OB/GYN services are being addressed by PCPs. We also have telemedicine access points in Region 2 to expand capacity.
Region 3	Within Region 3, the Aetna network is strong and consistently provides access to our enrollees. According to LDH's Louisiana State Health Assessment and Improvement Plan, there is an overall lack of education to enrollees regarding disease management and prevention. The use of community health workers in this parish to inform enrollees better will improve interest in self-care and provide connections to the appropriate qualified providers. We also identify a shortage of adult- and pediatric-licensed mental health specialists. To increase accessibility, we will work with PCPs, with consultation support from our behavioral health medical director to deliver services and expand access through telemedicine.
Region 4	Although there is an adequate network of providers in Region 4, similar challenges to Region 2 exist around reimbursement, which create barriers to access. There is a lack of education around behavioral health for both enrollees and the community at large. An opportunity exists to expand behavioral health services beyond our current network to ensure follow-up post-hospitalization and inpatient care through telemedicine, peer support, and value-based payment arrangements. In St. Martin Parish, there is a need to expand psychiatry. We will do so by utilizing psychiatrists in neighboring parishes, as well as telepsychiatry services through our contract with One TeleMed.
Region 5	Region 5 is deficient in specialty care for chronic disease management that is especially prevalent in the rural areas. We will continue to work with PCPs and appropriate specialties on chronic disease management programs with a focus on school-based health clinics and rural health clinics. We continue contracting efforts with all available dermatologists who see Medicaid enrollees in the region to close the current deficiency. PCPs do provide basic dermatology services; however, we will also identify services in neighboring parishes and support enrollees through expanded NEMT services to travel to neighboring regions. We will also continue to provide education regarding accessing telemedicine for dermatology services. Because of the breadth and reach of our national network, we will leverage our commercial/Medicare networks to improve dermatology access. For example, we have dermatologists in Beaumont, Texas, who can support these enrollees.
Region 6	The rural geography, poverty, and lack of providers will drive our network strategy in Region 6. Our commitment to working with local providers as they are available will help us address specific issues in central Louisiana such as lack of prenatal care, higher prevalence of chronic conditions, and a high prevalence of enrollees with behavioral health issues. As a rural region, connections and communication between providers are a challenge and opportunity for Aetna, along with our electronic care management platform, to resolve. While our primary care network is strong in this region, there is a deficiency in certain specialists that can be resolved by remote patient monitoring. PCPs currently treat many chronic conditions and provide diabetes management. We do have an adequate network for specialty services in neighboring regions that enrollees can access with our expanded NEMT benefit. Additionally, we are in the process of working with Rapides Regional Medical Center on a VBP arrangement to enhance specialty services to our enrollees.
Region 7	Outside of the urban centers of Region 7, there are access barriers for vulnerable populations such as those without transportation. Data suggests there is an overuse of emergency department (ED) services to access care versus PCPs. Through our collaboration with University Health and Willis-Knighton Physician Network, we will collaborate on enrollee education around accessing primary care and reducing language barriers between enrollees and providers. While we have a strong primary care network, we experience some issues with OB/GYN, allergy, dermatology, and behavioral health services. As noted in other regions, we will utilize providers in neighboring parishes, leverage our commercial/Medicare network in neighboring Texas and Arkansas, and utilize telemedicine services to meet enrollee needs. Additionally, we have a VBP arrangement with Willis-Knighton Health System, which ensures access for our enrollees in that health system.
Region 8	There are multiple barriers to ready access for enrollees in Region 8. As a rural region, enrollees face transportation challenges that exacerbate an overall lack of providers. There is an opportunity for Aetna to work to dispel stigmas

Region	Identified Access Challenges
	around behavioral health conditions as well as improve access to primary and specialty care in extremely rural areas like Tensas Parish. Although we contract with all available specialists who see Medicaid enrollees in the region, we still observe gaps in hematology, oncology, dermatology, endocrinology, and psychiatry. To ensure enrollees have access for acute needs, we contract with Riverland Medical Center, a critical access hospital. Additionally, we are exploring a contract with Merit Health, one of our commercial providers, in neighboring Vicksburg, Mississippi.
Region 9	Although the Aetna network is adequate in Region 9, including a strong primary care network, there are still challenges to enrollees around timely access to care. Continued focus will be placed on Region 9 to expand timely access to specialty care through value-based arrangements that will assist with coordination of care across the continuum of care for enrollees. Placement of community health workers in Region 9 will aid families in navigating the health care landscape as well as provide additional health and wellness education to enrollees. One identified network gap is access to psychiatry. To improve access, we will work with PCPs, with consultation support from our behavioral health medical director to deliver services, and expand access through telemedicine.

We review GeoAccess and provider data to determine the number and type of specialists, including behavioral health providers, in a geographic area in order to maintain an adequate number of providers to meet health care needs of our enrollees accessing the network. We look to continue to collaborate with associations, community organizations, hospitals, and academic organizations for new providers entering the area, or to develop relationships to meet specific needs, such as providing telehealth or community solutions to maintain and increase network accessibility, especially in rural markets or in geographic areas with limited access to scarce provider specialties.

"Aetna is a leader in closing the access gap and helping Louisiana reduce barriers to mental and substance use treatment."

—Charles Edwards
CEO, One TeleMed

Identifying and Meeting Future Needs

We continually assess our network's ability to meet future projections of enrollee needs using the following methods:

- Evaluate current population demographics and consider projected population demographic needs, anticipating cultural and health disparities as an integral part of our annual network monitoring plan and Quality Management/Utilization Management Committee meeting process
- Invite provider participation and input on future network needs through our Enrollee Advisory Committees, Provider Advisory Committee, and Quality Management Oversight Committee (QMOC)
- Invite participation and feedback in stakeholder meetings comprised of health care professionals, advocates, and enrollees to discuss issues, including network adequacy, provider complaints, and recruitment priorities for growing the network
- Obtain stakeholder feedback on network composition, operations, and quality improvement initiatives to make sure we meet the cultural needs of the community and assess any areas of concern
- Invite provider participation in a variety of educational forums and webinars to share ideas, questions, and concerns, as well as future network needs/projections
- Constantly seek feedback, suggestions, and innovative ideas from providers to help offer better access and increase enrollee convenience. This includes review of provider satisfaction results.
- Identify network needs: The Provider Services team is crucial in identifying network needs to ensure timely access for enrollees. Upon referral from the integrated care team or other community organizations, they conduct research and outreach to providers to mitigate any potential gaps in care.
- Utilize enrollee and provider referrals, which trigger recruitment activity
- Utilize quarterly and annual monitoring, which triggers recruitment action as we review GeoAccess reports

- Evaluate projected population needs against the current contracted provider network to identify any opportunities to recruit services and providers. Aetna maintains a recruitment database to help us track recruitment targets, and it shows our progress in obtaining signed agreements and applications. We offer providers an opportunity to sign an electronic contract using the Adobe e-signature capability to make it as convenient as possible for a provider to sign and return their document, decreasing turnaround time on a signed agreement from days to hours.

Our network is designed to meet all contract requirements, including access standards; appointment times; after-hours availability; type and number of facilities; and ancillary, specialty, behavioral health, and vision providers. We successfully manage our networks for high-quality, culturally diverse, credentialed, and physically accessible provider groups to increase access and choice.

Strategies to Increase Provider Capacity and Meet Needs in Gap Areas (2.10.8.2)

We use the following **global strategies** to address identified network deficiencies:

- **Leveraging existing providers:** Many of our existing Aetna commercial providers have practice locations in areas for which we may have a Medicaid deficiency. We leverage those commercial relationships to contract those practice locations.
- **Recruitment of out-of-network providers:** To proactively provide consistent access to services and avoid gaps in care, we recruit out-of-network providers with whom we have authorized care or executed an SCA. We assess use of out-of-network services on a monthly basis to verify that our network contains adequate numbers and types of providers and use this information to evaluate recruitment opportunities.
- **Recruitment of providers through stakeholder identification:** Enrollees, families, and advocates are highly successful in identifying potential providers in the community. Our Network team has successful strategies to recruit those providers into the managed Medicaid network, such as working with providers who have these enrollees in their established panels.
- **Expansion of access through telemedicine:** We utilize MDLIVE®, Teladoc, and One TeleMed to provide telemedicine services. These national contractors offer specific telemedicine services related to routine physical and behavioral health services, offering a web-based service enabling enrollees to access these services from the convenience of their communities, including wherever they live. It provides web-based, 24/7/365 access for enrollees to PCPs and behavioral health specialists. We are also adopting telepsychiatry solutions to grow access to these services. These capabilities improve timely access to behavioral health care, especially for those in the state for whom distances might present a challenge to access to care.
- **E-consult and telephonic consultation services to PCPs:** The primary care setting has become the gateway to behavioral health services, such as mental health and substance use. PCPs need support and resources to screen and treat persons with low acuity conditions. E-consult provides PCPs access to United States-licensed, board-certified specialists from major academic centers across the country via an electronic health record-linked portal, which increases overall capacity.

Aetna collaborates with One TeleMed (formerly Advance Telehealth) to provide telepsychiatry services for our enrollees and meet needs in gap areas. Enrollees can see a mental health provider from the privacy of their own home. Conditions for treatment include, but are not limited to, major depression, attention-deficit/hyperactivity disorder, and bipolar disorder.

In addition to the global strategies outlined in this section, we will employ these additional strategies to address the network gaps identified previously:

- Explore, as described previously, the expansion of CVS MinuteClinic access in rural parts of the state to address access issues and increase capacity by reducing low-acuity visits

- Leverage our current value-based payment arrangements and collaborations with large health systems to bring mobile clinics to areas of the state where there are no providers
- Expand the NEMT benefit as a value-added service to facilitate service access for enrollees in neighboring parishes when a service is not available in their community.
- Utilize RPM for select enrollees with chronic conditions such as diabetes, asthma, and high-risk pregnancies. Through RPM, we provide enrollees with an iPad and devices including glucometers, blood pressure cuffs, scales, and pulse oximeters, allowing our enrollees to communicate with their PCPs, specialists, and case managers in a near real-time manner. For example, RPM augments care provided to our enrollees with high-risk pregnancies by giving them access to non-stress test (i.e., fetal heart rate monitoring) equipment.
- Contract with Ready Responders to perform certain assessments of the enrollee in their home; this collaboration is designed to reduce ED utilization by providing in-home care management to frequent utilizers. It also works to reduce non-emergency ambulance transport by having trained emergency medical technicians stationed in the communities. This bridges the gap as it relates to transportation and other enrollee barriers.
- Contract with BehaveCare to provide care management services, home visits by physicians, and home-based interventions for both physical and behavioral health care; BehaveCare also performs in-home primary care and Early and Periodic Screening, Diagnosis and Treatment services.
- Continue to educate PCPs about the ability to utilize physician assistants and nurse practitioners to serve enrollees. The use of mid-level practitioners allows increased access and capacity to specialty care by having access to other provider types within the specialist's office.
- Pursue contracts with community organizations, such as churches and community outreach groups, through value-based payment models to help to close gaps in care and connect enrollees with services.
- Use our statewide transportation provider to roll out family transportation to reduce no-show rates, which increases service access and improves provider satisfaction
- Use event-based, community-focused clinics in rural parishes or areas with access issues for the aforementioned specialties, enabling our providers to treat enrollees' needs for dental, vision, and primary care
- Provide financial incentives to providers for the provision of after-hours care

In 2018, we paid out approximately **$400,000** in PCP-based incentives to providers in after-hour codes to increase accessibility and capacity.

Strategies to Monitor Compliance with Provider Network Standards (2.10.8.3)

Aetna actively monitors our provider network, including **all provider types**, for compliance with the provider network standards in **Attachment D to the Model Contract** to identify and mitigate network accessibility issues or provider noncompliance with policies and procedures that affect an enrollee's reasonable access to care delivery. We continually evaluate reports, including GeoAccess and network adequacy information, to determine where we need to increase the number and type of new providers to the network as well as appropriately prepare for anticipated network providers across the service area. GeoAccess reports are generated no less than monthly and they are reviewed by health plan and network leadership. Network staff will formulate a plan to close any identified gaps based on data or enrollee feedback. We use our provider data warehouse to create a suite of monitoring tools and reports to identify network gaps. The results of our monitoring efforts are reviewed by our Services Improvement Committee. The committee develops and monitors action plans to ensure identified gaps are addressed.

In the fourth quarter of 2018, our data indicated that we saw a spike in inpatient usage in Region 9 specific to the Hammond area. As a result, we identified an opportunity to contract with North Oaks Health System and physician group to address this capacity need.

- Reporting and monitoring:

  - **GeoAccess reports:** Monthly reports measure against LDH's access standard requirement for each ZIP code
  - **Network adequacy:** Review utilization data for prevalent conditions, SCAs, provider referral issues (availability of specialties), providers-gained-and-lost report, and unplanned network exits report to confirm sufficiency of the type and number of providers
  - **Operational dashboard that identifies enrollee ED utilization:** Continuous monitoring is performed using operational dashboards that measure and trend enrollee utilization including ED care. These dashboards allow us to identify opportunities to enhance our network by location, disease state, and enrollee type.
  - **Conducting network panel studies using open/closed panel report:** Assessing network access and availability needs
  - **Conducting provider directory audits:** Monthly audits confirm the accuracy of listings and make weekly updates to online directories with changes in demographics and panel status
  - **Conducting provider appointment availability (secret shopper) phone surveys:** Query providers on appointment availability, open scheduling, and after-hours care
  - **SCA data:** Analyze SCA trends to identify potential shortages of services or geographic gaps
- Enrollee feedback:
  - **Enrollee feedback:** Our call center monitors trend reports that are shared weekly with the Operations team to determine any network gaps or barriers.
  - **Grievances**: We review analysis and trending of enrollee grievances to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, if necessary. We receive committee findings and survey results on access, appointment availability and wait times, non-participating prior authorizations, and out-of-network requests.
  - **Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey**: We create action plans for opportunities presented in the CAHPS results.
- Provider outreach and support:
  - **Interdisciplinary team collaboration:** Identify any access or capacity concerns and addressing special needs
  - **Reviewing PCP-to-enrollee status:** Review ratios by provider type and region to confirm availability of an adequate number of PCPs
  - **Reviewing providers' panel status:** Review open panel status to confirm where new enrollees can be assigned and identify providers who have reached their capacity and/or referral limits

Our strategy for monitoring provider network compliance uses a holistic approach. It is imperative that the network not only achieve adequacy, but also be usable to our enrollees in as close to real time as possible. In order to achieve usability for our enrollees, we utilize the strategies detailed in this section as well as these supplemental strategies to monitor compliance with network standards for the provider types presented in **Table 2.10.8-3**.

Table 2.10.8-3: Supplemental Strategies for Monitoring Provider Compliance for Specific Provider Types

Specialty		Supplemental Strategies for Monitoring Provider Compliance
Cardiologists	←Applies to all→	Our provider integration program monitors providers' open and closed panels, and ensures that our online directory processes daily updates to maintain as up-to-date as possible to inform enrollees of access opportunities
Dermatologists		
Endocrinologists		Ongoing monitoring and reporting through surveys such as child and adult CAHPS, secret shopper calls, and when enrollees believe providers may not be compliant in appointment availability or Americans with Disabilities Act (ADA) standards
Licensed mental health specialists (pediatric and adult)		

Specialty		Supplemental Strategies for Monitoring Provider Compliance
Neurologists (pediatric and adult)		Continual analysis of provider survey results to head off any potential issues
OB/GYNs (adult)		
Orthopedists (pediatric)		Direct enrollee feedback given to health plan staff through Enrollee Services, Care Management, Grievance and Appeals, and community outreach workers
Primary care providers (pediatric and adult)		
Psychiatrists (pediatric and adult)		Pharmacy reporting that measures spike in prescriptions written of a certain type in a geographical area that may signal an increase in enrollee need. Measuring the need may trigger the addition of specialty providers to increase accessibility.
Pulmonologists (pediatric and adult)		

Our goal is to maintain a comprehensive network of facilities, clinics, physicians, and related support providers that demonstrate a pattern of practice that understands the varied health care needs of our Medicaid enrollees. A key network initiative is to configure our network of providers such that providers are in close proximity to where our enrollees live, work, and play. We engage with community resources and stakeholder groups to identify and respond to our enrollees' needs. If we determine a need to increase the provider network or emphasize certain provider specialties in a specific area, we proactively conduct contracting outreach to providers to mitigate a potential for network gaps or noncompliance with access and wait-time standards disrupting an enrollee's access to appropriate and timely health care services. In addition to offering standard provider contract efforts, we consider targeted rate increases or explore value-based arrangements to compensate providers fairly for quality outcomes. This is evidenced by the fact that 51 percent of our current payments are value-based arrangements.

Supporting Enrollees and Providers in Scheduling Appointments

Aetna uses our integrated system of care model to support enrollees and providers with improving the outcome of their health. In instances where enrollees are not able to make appointments with the appropriate provider, Aetna case managers and Enrollee Services representatives will step in, facilitate the request, and even make the appointment if necessary. In addition, if a provider is attempting to assist an enrollee with getting an appointment with another provider, Provider Services staff will assist in obtaining the appointment so that the enrollee can receive the care they need in a timely manner. We continuously explore new technology. An emerging technology Aetna is evaluating is the use of a chatbot. The chatbot will interpret the online chat request and assist with identifying a provider and obtaining the appointment.

Because of our intensive monitoring and outreach activities with providers to ensure compliance, we actively support our PCPs in the scheduling of appointments for cardiologists, dermatologists, endocrinologists, licensed mental health specialists, neurologists, OB/GYNs, orthopedists, psychiatrists, and pulmonologists. We also recognize that providers benefit from additional support, which includes call center support to identify and contact specialists accepting new enrollees, scheduling appointments, locally embedded provider services support, care management outreach, and field-based community health workers.

Strategies for Recruitment and Retention (2.10.8.4)

Our goal and strategy are to build a comprehensive region-specific, experienced, and high-quality network that offers provider selection, preserves existing community referral patterns, and ensures access to care for the underserved. When possible, Aetna is committed to using local providers; however, when local providers are not available, we will draw on our national expertise to deploy innovative alternative models as we did with telemedicine services. We will continue to use our comprehensive contracting methodology, VBP programs, technology/telehealth services, and an ongoing level of engagement and

diligence to continuously recruit providers and scale our provider network to meet the needs of our Louisianan enrollees. We also employ enhanced recruiting and retention methods based on our level of engagement with providers. **Figure 2.10.8-1** depicts our recruitment and retention strategies by provider type.

Aetna's Provider Services team is crucial in identifying needs to expand the network to increase timely availability for enrollees across all provider types. Upon notification of a provider need, we immediately initiate recruitment efforts. These notifications may be received from a variety of sources, such as referrals from the integrated care team/medical management or other community agencies. Once notified, the Network team conducts outreach to providers in that area or specialty.

Our strategy is to build the most effective, experienced, and highest-quality network that offers provider selection and meets the needs of enrollees, as evidenced by the current network in the regions where we currently operate. For example, in Region 4, even though Aetna has no gaps in our PCP network, we observed there was an opportunity to improve the usability of our network. We collaborated with St. Martin Hospital in Breaux Bridge to create a nurse practitioner clinic focused on Medicaid enrollees, and expanded services into this region's school-based clinics. We were able to provide enhanced fee-for-service reimbursement as well as shared savings opportunities through a customized value-based agreement to expand access for our enrollees and improve the usability of our network. This arrangement also had a positive impact on the use of ED services. In Independence (Region 9), we entered into a contract with Lallie Kemp Regional Medical Center to fill a network gap for acute care hospital services, and multi-specialty physicians.

Our model of provider engagement is designed in support of the philosophy that developing long-term relationships built on mutual trust improves provider retention. Aetna continually looks for innovative strategies to engage, satisfy, incentivize, and retain providers. We use performance improvement projects, educational initiatives, community forums, and pilot projects to help providers improve their practices, create better health outcomes for enrollees, and reduce administrative costs and burdens. Examples of strategies to retain providers include the following:

- Simplified contracting using streamlined agreements that are fully compliant with State requirements, and the ability to sign an electronic agreement using Adobe e-signature, making it convenient for a provider to return and sign their document within hours.
- Face-to-face engagement activities including one-on-one meetings with our Provider Services staff to help them understand their managed care contract, Aetna's policies and procedures, how to file claims, and receive electronic payments
- No requirement to submit paper or electronic referrals for services
- A dedicated Provider Services call center
- Technical assistance and training related to Medicaid managed care claims submissions and the technical interfaces providers will have with Aetna
- Online tools through the provider portal that make it easier for providers to interface with Aetna
- A committee structure that welcomes provider participation and feedback; examples of these committees include the following:
  - The **Provider Advisory Committee,** which will be comprised of enrollees and providers; they will meet **quarterly** to provide feedback. The committee provides expert council to the plan to improve access, provider satisfaction, and assistance with connecting with specialty providers. The committee is also responsible for reviewing satisfaction survey results and providing feedback and input on policies and programs. These findings are submitted to the QMOC for further review and integration into our existing programs/policies. Our Network team uses this information to identify potential areas of provider shortages.
  - **Hospital Advisory Committee,** which will consist of providers in the Aetna network that represent medical and behavioral health hospitals, clinics, health centers, and key advocacy

groups. The committee conducts **monthly** meetings to provide feedback on new quality improvement initiatives, provide invaluable insight into local population health concerns, and identify and assist Aetna in strategic planning, addressing issues and concerns, assessing plan initiatives and identifying needed areas of correction and improvements in operations.

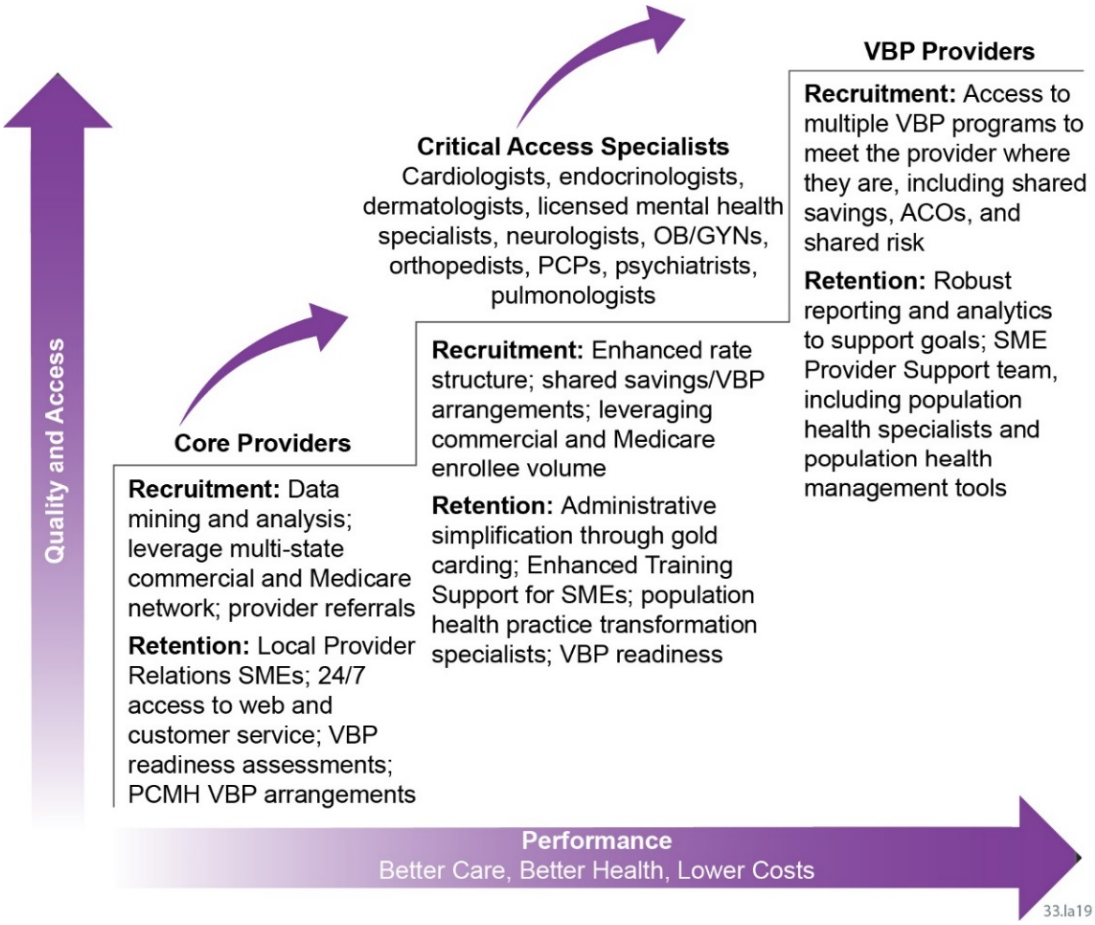

Figure 2.10.8-1: Recruitment and Retention Strategies by Provider Type

Aetna's provider recruitment and retention strategies are customized based on provider type.

Our **Provider Support** and **Value-Based Payment** activities, as further described in **Sections 2.10.9 and 2.10.12**, respectively, also support provider retention.

Quality and Performance Metrics to Determine Provider Success

Aetna remains committed to continuous quality improvement to fulfill LDH's Triple Aim of better health, better care, and improved cost. We monitor provider performance on an ongoing basis to make certain providers meet the required standards.

Many high-quality providers find value-based arrangements an attractive means through which to join a network. Through Aetna's value-based payment arrangements, we can incentivize cost, utilization, and quality improvement through a reduction in potentially preventable events (primary, specialty, and hospital-based) such as hospital readmissions, avoidable ED visits, avoidable inpatient visits, and preventable complications. Using quality and performance measures in the VBP contracts helps us to determine the provider's success, and together we make continuous progress toward LDH's goals for enrollee access to quality care.

As part of our recruitment and retention strategy, Aetna offers providers a variety of alternative payment arrangements through our Aetna Better Value program. To date, Aetna has entered into an alternative payment arrangement with several providers such as Willis-Knighton Physician Network in the northern area of the state, FMOLHS in central Louisiana, and Ochsner-LSU HSC Physician Group in New Orleans, to name a few. Our programs are customizable, allowing us to combine the most applicable components for a particular provider into a comprehensive and effective, innovative alternative payment model.

Other approaches we use include the following:

- Meeting with stakeholder focus groups to understand the availability and adequacy of care and perceived gaps in services: We provide flexibility and choice through our community-based provider collaborations, resulting in optimal, compassionate care to enrollees. Our health plan leadership will meet at least **quarterly** with enrollees, families, and providers in each region, which will enable us to identify unique needs and challenges.
- Providing trauma-informed care (TIC) training: Aetna Inc. has collaborated with the National Council on Behavioral Health to assess the impact of trauma on enrollees. Aetna has trained all staff on trauma-informed principles, motivational interviewing, and the impact of trauma, and is working with the provider network in a yearlong collaborative to assess and develop standards for trauma-informed care for enrollees.
- Identifying non-participating providers to improve accessibility: Our Provider Services team analyzes our commercial network to identify high-performing providers in addition to providers in existing groups that do not currently serve Medicaid enrollees. We actively recruit these identified providers to join our provider network.
- Using the integrated care model: Aetna uses a whole-person integrated care approach to solve for the fragmented physical and behavioral health and community support systems that, when coordinated for enrollees, leads to better health outcomes.

Strategies to Meet Enrollee Multilingual, Multicultural, and Disability Needs (2.10.8.5)

Cultural competency and health literacy are at the core of our service delivery. Aetna's health care equity director prepares a detailed Cultural Competency Plan (CCP) annually to ensure engagement of all health plan leaders and alignment with Culturally and Linguistically Appropriate Services (CLAS) standards and to ensure compliance. The CCP outlines the processes used to develop and maintain a culturally competent staff and provider network. This comprehensive plan includes strategies designed to assist our staff, providers, and subcontractors with integrating cultural and linguistic competence and health literacy into every aspect of our organization. Our CCP focuses on effective and equitable care and services by respecting and honoring each enrollee's cultural health beliefs, practices, preferred language, special needs, and socioeconomic background. Cultural competency is part of the fabric of our organization, and it should infuse every aspect of enrollee interaction and local, community-based care delivery.

To deliver quality health care services, it is necessary to understand the needs of our enrollees, particularly their cultural and linguistic needs. This understanding enables us to provide, through our provider partners, culturally competent services and to assess where disparities in health care outcomes exist. All our contracted providers, including behavioral health, receive cultural competency training at orientation and on an ongoing basis, including the following:

- Cultural competency and impacts on health care
- Provider obligations for delivering culturally competent care
- Tools and resources such as Aunt Bertha, an online repository of community services
- Social determinants of health and trauma-informed care

- Training staff on the need to understand and respect cultural differences and develop services that better meet the needs of minority populations and remove barriers to care
- Assisting enrollees with limited English proficiency
- Providing access to interpretive and American Sign Language services for Aetna enrollees
- Assessing feedback from enrollees about programs, quality initiatives, enrollee materials, and other education and outreach tools to meet their cultural and linguistic needs

We realize that a critical element to providing quality service involves developing and maintaining culturally appropriate services that address diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs including the enrollee prevalent language(s) and sign language interpreters. Aetna utilizes the U.S. Department of Health and Human Services (DHHS) Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care and follows DHHS' *A Blueprint for Advancing and Sustaining CLAS Policy and Practice* to inform the annual revision of our policies.

Our most frequently utilized interpreter and translation services are for Spanish and Vietnamese. Aetna currently has two certified Spanish-speaking Enrollee Services staff to assist our Spanish-speaking enrollees. We arrange for providers and enrollees to access our translation line services when needed, as well as connecting enrollees to translation services through local organizations such as CrescentCare. Aetna offers a choice of providers for enrollees who can communicate in their preferred language. **Table 2.10.8-4** details the prevalent languages spoken by Aetna's enrollees with corresponding contracted provider counts.

Table 2.10.8-4: Prevalent Spoken languages of Aetna's Enrollees and Contracted Providers by Region

Region	English		Spanish		Vietnamese	
	Enrollees	Providers	Enrollees	Providers	Enrollees	Providers
Region 1	28,667	7,987	749	263	174	53
Region 2	14,013	4,393	169	86	44	14
Region 3	8,645	1,499	94	29	12	2
Region 4	14,375	2,660	105	46	48	8
Region 5	4,374	1,441	27	22	4	4
Region 6	7,186	1,497	36	18	8	1
Region 7	15,881	3,570	74	58	6	10
Region 8	8,203	1,870	17	27	3	3
Region 9	12,763	3,048	93	63	23	6

The largest ethnic groups in Aetna's current membership are white (non-Hispanic) and African American, followed by the Hispanic and Vietnamese populations. The Hispanic and Vietnamese populations contribute to the fabric that makes Louisiana unique, and bring their own values, beliefs, and perceptions, which must be considered when providing quality care. **Table 2.10.8-5** details the cultural traits of the Hispanic and Vietnamese populations that may affect the delivery of health care.

Table 2.10.8-5: Cultural Nuances Affecting Health Care

Population	Cultural Traits
	Community- and Family-oriented
Hispanic/Latino	• Hispanic/Latino cultures have a strong sense of obligation and loyalty to their family, extended family, and their community • Hispanics/Latinos rely on family members for advice and encouragement

Population	Cultural Traits
Vietnamese	• Vietnamese culture emphasizes community; as they often live in tight-knit groups, they are supportive of one another • Family plays an essential role for Vietnamese and is highly revered • Among the Vietnamese, family is not conclusive of the nuclear family, and is inclusive of extended relations such as daughters-in-laws and grandchildren
	Faith and Religion
Hispanic/Latino	• For Hispanic/Latino populations, faith and church are fundamental to family and community life, and provide a source of strength and hope • Faith and church are influential in providing hope during times of illness • A majority of the Hispanic/Latino population is Catholic • Health, sickness, and day-to-day life are impacted by spiritual and religious beliefs
Vietnamese	• The majority of Vietnamese in Louisiana are Catholic and Buddhist; includes some Baptists • Religion plays a significant role in uniting their communities and keeping their culture thriving
	Respect and Authority
Hispanic/Latino	• Hispanic/Latino populations tend to emphasize respecting authority. For many Hispanic/Latino populations, it is the norm for the father or the eldest family member to hold authority. The Hispanic/Latino population may also extend respect for other authority figures such as doctors.
Vietnamese	• Respect is an integral part of the Vietnamese as it is the basis of Confucius' teaching, which is strongly followed. It is expected that one show respect for parents and family members at home, and for seniors, teachers, and those with authority when outside of the home environment.
	Fatalism/*Personalismo*
Hispanic/Latino	• This population has a belief that one cannot alter their fate and outside forces impact life events, such as illness or disease • Hispanics/Latinos have the expectation that they will cultivate a personal relationship with their health care provider, which is referred to as *personalismo*
	Health
Hispanic/Latino	• Hispanics/Latinos may use a combination of folk (traditional healing practices) and Western medicine
Vietnamese	• Vietnamese may use a combination of folk (traditional healing practices) and Western medicine

For example, for **Hispanic enrollees**[1], we understand that health is a family affair and any health decisions are made as a family. Caregivers and family members are strong influencers along the health journey and take part in key decisions. Family responsibilities are a priority over health, and juggling responsibilities can get in the way of enrollees taking care of their own well-being. Health care providers (HCPs) are often viewed as authoritative and respected figures for Hispanics who highly respect their HCP and expect a formal yet warm and personal relationship with them. For **Vietnamese enrollees**[2], we understand that family is essential to this population and is highly revered. Family is inclusive of extended relations such as daughters-in-laws and grandchildren, and not just parents and their immediate children. In Vietnamese families, wives often make health care decisions for the family, and the common good of the family is considered when making decisions. Illness or sickness may be treated with traditional and Western medicine, and HCPs should be aware of sometimes incorporating traditional methods with Western methods, which may affect adherence to treatment.

[1] Brethenoux, Caroline, and Furey, Patrick, "Attitudes towards Health & Wellness from the Voice of Hispanics and African Americans in the U.S.," *CulturIntel*, January 2018: accessed February 1, 2018.
[2] U.S. DHHS Centers for Disease Control and Prevention, "Promoting Cultural Sensitivity ": https://www.cdc.gov/tb/publications/guidestoolkits/ethnographicguides/vietnam.pdf, 2008: accessed April 11, 2018.

Meeting Enrollee Linguistic and Cultural Needs

Our network will deliver care in a culturally competent manner based on the prevalence of languages (including American Sign Language) and conditions within ethnic groups. Many of our providers offer multilingual or bilingual staff to meet our enrollee needs as evidenced in the previous **Table 2.10.8-5.** We have developed relationships with key providers and organizations to provide services and support to our diverse membership. For example:

- We have a strong relationship with the Chitimacha Tribe and we are contracted with the RHC in Houma.
- We have a sound rapport with La Leche League, which has Hispanic-focused peer specialists that work directly with the Hispanic populations in all nine regions. We invite them to all maternal health events.
- We work directly with Vietnamese Initiatives in Economic Training (VIET) in their Head Start program, Keep Kids Active, and Family First Program. The Michoud area of New Orleans is a primarily Vietnamese community. We regularly host family days and health and wellness events, and directly work with providers in this area to meet with enrollees in their community.
- We cohost quarterly health and wellness fairs for the Jena Band of Choctaw Indians, bringing education resources and materials to tribal members on how to maintain a healthy and active lifestyle. We have invited yoga and Zumba instructors to teach lessons as well as provided healthy and nutritious lunches to tribal members.

To monitor and evaluate that our network is meeting cultural and linguistic needs, we obtain stakeholder feedback on network composition, operations, and quality improvement initiatives. We evaluate current population demographics and consider projected population demographic needs, anticipating cultural and health disparities as an integral part of our annual network monitoring plan and QMOC meeting process. Standards for competency, expertise, and cultural sensitivity are communicated through the provider manual, newsletters, during site visits, and in training documents. Aetna's provider directories indicate the provider's cultural and linguistic capabilities including languages spoken by provider or skilled medical interpreters at the practitioner's office, such as staff that speak in Spanish or American Sign Language, as well as gender, board certification, and accessibility for persons with disabilities. In addition, the provider directories identify whether the provider has completed cultural competency training.

Meeting Enrollee Disability Needs (Access, Accommodations, Equipment)

Aetna employs several methods to determine a provider's compliance with ADA standards for physical accessibility and reasonable accommodations including parking, exam and waiting rooms, and accessible equipment for Medicaid enrollees with physical or mental disabilities. We emphasize interest in identifying providers with key accessibility to care opportunities such as providing oversize exam tables, specialized staff assistance for enrollees with needed care requirements, or materials in braille to serve the varied health care needs of our enrollees. Through our national durable medical equipment (DME) contracts, we provide same-day or next-day delivery statewide for DME. We also contract with Hanger Prosthetics and Orthotics, Numotion, and Still Me to meet enrollees' disability needs.

Aetna assesses a provider's capability during onsite visits, through credentialing and re-credentialing processes, monitoring enrollee complaints, and gathering information used in our provider directory, such as physical accessibility and accommodations. These indicators are available across all provider types, including behavioral health, long-term care, home health, nursing care, and home- and community-based providers to help make sure the enrollee selects the right provider for the right service and in the right setting. We have a process in place where all potential findings related to patient quality of care are reported, investigated, and when necessary, corrective action plans and enforcements are put in place to address the concern.

Protocol for Terminating Network Providers for No Cause (2.10.8.6)

Aetna makes every effort to ensure that our relationships are strong enough with our providers to resolve issues as they may arise. We take every step to resolve deficiencies, complaints, grievances, and any other concerns to ensure that our enrollees have a solid and comprehensive network to rely upon. It is our practice to terminate

provider contracts for cause when we identify safety or significant quality concerns, or noncompliance with credentialing requirements. It is not our practice to terminate provider contracts arbitrarily for no cause. To date, Aetna has zero terminations for no cause. If Aetna desires to terminate a provider located in a health professional shortage area for no cause, we seek written approval from LDH prior to terminating the provider.

Even though we make every effort to avoid it, Aetna maintains policies and procedures regarding the termination of providers and provides delegated oversight of all network activities. Our process includes quickly identifying and reporting changes in the provider network to LDH prior to termination, including our plan to notify enrollees of the termination, our strategy to ensure timely access for enrollees, and our plan for ensuring there is no stoppage or interruption of services to enrollees. Additionally, Aetna will send LDH a file that identifies the enrollees affected by any termination and notify LDH's provider management contractor by close of business the next business day of a network provider's termination.

We monitor the provider network to confirm compliance with the previously stated requirements. The written notice to the provider includes the reason for Aetna's decision; the effective date of termination; the provider's right to appeal the decision; and how to request an appeal. The focus of our processes, monitoring, reporting, and communication is to make certain covered and medically imperative services are available to enrollees.

Notifying Enrollees of Provider Terminations to Minimize Negative Impact

Aetna's processes and policies make certain enrollees are notified in a timely manner and the enrollee has continued access to covered services in the event a provider is terminated. Our Provider Services team coordinates with Enrollee Services staff to start the process of enrollee notifications and maintain continual care for enrollees impacted by the termination of a provider. Aetna provides written notice to enrollees within 15 calendar days from the date a termination notice is sent to the PCP, or from the date Aetna receives notice from the PCP of non-participation in the network, and no less than 60 calendar days before the effective date of the termination to each enrollee who received their primary care from, or was seen on a regular basis by, the terminated provider within the past two years. We use similar care when terminating a specialist from our provider network by analyzing claims data to identify potential impacted enrollees.

Aetna allows an enrollee to continue an ongoing course of treatment with the provider/practitioner for up to 90 calendar days from the date of our enrollee Notification Provider Termination letter. Aetna's definition of 'ongoing course' is defined as an enrollee receiving treatment from a practitioner during the previous 12 months for a condition that requires follow-up care or additional treatment, or the services have been prior authorized, such as in the case of an enrollee who is pregnant and in her second or third trimester. Maternity services can continue with the provider/practitioner who is being terminated through the completion of the enrollee's postpartum care. Enrollee choice, including the ability to select a PCP, is our principal goal, especially when transitioning care. When a provider is terminated, enrollees receive information and assistance to make a PCP change. Aetna's Enrollee Services staff and Care Management team are available to assist enrollees in selecting a new PCP.

We will align any termination for no cause with the annual open enrollment period. If an enrollee is receiving an active course of treatment or care at the time, we terminate a provider's participation in the network, we arrange for the continuity of care through the current active treatment period with the same provider as long as there is not a quality of care or licensure issue, regardless of the provider's network status. The extension will continue until care has been fully transferred to a treating provider who has agreed to assume responsibility for the enrollee's care for the remainder of that episode and subsequent follow-up care. We realize the importance of communicating with enrollees quickly and with the appropriate supporting steps to facilitate continual care for those impacted by a provider termination; therefore, our timely and effective communication is critical.

2.10.9 Provider Support

Twenty-nine percent of Louisiana residents live in communities designated by the United States Department of Agriculture as having low access to grocery stores. Aetna provides resources for communities to use sustainable practices, grow healthy foods, provide education for healthy lifestyles, and empower communities. Aetna regularly participates in helping neighborhoods curate food hubs to address the barriers for accessing nutritious foods.

2.10.9 Provider Support

With a lasting presence and commitment to Louisiana, Aetna Better Health of Louisiana (Aetna) has been actively engaged with the provider community since 2015, currently holding contracts with over 23,000 providers. We have developed strategic relationships with providers, community agencies, and LDH partners in all nine regions of the state, serving Medicaid enrollees through our provider services model and bidirectional communication philosophy. Aetna currently serves over 120,000 Medicaid enrollees throughout the state, and we will continue to provide enrollees with services and solutions to improve their health. We will acknowledge, understand, and will comply with the requirements detailed in **Section 2.10 Provider Services and Support of the Model Contract.** For ease of reading this section, we use the term 'provider services' to refer to provider relations, field agents, and representatives, as referenced by the RFP.

Process for Determining Adequate Provider Services Staffing (2.10.9.1.1)

Aetna remains committed to providing locally directed Provider Services staff and health plan subject matter experts. This approach reflects the local, regional, and culturally diverse communities throughout Louisiana parishes. Aetna bases our Provider Services staffing and geographic placement by assessing the utilization of covered services, evaluating claims submitted by providers, identifying how providers serve enrollees, and finally, assessing claims denial rates and the reason for denials and subsequent claim appeals. We conduct our dynamic evaluation process frequently—no less than monthly—which allows us to reallocate and shift staffing resources as needed to support the provider network. We stratify providers by the complexity of their reimbursement model and enrollee case mix. For example, our value-based payment (VBP) providers may require more intensive support to achieve contractual goals than some of our fee-for-service practitioners do. We enhanced our staffing approach to allow for closer collaboration with VBP providers as our team guides them in achieving higher quality outcomes and, as necessary, we adjust our staffing accordingly. This continuous evaluation is keenly emphasized with our behavioral health providers who deliver specialized services that require dedicated Provider Services staff with relevant knowledge and experience. **Aetna's approach to determining appropriate staffing levels for provider education, outreach, and resolution support is flexible and will change based on the special health care needs of the enrollees served, geography, and the number and type of contracted providers needed to serve our enrollees.**

Strategies for Communicating Effectively with Our Providers (2.10.9.1.2)

Aetna values and promotes effective and timely two-way communication between our plan and our provider partners. Through this ongoing communication, we provide assistance, guidance, and expertise to develop and retain long-term relationships with providers. We understand that providers are our most valuable asset. Our emphasis is to empower each of them through education, assistance, and providing the resources needed to achieve quality enrollee engagement.

Aetna employs the following strategies, as also depicted in **Figure 2.10.9-1**, to communicate effectively with our providers starting from broad network-based to more specialized and customized communication:

- Face-to-face provider visits to provide education and technical assistance

Figure 2.10.9-1: Aetna Provider Communication Strategies

Aetna uses a wraparound philosophy with multiple strategies to communicate with our providers.

- Electronic communications including targeted emails, text messaging, fax, push notifications from the Aetna website, and soon, an Aetna provider mobile application. These communications are disseminated by provider type and specialty, as appropriate, and used to communicate updated information, policy changes, or other Aetna/LDH information.
- Regularly scheduled webinars and pre-recorded videos that are accessible to providers at all times through our website
- Local onsite trainings that soon will offer continuing education credits for behavioral health specialties led by licensed behavioral health professionals; these operational and clinical trainings will reflect topics that are derived from data analyses and provider feedback
- For our key provider groups, such as VBP providers, hospitals, federally qualified health centers/rural health clinics, and multispecialty groups, we conduct Joint Operating Committee meetings no less than monthly to allow for bidirectional communication and training on topics affecting both providers and Aetna in areas such as quality, care management, social determinants of health identification, and plan operations

Our 2019 YTD provider **post-call survey satisfaction rate is 94.7%.** Additionally, **9 out of 10 provider calls are resolved** at first contact.

A key component facilitating bidirectional communication is our Provider Services line, which operates as a seamless entity via knowledgeable and skilled staff trained on LDH requirements and health plan policies and procedures. Provider Services staff are empowered and equipped to manage inquiries and all concerns about the Aetna program, and strive for first-call resolution; however, if unable to resolve in the first call, our Provider Services team will research and establish a timeline for resolution within two business days. Inquiries are received by phone, fax, written correspondence, in person, or through other electronic means. Our Provider Services line is a toll-free telephone line available from 7 a.m. to 7 p.m. Central time, Monday through Friday. Non-routine prior authorization requests can be accessed 24/7/365 through our Enrollee Services line or our provider portal. Our Enrollee Services line will handle after-hours inquiries from providers seeking to verify enrollment for an enrollee in need of urgent or emergency services. Emergent provider issues can also be handled 24/7/365 through our rotating schedule of on-call local Provider Services liaisons. We administer an automated survey evaluating provider satisfaction and willingness to recommend Aetna to others. Callers complete this survey at the end of a call using their telephone keypad, or they can select the option to leave a voicemail.

Provider Training and Education Program

Our training and orientation program is designed to support our providers to meet LDH's Triple Aim of better health, better care, and lower costs while giving providers a comprehensive understanding of Aetna and LDH requirements to assist them in meeting enrollee needs. Our training program also provides the information and tools our provider partners need to serve our enrollees appropriately. We understand that many enrollees have special health care needs due to limited English proficiency, language, cultural and social barriers, as well as behavioral health, medical, and physical limitations that directly affect their receiving the appropriate health care service; therefore, specialized training that emphasizes enrollee accommodations to access care is our critical priority.

Our provider education program starts with a customized orientation program, which occurs within 30 days of the provider's effective date with the plan and includes ongoing training to communicate changes to our system and processes. On an ongoing basis, providers are presented a scorecard, which provides an operational snapshot of the provider's performance. This scorecard addresses performance metrics such as paid and pended claims, appeals by reason, and Healthcare Effectiveness Data and Information Set (HEDIS) quality measures including emergency department (ED) utilization. This feedback on performance improves care delivery as well as identifies opportunities for future training and technical assistance. Additional detail regarding our training program can be found later in this section.

Processes to Support Providers with High Claims Denial Rates (2.10.9.1.3)

Aetna's denial management program utilizes a focused strategy that proactively identifies, manages, monitors, and prevents inappropriate claims denials. We understand that denied claims represent unpaid services and delayed revenue to our providers. Aetna vigorously reviews claims denial metrics on timeliness, accuracy in claims processing with emphasis in areas such as missing information, duplicate claims for service, service already adjudicated, services not covered, and limits for timely filing. We analyze reports on these metrics and utilize operational dashboards to identify the providers who are likely to remit incomplete claims or experience high denial trends. These include specialty physician providers, home health providers, skilled nursing facilities, behavioral health providers, and specialty durable medical services and supplies. The denial management program prioritizes field-tested training, and best-practice tools and resources for our providers to assist in recognizing opportunities to understand and correct issues that cause claims to be denied. Through direct provider outreach, routine onsite servicing, educational webinars, and joint operating meetings, we ensure both understanding and adherence to LDH and Aetna policies that help practices effectively manage their claims with Aetna. For example, in 2018, we received extremely high claims denials from providers statewide who did not understand our policy requiring prior authorizations for all obstetrics ultrasounds. We collaborated with Woman's Hospital in Baton Rouge, which had difficulty meeting the requirement, to modify our policy. The policy modification helped reduce administrative burden for both the provider and Aetna while also creating process efficiencies. Our system was reconfigured and all impacted claims were reprocessed timely without the provider having to resubmit.

Evaluating and Resolving Provider Disputes in a Timely Manner (2.10.9.1.4)

Aetna classifies any expression of dissatisfaction as a grievance, and issues related to claim payments or denials as an appeal. Contracted and non-contracted health care providers may file appeals related to claim payments, denials, or grievances related to dissatisfaction with any of our staff, vendors, or enrollees. A dispute between a provider and Aetna does not disrupt or interfere with the provision of services to the enrollee.

All cases are documented in our grievances and appeals application, including those received through LDH. Each case is automatically assigned a tracking number/unique identifier that links together all components of the case. This tracking number is used to identify individual cases for processing and to monitor each case throughout the process. All information pertaining to provider grievances and appeals is maintained in accordance with State and Health Insurance Portability and Accountability Act requirements to protect enrollee privacy. We further maintain a policy that requires no punitive action occurs against providers filing a grievance or an appeal. Providers may file a grievance either verbally or in writing directly with Aetna at any time about our policies, procedures, or any aspect of our administrative functions. Providers must request an appeal in writing within 60 calendar days from the notice of action. Determinations are made within 30 calendar days of receipt.

We track, analyze, and define trends in our provider grievances and appeals to identify opportunities to educate providers and enhance our processes. We never delegate grievances or appeals processing to a subcontractor. Aetna retains responsibility for all grievance and appeal processing, investigations, and case resolutions/decisions. All provider grievances and appeals reviews are conducted in accordance with our policies and processes, which comply with LDH requirements.

Disputes Specific to Automatic Assignment Policy

Aetna is committed to collaborating with providers to ensure appropriate access for enrollees to primary care services and improving enrollee assignment that ensures costs are aligned with the appropriate provider. This is especially critical for providers aligned to a VBP contract as it affects shared savings and quality targets when enrollees are not attributed correctly. A provider can request or dispute an enrollee

assignment at any time. Aetna will conduct claims analysis within 30 days to determine if assignment was correct based on claims history. If a provider chooses to dispute any enrollee assignments, they can contact their assigned Provider Services liaison to initiate the dispute. To dispute successfully any reassignment to another provider, the provider must show documentation such as medical record or proof of billed claim for at least one date of service that the provider has seen the enrollee(s) within the claims analysis 12- to 18-month lookback period. A primary care provider (PCP) may request that an enrollee be reassigned to another provider based on either claims analysis or one of LDH's identified specific criteria. Providers have 15 business days to review changes made to their roster prior to any modification.

Improving Quality and Reducing Costs (2.10.9.2)

Eighty-five percent of our contracted PCPs serve seventy-six percent of the enrollees contracted under a value-based payment arrangement.

At Aetna, our goal is investing in relationships with enrollees, provider partners, employees, and community stakeholders to enhance the care provided to enrollees, lowering cost, and improving overall well-being. Aetna is here to support our providers to develop and execute successful strategies to produce better outcomes for our enrollees. A multidisciplinary team—made up of the case manager and Provider Services, Population Health, Quality, and Community Health staff—integrates with provider partners to drive quality outcomes, provide education, create additional access points for our enrollees, and provide a red-carpet experience for our providers. Together, innovative solutions are applied to the existing health care model to create positive outcomes for enrollees.

The Aetna provider integration program uses both provider and enrollee data to select provider partners that can achieve the Triple Aim initiatives for our enrollees. These partners will have access to the full breadth of Aetna's resources, allowing them to focus on enrollee care and driving outcomes. The objectives of the program are to make certain of the following:

- Integrate with and support provider partners to assist them in practice transformation to achieve the Triple Aim of health care with population health, operational, and clinical team support
- Support transition from a fragmented and episodic health care delivery system to an enrollee-centered and quality-focused system
- Make significant investments in improving enrollee health by collaborating with providers to assist with the data analysis, tools, and support needed to support their management of an enrollee's care
- Supply providers with tools, such as Aetna's electronic population health management platform, that promote enrollee access, shared decision-making, proactive health management, coordinated care delivery, adherence to evidence-based guidelines, improved quality outcomes with an emphasis on closing gaps in care, improved operational performance and decreased administrative burden for providers, real-time access to subject matter experts to support practice transformation, resources that focus on care coordination, individual enrollee care planning, enrollee outreach, and focused practice attention on opportunities to lower cost of care while improving quality outcomes

Supporting Primary Care Providers to Reform the Delivery System (2.10.9.2.1)

In Louisiana, we paid over **$2 million** in provider incentive payments in 2018.

When designing fee-for-service contracts or value-based payment strategies, we collaborate with providers to understand their needs and preferences better to develop solutions that enable transformation of the care delivery system. We believe the best opportunity for PCPs to succeed in delivery system transformation is through Aetna's primary care infrastructure and practice coaching. This is achieved by implementing strategies such as the Comprehensive Primary Care Plus (CPC+) model and population health. In support of these strategies, Aetna has invested in staff resources, process, technology, and value-based payment arrangements.

CPC+ Model: A national advanced primary care medical home model that strengthens primary care through regionally based multi-payer payment reform and care delivery transformation. Through technical assistance, population health data access, and reporting support, we help providers enhance services for enrollees living with multiple chronic diseases and higher needs. We accomplish this by advancing electronic health records, assistance in adherence to HEDIS measures, and reporting and analytics as examples to improve quality and utilization meeting cost targets. We are one of only three health plans participating in this initiative serving over 1,100 enrollees through three providers—Acadiana Family Medical Associates, Crescent City Physicians, and Lafayette Health Ventures.

Population Health: Aetna views our population health strategy as a true partnership with our provider network, especially our PCPs. We know that in order to obtain the collective vision of achieving the Triple Aim, we must be locally engaged and closer to our provider network—working in close collaboration with a clinically integrated approach that supports and enhances the provider/enrollee relationship. Our population health specialists, who are licensed clinicians, facilitate practice-level transformation. They are part of our team of subject matter experts from departments across the organization who understand the dynamics and challenges of helping enrollees navigate the health care system, whether in a small community clinic setting or through a large integrated delivery system.

The CPC+ and population health programs are supported by next-generation tools such as actionable analytics (including provider performance information), paired with experienced plan leaders, population health specialists, and Quality and Medical Management staff, and dedicated value-based and network experts. We continuously seek ways to innovate, inspire, and create improved opportunities for provider partnerships and rewards for quality care. We accomplish this through our relationships with national organizations, industry developments in the private and public sectors, and State transformation efforts.

Strategies to Support Behavioral Health and Other Specialties (2.10.9.2.2)

Aetna has an integrated system of care for quality physical health and behavioral health service delivery through a fully integrated managed health plan. Aetna's rich history throughout Louisiana has informed our understanding of LDH's physical and behavioral health populations and their very specific health care needs, which is why Aetna has a dedicated behavioral health director that practices efficacy as the core of our enrollee-centered service delivery focus. We also have dedicated behavioral health provider services liaisons with experience supporting behavioral health providers. At Aetna, we never delegate this important element of care delivery. Instead, we manage our network of behavioral health providers in conjunction with enrollee care management requirements here locally.

Our tactical intent in transforming the system of care in Louisiana is through incentive agreements, direct training, technical assistance, and development of information-sharing tools such as our electronic population health management platform. Aetna is furthering the following strategies to support delivery system reform for behavioral health providers:

- Providing direct support to new providers added to the network through expansion efforts, including non-traditional providers that support integration of behavioral health and physical health
- Developing integrated health homes with dedicated coaching resources to support behavioral health and specialty providers as they integrate care delivery
- Emphasizing behavioral health clinicians as key personnel on each integration team
- Deploying interdisciplinary care teams in which clinical team members collaborate with licensed clinical social workers, pharmacy, community health workers, and peer support specialists to meet the enrollee's needs

To best serve behavioral health providers, we have implemented alternative payment models (APMs) outside the acute care arena to achieve the Triple Aim of better health, better care, and lower costs.

Because of this, we are in current contract negotiations for APMs surrounding behavioral health and other specialties for per diems and geographical capitation models.

Strategies for Sharing Provider Performance Data (2.10.9.2.3)

To achieve the mutually stated goals of the contract, the health plan and its providers must be aligned. Aetna works collaboratively with providers to identify and implement appropriate metrics that best represent the needs of the enrollees in a given region to improve health outcomes, reduce costs, and improve satisfaction. Provider Services liaisons review utilization data in real time to identify training and educational needs and work one-on-one with providers to help improve enrollee outcomes. Utilization data is also used to assist in developing provider incentive programs such as our shared savings VBP arrangements.

Provider scorecards for both the individual provider and/or group are available to providers as well as reviewed during operational and Joint Operating Committees. The multi-page scorecard gives providers actionable data around enrollment, current enrollee gaps in care, claims payments, denials, and pended claims, ED utilization, and pharmacy utilization. The scorecard also provides the total number of grievances and appeals submitted by type and outcome. We benchmark providers in ED and pharmacy against all other Aetna providers to provide a comparison of how they perform versus the total network. **Figure 2.10.9-2** presents a sample page from a provider scorecard. All providers can access gaps-in-care reporting through either the provider portal or our electronic population health management platform to integrate that data into their practice. The electronic population health platform offers complete transparency, including the cost of care.

Figure 2.10.9-2: Sample Scorecard Page

Aetna's scorecard provides actionable data to providers.

Additionally, Aetna's provider performance profile report reflects the enrollee panel and costs of clinical services or health care status for the profile measurement and/or reporting period. Aetna utilizes profiles for various programs and initiatives. The provider performance profile report is comprised of data such as HEDIS measures, inpatient admissions, emergency department utilization trends, readmission rates,

detailed utilization data, costs per enrollee, predictive modeling data, provider-level detail on specific performance measures, and innovative performance programs.

Aetna's Provider Engagement Model (2.10.9.3)

> *"There is absolutely no partnership between most of the MCOs and the providers, and it is tearing apart practices in rural communities. Aetna Better Health has been an exception to this by using a systematic approach to provider relations."*
>
> **—Alec Jeansonne**
> **CEO, Collective Healthcare Solutions**

Aetna's passion for and dedication to serving Louisiana's Medicaid population translates into authentic and meaningful provider relationships that result in our ability to make a significant and positive difference in the lives of our enrollees. An integral part of improving enrollees' health outcomes is our strong provider relationships that begin at the top of our organization and extend to every staff member. Aetna has strengthened our model for engaging, educating, and supporting providers by using a deliberate and thoughtful approach to working with provider communities. This approach uses a technological, hands-on, and collaborative strategy to help make certain all types of providers fully understand their responsibilities in a managed care environment and the requirements under the contract. Additionally, our approach includes an overview of LDH's goals, information on where to seek assistance, access to the provider portal, how to bill for services or how to seek answers regarding claims, how to request prior authorizations, criteria for Medicaid eligibility, and our integrated care management model.

Staff Roles in Provider Engagement (Provider Services) (2.10.9.3.1)

Aetna has designated region-based provider services teams comprised of subject matter experts that are available to support and collaborate with provider partners to achieve successful outcomes and reach practice goals. Integrated teams from both the provider and Aetna create operational and clinical goals through a series of workgroups, co-sponsored events, education, and mutual accountability. A Joint Operating Committee comprised of the executive teams from both Aetna and the provider hold the workgroups accountable to the contract's stated goals while working collaboratively to improve care, improve health, and lower costs. **Table 2.10.9-1** describes the positions developed to support the program. The names of these staff members and contact information are available via Aetna's provider portal.

Table 2.10.9-1: Provider Services Positions that Support Providers

Position	Role
Provider Services Liaison	Single point of contact for provider organizations; functions as integration team project manager and the liaison between Aetna and the provider
Manager, Care Management (Physical and Behavioral)	Drive clinical performance by working with the provider to ensure that all enrollees attributed to the practice/facility that have been stratified as high or rising risk have access to care management services
Provider Data Analyst	Serves as the subject matter expert in support of value-based agreements and data audits to enhance provider outcomes
Operations Analyst	Provides operations support to the integration team to ensure that each provider partner's contract is executed and loaded correctly, claims are paid accurately and timely, and any concerns a provider may express are resolved timely
Population Health Specialist	Serves as a clinical subject matter expert on quality and care management activities, including, but not limited to, review and analysis of quality metrics, HEDIS scores, all regulatory body quality requirements, performance improvement, and recommendations related to clinical practice guidelines
Housing Specialist	Serves as a subject matter expert and shall be responsible for ensuring that enrollees transitioning from facility to community are connected to appropriate housing resources

Position	Role
Network Manager	Reviews and analyzes data to ensure our network meets adequacy requirements and meets the needs of our enrollees; conducts recruitment activities to address any identified gaps; negotiates provider contracts and rates. Coordinates closely with our VBP team

Presence and Role of Local Provider Field Representatives (Provider Services) (2.10.9.3.2)

Face-to-face contact is critical to developing strong relationships with providers. Provider Services liaisons are a critical component of our provider engagement model. They visit provider offices throughout the state to review the provider scorecard, provide education, answer questions, and resolve issues and concerns. Aetna has staff in each of the 9 regions who conduct no less than 15 onsite provider visits per week. We have developed and will continue to execute an interdisciplinary provider services collaborative approach to service our provider partners across the state. We hire staff based on their experience in the local marketplace as well as solid customer service and provider experience. Our comprehensive training curriculum for Provider Services staff includes a variety of topics, including contract requirements, program requirements, claims, billing, prior authorizations, grievances and appeals, fraud, waste, and abuse, how to handle provider concerns effectively and timely, and most importantly, cultural competency. Aetna's current 19 Provider Services staff members and 4 Population Health staff '**work for the community and will be from the community**.'

Mechanisms to Track Interactions with Providers (2.10.9.3.3)

To effectively monitor, manage, and maintain a provider network, it is necessary to track, trend, and analyze data obtained through provider interactions and contacts. We use a tool that tracks all provider interactions and serves as a workflow tool to ensure timely resolution. It provides a robust reporting suite allowing us to trend visits and provider complaints by type, location, or outcome. The tool also has accountability built into the system, ensuring that plan leadership is made aware when tasks are coming due or they are past due. This data provides valuable information about clinical and administrative performance gaps and opportunities for improvement. Provider contact that occurs by phone, web portal, webinars, educational seminars, or through provider collaborations, is tracked and documented in a formal manner and reviewed at least quarterly. Data collected through our tracking methods are reviewed through our Quality Management Committee structure for identification of trends and possible process improvement opportunities.

Collecting and Analyzing Utilization Data and Provider Feedback (2.10.9.3.4)

We use an operational dashboard report that enables us to review and analyze data, including utilization data. This comprehensive reporting system allows us to monitor plan and provider performance to the contract and apply real-time interventions based on data and analysis to ensure positive outcomes. We have the ability to drill down to the provider level and identify individualized training opportunities for specific providers when we see the prevalence of certain issues. Aetna also has dedicated staff members who monitor provider payment research requests. These requests are trended and patterns are addressed proactively through system audits. Our approach is to address the root cause of an inquiry, so that we proactively address the issue for all impacted providers. This holistic approach reduces provider complaints, phone calls, and claims issues. Through our weekly health plan operations meetings, we review utilization data, claims, appeals and grievance information, and provider feedback to determine systemwide or provider-specific training needs.

Metrics to Measure Overall Network Provider Satisfaction (2.10.9.3.5)

Aetna consistently scores in the **top three health plans** in overall provider satisfaction.

Provider satisfaction is dependent on a solid partnership between the health plan and the provider, so we work to ensure we proactively address providers' concerns and needs. Aetna uses a National Committee for Quality Assurance-certified survey vendor to conduct an annual provider satisfaction survey to assess how well we meet provider expectations and needs in Louisiana. We survey PCPs and specialists, including behavioral health providers, hospitals, and providers of ancillary services through this method. The results from the survey summarize satisfaction through ratings, composites, and attribution rates, and it assists with identifying the plan strengths and opportunities for improvement. We conducted our own provider satisfaction surveys in 2016, 2017, and 2018. In 2018, LDH also conducted an annual provider satisfaction survey. Metrics from each Aetna survey are provided in **Table 2.10.9-2** found in subsection **Aetna Provider Satisfaction Survey Results** herein; however, we focus on the following composite metrics and related questions as key indicators of overall provider satisfaction:

- Overall Satisfaction
- Finance Issues
- Utilization and Quality Management
- Network/Coordination of Care
- Health Plan Call Center Staff
- Provider Relations
- Recommend to Other Physicians Practices

In addition to the annual provider satisfaction survey, we monitor provider appeals and grievances and claim denial rates for trends and problem areas. We utilize this information to develop a plan of action to identify any performance opportunities. We also conduct annual provider seminars across the state for provider education and outreach. We perform post-seminar satisfaction surveys that generate data and analysis for the Quality Management Oversight Committee to establish a plan of action to improve our future survey results. By constantly evaluating the satisfaction level of our provider community, we target and identify providers we can work with more closely to strengthen our relationships.

Approach to and Frequency of Provider Training (2.10.9.3.6)

We structure our provider education programs so that our network providers and their staff receive comprehensive, ongoing education on LDH requirements as well as our clinical, operational, and transactional processes. Our training program meets the requirements outlined in **Section 2.10.4 Provider Training Requirements of the Model Contract**. Training for our providers begins with our initial contracting conversation and continues through orientation and, on an ongoing basis, through regularly scheduled site visits from our Provider Services liaisons and the Provider Integration team. Training materials are online, available upon request, and can be downloaded from either our secure web portal or main website. Aetna is also in the process of becoming a continuing education unit (CEU) provider to offer credits. We will offer CEU training videos to providers.

Orientation Training: Aetna conducts orientation and training for newly contracted providers within 30 days of their effective date with the plan. We are flexible and we will work to accommodate the availability of the provider within LDH requirements. Training includes, but is not limited to, the following topics:

- Contract requirements, along with any amendments
- Release of information forms
- Integrated care, including, but not limited to, appropriate utilization of basic behavioral health screens in the primary care setting and basic physical health screenings for the behavioral health special needs of the enrollees the provider serves

- Social determinants of health, such as poverty, trauma, and hunger
- Service coverage guidelines
- Prior authorization requirements
- Claims submission and processing (including payment timeframes and requirements)
- Dispute resolution process and timeframes; grievance and appeals process and timeframes
- How to access information through our website or provider portal
- Fraud, waste, and abuse
- Cultural competency
- Locally specific issues or concerns to assist providers in meeting enrollee needs
- Other items required under the contract's scope of services

During orientation, each provider is shown how to access the online provider manual that includes, but is not limited to, the following information:

- A description of Medicaid and the Louisiana Statewide Medicaid Managed Care program requirements
- How to obtain service-specific coverage requirements and medical necessity criteria
- How to obtain prior authorization and referral procedures, including the required forms
- Quality program requirements
- Claims submission protocols and standards and all information required to submit a clean claim
- Marketing activity requirements and prohibitions
- Provider complaint procedures, including how to contact the plan to file a complaint
- How to identify and report abuse, neglect, and exploitation of enrollees, including identifying victims of human trafficking
- Enrollee rights and responsibilities
- Enrollee grievance process and the right to request continuation of benefits while utilizing the grievance and appeal system

Ongoing Training: We recognize that the provider community is critical to our success, so we make provider engagement and collaboration a cornerstone of our processes. Depending upon the size of the provider practice and enrollee volume, our Provider Services liaisons meet with providers in their offices for regularly scheduled visits to answer questions, mitigate issues or problems, and educate providers. These visits are typically annually, but more often as requested by the provider or indicated based on provider performance. In addition to onsite visits, we offer technology-based solutions such as webinars, provider notices, and online tutorials in addition to phone contact with the Provider Services liaison. We conduct regional provider education forums to discuss recently issued amendments, regulations, or emergency notifications. We conduct ongoing training throughout the year on changes to our system and processes, such as recent enhancements. We publicize all trainings and educational opportunities through marketing materials, on our provider web portal, and through fax blast communications. For large provider groups and organizations, Provider Services liaisons conduct monthly or quarterly Joint Operating Committee meetings onsite to address any concerns, discuss quality metrics, and review new initiatives.

Provider Satisfaction (2.10.9.4)

As discussed previously, Aetna uses provider satisfaction surveys to monitor provider satisfaction levels. We conducted our own provider satisfaction surveys in 2016, 2017, and 2018. In 2018, LDH also conducted an annual provider satisfaction survey.

Aetna Provider Satisfaction Survey Results

Results of the Aetna surveys are provided in **Table 2.10.9-2: 2016, 2017, and 2018 Provider Satisfaction Survey Summary**. The surveys are designed to measure provider satisfaction related to call

center/medical services, provider services, utilization management, quality management, overall satisfaction, and loyalty among other data. Results of the survey are presented by summary rates and the composite scores are calculated by taking the average summary rates of the attributes specified in the section.

Table 2.10.9-2: Aetna 2016, 2017, and 2018 Provider Satisfaction Survey Summary

Composites and Key Questions	2018 Summary Rate	2017 Summary Rate	2016 Summary Rate	2017 SPH Analytics Medicaid Book of Business Benchmark
Overall Satisfaction	**68.4%**	**75.4%**	**66.4%**	**68.1%**
7A. Would you recommend Aetna Better Health of Louisiana to other physicians' practices?	86.5%	88.1%	76.7%	81.3%
7B. Please rate your overall satisfaction with Aetna Better Health of Louisiana.	68.4%	75.4%	66.4%	68.1%
7C. Please rate your overall satisfaction with United.	62.7%	78.3%	70.9%	NA
7D. Please rate your overall satisfaction with LHCC (Centene).	57.9%	74.2%	66.7%	NA
7E. Please rate your overall satisfaction with AmeriHealth.	70.1%	74.6%	67.8%	NA
7F. Please rate your overall satisfaction with AmeriGroup.	70.3%	72.9%	68.5%	NA
All Other Plans (Comparative Rating)				
1A. How would you rate Aetna Better Health of Louisiana compared to all other health plans you contract with?	27.8%	27.6%	31.8%	36.0%
Finance Issues	**25.7%**	**30.7%**	**35.9%**	**31.5%**
2A. Consistency of reimbursement fees with your contract rates and/or regulatory fee schedules.	23.6%	25.7%	31.8%	30.2%
2B. Accuracy of claims processing.	28.8%	32.2%	39.6%	33.4%
2C. Timeliness of claims processing.	27.1%	30.3%	38.5%	34.1%
2D. Resolution of claims payment problems or disputes.	23.4%	34.8%	33.6%	28.3%
Utilization and Quality Management	**25.4%**	**27.3%**	**34.0%**	**33.3%**
3A. Phone access to knowledgeable UM staff.	23.7%	26.0%	29.4%	30.9%
3B. Procedures for obtaining pre-certification/authorization information.	26.7%	26.3%	37.3%	32.7%
3C. Timeliness of obtaining pre-certification/authorization information.	28.0%	32.0%	33.3%	32.9%
3E. Access to Case/Care Managers from this health plan.	24.0%	24.8%	31.4%	30.6%
3F. Degree to which the plan covers and encourages preventive care and wellness.	24.9%	27.4%	38.8%	39.6%

Composites and Key Questions	2018 Summary Rate	2017 Summary Rate	2016 Summary Rate	2017 SPH Analytics Medicaid Book of Business Benchmark
Network/Coordination of Care	**23.4%**	**27.0%**	**31.2%**	**29.0%**
4A. The overall number of specialists in this health plan's provider network to whom I can refer my patients.	22.0%	28.3%	27.6%	26.8%
4B. The quality of specialists in this health plan's provider network to whom I can refer my patients.	26.5%	28.9%	36.3%	32.3%
4F. The timeliness of feedback/reports from specialists in this health plan's provider network.	21.7%	23.6%	29.8%	27.8%
4C. The number of behavioral health clinicians in this health plan's provider network to whom I can refer my patients.	17.6%	N/A	N/A	27.9%
4D. The quality of behavioral health clinicians in this health plan's provider network to whom I can refer my patients.	21.2%	N/A	N/A	26.2%
4I. Timeliness of feedback/reports from behavioral health clinicians for patients in your care.	19.7%	N/A	N/A	22.9%
Health Plan Call Center Service Staff	**33.6%**	**34.6%**	**37.8%**	**38.6%**
5A. Ease of reaching health plan call center staff over the phone.	29.8%	33.8%	36.6%	35.6%
5B. Process of obtaining member information (eligibility, benefit coverage, co-pay amounts).	37.4%	35.3%	39.0%	41.7%
Provider Relations	**30.1%**	**33.2%**	**32.2%**	**36.5%**
6A. Do you have a Provider Relations representative from this health plan assigned to your practice?	50.6%	51.6%	53.0%	49.1%
6B. Provider Relations representative's ability to answer questions and resolve problems.	40.0%	43.5%	41.8%	46.5%
6C. Quality of provider orientation process.	25.8%	28.8%	23.9%	30.6%
6D. Quality of written communications, policy bulletins, and manuals.	24.5%	27.4%	30.8%	32.4%

LDH Provider Satisfaction Survey Results

A snapshot of the results of the LDH survey is as follows:

- **Overall Satisfaction:**
  - 86 percent of providers rated Aetna's provider contracting process with ratings of 'Good' or better, the highest rate across the five managed care organizations (MCOs).
  - Aetna rated the second highest with 76 percent providers indicating they would recommend the MCO to other providers.
- **Communication, Education, and Training:** Aetna providers reported the highest rates of satisfaction for three areas of education and training; 58 percent reported satisfaction with provider orientation, 59 percent reported satisfaction with the provider manual, and 53 percent reported satisfaction with access to State-mandated behavioral health training.

- **Claims Processes:** Aetna providers reported 38 percent satisfaction with the Aetna complaint system, which was in the top three of all MCOs.
- **Experience with No-Show Appointments:** When asked if they have an issue with enrollees not showing up for appointments, Aetna providers reported the lowest rate (67 percent) of issues with no-show appointments across all MCOs.
- **Experience with Provider Relations Representatives:** When asked about their experience with MCO Provider Relations representatives and whether they had an MCO Provider Relations representative assigned to their organization, 26 percent of Aetna providers reported not having a representative.
- **Experience with Utilization Management (UM):** 64 percent of Aetna provider respondents rated Aetna's Medical Record Review process positively.
- **Satisfaction with Utilization Management:**
  - Aetna providers reported the highest rate of satisfaction ('Very Satisfied' or 'Somewhat Satisfied') in regard to the efficiency of the UM process overall (49 percent).
  - Aetna reported the highest levels of satisfaction with the clinical appropriateness of UM decisions (43 percent).
- **Experience with MCO Call Center:** Aetna providers most often indicated the Aetna was better than the others in the state when asked about the helpfulness of staff in obtaining referrals (31 percent).

Based on analysis of the Aetna and LDH survey results, we identified the following aggregate areas where we have opportunities to improve to the SPH Analytics Medicaid Benchmark:

- Finance Issues
- Utilization and Quality Management
- Network/Coordination of Care
- Health Plan Call Center Staff
- Provider Relations

To address these opportunities for improvement, we have implemented the following interventions and conducted monitoring to measure improvement in provider satisfaction:

- **Finance Issues:** Developed more succinct operational policies to inform providers of our plan configuration and market rules; we published these on our website to inform providers of our policies to reduce denied claims and we provided education to our providers
- **Utilization and Quality Management**
  - Evaluated and streamlined our prior authorization processes
  - Implemented tools for providers to obtain prior authorizations through the provider portal
- **Network/Coordination of Care**
  - Expanded our provider network to improve capacity and accessibility
  - To address dissatisfaction regarding 'no-show' appointments, we gave a grant to a rural health clinic to conduct a study of Medicaid enrollees to understand no-show rates better. The findings indicated that non-emergency medical transportation (NEMT) was a major factor when moms with multiple children or families could not all travel together to appointments. Our solution was to develop a value-added NEMT program for maternity/mothers.
- **Health Plan Call Center Staff and Provider Relations**
  - We conducted a continuous quality improvement activity to redesign our Provider Services and Operations teams to meet the needs of our providers; we shifted our focus to be more field-based with education and communication while creating localized back-office support for each field-based Provider Services liaison—ensuring the provider's operational needs were met. To address the issue of communication, we have added a provider communications coordinator position.
  - Redesigned Provider Services and Contracting teams to align under one leader to provide a more unified experience to the provider

Because our integrated quality improvement programs are woven into all aspects of our operations, we use these surveys and follow up with listening sessions to assess our program and identify needed interventions. This performance evaluation of our integrated programs includes areas of focus, such as physical and behavioral health gaps in care; meeting HEDIS metrics, performance benchmarks, and Early and Periodic Screening, Diagnostic and Treatment; birth outcomes; and preventable events tied to treatment of both physical and behavioral health conditions. We design our communications following survey analysis to foster two-way interaction to demonstrate improvements, build strong partnerships, and implement feedback on our performance. We rely on carefully focused trainings and education with providers but also utilize onsite visits, weekly webinars, fax bulletins, provider portal updates, and dedicated Provider Services liaisons who offer a suite of self-service tools and supports to aid continuous provider improvements.

Aetna reviews all survey results and assesses what we can do better—not just to increase scores, but to improve provider satisfaction, processes, and procedures. Always seeking improvement in our ratings, we utilize this survey to develop more innovative solutions, educate and train providers, and further refine our processes to make it easier for providers to serve our enrollees. We garner feedback from providers to see what we can do to increase provider satisfaction. Our Provider Advisory Committee, which will be comprised of providers and enrollees, provides expert council to the plan to improve access, provider satisfaction, and assistance with connecting with specialty providers. The committee is responsible for reviewing satisfaction survey results and providing feedback and input on policies and programs.

2.10.10 Utilization Management

We are Louisiana. The Aetna Community Outreach team participates in events to bring educational and support resources directly to the community. This past Halloween, at the Perkins Rowe Spooktacular, the Community Outreach team handed out treats, coloring sheets, and information about the health benefits the plan has to offer.

2.10.10 Utilization Management

Aetna's utilization management (UM) program provides whole-person care for our enrollees in the most appropriate setting. We identify, evaluate, manage, and improve clinical care and services. Our unique national experience and local leadership demonstrate our ability to improve enrollees' lives while reducing complexity and administrative burden and serving as responsible stewards of State resources. Our UM program goals and objectives aim to improve enrollee health and positively affect unmet health care and social needs. Aetna acknowledges, understands, and will comply with all the requirements of the Managed Care Organization (**MCO) Manual and the Model Contract**. Please refer to **Figure 2.10.10-1** at the end of this response for Aetna's UM workflow from initial request to final disposition, including the workflow for expedited authorizations.

Meeting and Exceeding Service Authorization Requirements (2.10.10.1)

Our UM program description and written policies and procedures are compliant with the requirements outlined in **Section 2.12 of the Model Contract**, and include processes, guidelines, review criteria, turnaround timeframes, and qualifications of health plan staff involved in UM processes. The UM Committee provides oversight of the entire UM program and works to integrate the program with other Aetna departments, including Quality Management and Care Management. Our program is National Committee for Quality Assurance (NCQA) health plan-accredited in Louisiana. We complete service authorization requests timely and efficiently in compliance with established NCQA turnaround timeframes, the requirements indicated in **42 C.F.R. §438.210**, and any court-ordered requirements. Upon receipt of a service request, UM staff reviews the request, applies the hierarchy of appropriate medical necessity guidelines, and evaluates the individual enrollee's circumstances. UM staff first review respective enrollee information in our UM business application system and may outreach to the requesting provider or case manager to obtain additional information to support the request for services. A medical director is the only staff member within the UM team that can deny a service authorization request for medical necessity reasons.

Our Gold Card-tiered preferred provider performance incentive program eliminates prior authorization requirements, reduces administrative burden on providers, and leads to cost savings and high provider satisfaction.

Aetna works to streamline the service authorization process to reduce administrative burden. **We are reducing prior authorization requirements for high-performing practices on value-based payment arrangements as we do now in Kentucky and Florida.** Our Gold Card providers must show low denial rates and must exceed quality standards.

Standard Service Authorization (Prior Authorization)

Prior authorization enables us to monitor utilization of defined services and non-emergent procedures and hospitalizations before the enrollee receives the service. For services requiring prior authorization, we confirm services are the following:

- Requested for eligible enrollees and included in the covered benefits
- Provided at an appropriate level of care or place of service based on individual circumstances
- Determined to be appropriate, timely, and cost-effective
- Coordinated as necessary with Quality Management or Care Management and communicated to applicable operations areas or to the external contractor per contractual requirement
- Documented to facilitate timely reimbursement and accurate reporting

Aetna is compliant with all prior authorization requirements outlined in **Section 2.12.9 of the Model Contract**. We conduct over 80 percent of standard service authorization determinations within two business days of obtaining appropriate medical information. For mental health rehabilitation (MHR) services, we conduct over 80 percent of determinations within five calendar days of obtaining appropriate

medical information. We make all standard service authorization determinations no later than 14 calendar days following receipt of the request for service. We may extend decisions up to 14 additional calendar days if the enrollee or the provider requests the extension; or if there is clear need for additional information and the extension is in the enrollee's interest. **Table 2.10.10-1** demonstrates Aetna's ability to exceed service authorization timeframes.

Table 2.10.10-1: Aetna Meets or Exceeds Service Authorization Timeframes

Decision Type	Period	Expedited PA	Non-urgent PA	Urgent Concurrent Approval
Physical health	Q1 2019	100% within 72 hours	• 96% within 2 business days • 100% within 14 calendar days	• 98% within 1 business day • 100% within 2 business days
Behavioral health	Q1 2019	100% within 72 hours	• 99% within 2 business days • 100% within 14 calendar days	• 100% within 1 business day • 100% within 2 business days

Aetna has also enhanced the prior authorization process by implementing pharmacist review of medical drugs. The clinical pharmacist conducts prior authorization review for drugs utilized as a medical benefit. This improves timeliness of reviews and promotes a thorough and well-documented evidence-based approach to coverage decisions for complex specialty medications. Aetna continually evaluates prior authorization requirements by adjusting policies to accommodate evidence-based practices, providing educational material to providers, and by providing advance notification to providers and enrollees concerning changes in the preferred drug list, including drug alternatives.

If the standard service authorization timeframe could seriously jeopardize an enrollee's life, health, or ability to attain, maintain, or regain maximum function, we make an expedited authorization decision as quickly as clinically needed given the enrollee's health condition and provide notice no later than 72 hours after receipt of the request for service. In addition, we do not deny continuation of higher-level services (e.g., inpatient hospital) for failure to meet medical necessity unless we can provide the service through an in-network or out-of-network provider at a lower level of care.

Concurrent Review

Using applicable inpatient and observation stay guidelines, our concurrent review process examines the medical necessity of all acute and post-acute admissions and stays and appropriate use of inpatient medical resources for continuing services for hospitalized enrollees. Concurrent review activities also link the enrollee to needed care management services and identify occurrences of over- or under-utilization, physician practice patterns, and ways to improve health care outcomes and cost-effectiveness of services. **Discharge planning begins on day one of admission, utilizing the concept of root-cause discharge planning**. For example, if an enrollee stopped taking their medications, which led to increased symptoms and a hospitalization, the root cause is not that they did not take their medications. The root cause may be related to other reasons such as "the medications made me feel worse," "I could not afford the medications," or "I got evicted and ran out of medications." Root-cause discharge planning allows us to address enrollee needs effectively through integrated care practices. We conduct interdisciplinary rounds for all enrollees in acute or post-acute settings to make sure their transition is to the most appropriate setting within the continuum of care in a timely manner. We complete over 95 percent of concurrent review determinations within 1 business day and over 99.5 percent of concurrent review determinations within 2 business days of obtaining the appropriate medical information.

Post-authorization (Retrospective Review)

Reimbursement for services may be determined retrospectively (e.g., we receive notification of a hospitalization after the enrollee's discharge) for enrollees who receive retroactive Medicaid eligibility. We base our retrospective reviews solely on the medical information available to the attending physician

or ordering provider at the time the enrollee received health care services. We review retrospective determinations utilizing the same criteria as concurrent determinations for the same service.

Service Authorization Decisions

Our expert licensed clinicians review and approve medically necessary services under the supervision of medical directors. When a clinician is not able to approve or has a question, they engage Aetna medical directors for assistance. Medical directors conducting clinical reviews are available to discuss review determinations with attending physicians or other ordering providers via peer-to-peer consultations for any request that may result or has resulted in a denied authorization. Aetna makes written and telephonic notification available to the provider and we complete a Notice of Action (NOA) and send it to the enrollee for any decision made to deny, reduce, suspend, or terminate a service authorization request. Our UM program description and policies and procedures describe the information contained in the NOA, which includes a description of enrollees' rights and the process to file an appeal or request a State Fair Hearing. Our Enrollee Services line assists enrollees and their families to discuss any questions about care determinations, NOAs, and appeal processes. Aetna will comply with all noticing requirements and timeframes in the **Model Contract**.

Pharmacy

To support evidence-based use of medications, Aetna has established protocols and processes that ensure the appropriate and timely application of prior authorization criteria during the clinical review of preferred and non-preferred drugs. We develop and update criteria in alignment with nationally recognized treatment standards. Consulted sources for evidence-based medication use include Centers for Medicare & Medicaid Services (CMS)-recognized compendia, the U.S. Food and Drug Administration (FDA), American Psychiatric Association, American Diabetes Association, medical literature, and manufacturers. Medical practitioners support and conduct medical necessity reviews of preferred and non-preferred drugs requiring prior authorization or triggering other UM edits such as age restrictions, specialist requirements, quantity-level limits, and step therapy. The dedicated pharmacy director provides oversight of the pharmacy prior authorization function administered by our team of licensed pharmacists and certified pharmacy technicians according to Louisiana's criteria and requirements.

Aetna has implemented service capabilities and automated reviews of medication that allow a prescription to process at the point of sale without requiring the provider to submit a prior authorization request. We accomplish this through SmartPA edits for specific drugs, which consider the enrollee's pharmacy claim history, the medical diagnosis loaded from our medical claims system, and the prescriber's specialty type in the evaluation of prescribed medications at the point of sale. **SmartPA edits allow for automated determinations of coverage based on predefined pharmacy and medical parameters.** Aetna's Louisiana pharmacy director works with Aetna's Medicaid Pharmacy team to build SmartPA edits to meet the requirements of the Louisiana preferred drug list of covered drugs. SmartPA edits are in place for Louisiana in the following drug categories: ophthalmic agents, psychotherapeutic and neurological agents, antifungals, and anticonvulsants. In 2018, Pharmacy processed 4,255 smart edits, allowing faster access to medications for prescribers, pharmacists, and enrollees.

Promoting Efficiency and Enhancing Provider Experience

In 2018, Aetna's pharmacy prior authorization turnaround time compliance rate was greater than 99.7 percent for 22,000 requests received. To promote even greater efficiency and enhance the provider experience, our Pharmacy Prior Authorization department implemented electronic prior authorization (ePA) on June 1, 2018. With ePA, providers can transmit a prior authorization request electronically, thus eliminating the need for handwritten fax forms and/or phone calls. Providers submit pharmacy prior authorization requests via a secure web portal using Surescripts, an information technology company that supports e-prescriptions, and CoverMyMeds, a software company that automates the prior authorization process. The ePA tool also enables providers to check approval and denial statuses after submission.

Upon submission, ePA reviews the request against criteria and either approves for coverage or submits for further review from a pharmacist and/or medical director. By utilizing the ePA tool, providers see a decrease in their administrative burden while supporting continued compliance with LDH's preferred drug list and clinical criteria. Currently, **31 percent of all pharmacy prior authorization requests are submitted via ePA, resulting in a 55 percent decrease in faxed requests and a 58 percent decrease in inquiry calls**. Aetna actively works with providers to meet our internal goal of 50 percent of prior authorization requests submitted via ePA by July 1, 2019.

Aetna's Pharmacy department conducted a satisfaction survey of the top 20 Louisiana providers utilizing ePA. The survey revealed that 96% of respondents stated that ePA saved time, provided a faster response and decision, and that they would continue to utilize the service.

Aetna's Pharmacy Prior Authorization Call Center leverages CaremarkPCS' pharmacy prior authorization business application for processing prior authorization requests. CaremarkPCS is Aetna's pharmacy benefit manager. To support point-of-sale processing of prescriptions within minutes of an approval of the prior authorization request, the system loads the authorization into the claims adjudication system. We generate reports throughout the day to monitor inventory and to intervene if there are areas of concern that could negatively affect compliance with timeliness standards. To allow an enrollee access to appropriate medications during the prior authorization review process, the dispensing pharmacist can initiate an override for a 72-hour emergency supply when they cannot reach the prescribing provider.

Implementing Pharmacy Best Practices

To advance evidence-based practices and improve efficiency with coverage decisions, we implemented a clinical pharmacist review and support of prior authorization requests for medical drugs. The clinical pharmacist reviews medical drug (J-code) prior authorization requests using approved criteria and all clinical documentation provided by the requesting provider. If a request meets criteria, the clinical pharmacist issues an approval including duration and units. If the UM team approves all other requested services, we forward the case to the UM representative to complete the authorization and notification requirements. We refer recommendations for denial or further review of the case to the medical director.

In collaboration with the Integrated Care Management and UM teams, the chief medical officer, pharmacy director, and community providers, Aetna continually seeks opportunities to develop additional evidence-based initiatives that support improved enrollee outcomes and access to care. During 2018, Aetna pharmacy and medical staff collaborated with LDH and local providers to implement customized point-of-service safety edits for AIDS/HIV medications that improve enrollee care and monitor utilization. We also employ a dedicated behavioral health clinical specialist and a licensed registered nurse to lead discussions, provide training, and develop partnerships with providers to help impact and decrease the overuse and misuse of opioid medication utilization, including the safe disposal of unused medications.

Service Authorization System

Aetna uses integrated systems and interdepartmental processes to coordinate services for an enrollee. The UM business application system allows departments to share enrollee and provider information, coordinate procedures such as discharge planning, transition an enrollee from an institutional setting back into the community, authorize post-hospital services, and follow up on complex cases or emergency department (ED) care. Aetna's UM business application system also provides the authorization number and effective dates for authorization to participating providers and applicable non-participating providers. Aetna's UM business application system stores and reports the time and dates all service authorization requests received, decisions made regarding the service requests, clinical data to support the decision, and timeframes for notification of providers and enrollees of decisions.

Meeting and Exceeding Utilization Management Requirements (2.10.10.2)

Aetna uses nationally recognized, evidence-based criteria, which we apply based on the needs of individual enrollees and characteristics of the local delivery system. Our medical management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. To assure adherence to NCQA, LDH's clinical coverage policies, and Louisiana's definition of medical necessity, outlined in **Section 2.12.1.2** of the **Model Contract**, we review our existing policies and make updates as appropriate.

Applying UM Criteria (2.10.10.2.1)

We review and adopt criteria and update annually or as applicable based on revision of national or community-based clinical practice guidelines. The annual review process involves qualified, expert physical and behavioral health medical directors in developing, adopting, or reviewing criteria. We advise providers that criteria are available upon request in the NOA, provider manual, and provider newsletters. In addition, Aetna integrates into our systems and reviews annually a common hospital observation policy developed and maintained collectively by MCO personnel and LDH. We detail the established hierarchy of referenced criteria in **Table 2.10.10-2.**

Table 2.10.10-2: Aetna's Hierarchy of UM Criteria

Resource	Description
Regulatory Guidelines	Pharmacy prior authorization guidelines and LDH pharmacy prior authorization criteria; LDH home- and community-based services waiver; special populations receiving services such as Pediatric Day Health Centers (PDHC) and Applied Behavioral Analysis (ABA); proprietary guidelines when other guidelines are not available
MCG (formerly Milliman Care Guidelines)	National, evidence-based clinical guidelines, best practices, and care planning tools across the continuum of care to support clinical decision-making
Aetna Medicaid Pharmacy Guidelines	Aetna's proprietary pharmacy guidelines follow objective, credible sources, such as the Academy of Managed Care Pharmacy, the American Association of Pharmaceutical Science, and the American Association of Colleges of Pharmacy, best clinical treatment practices, and expert opinions. **On May 1, 2019, we will use the LDH preferred drug list and clinical criteria for coverage.**
Level-of-Care Utilization System	A level-of-care tool to help behavioral health clinicians determine the intensity needs of enrollees who receive behavioral services, including Mental Health Rehabilitation.
Child and Adolescent Service Intensity Instrument (CASII)	CASII is a standardized assessment tool that provides a determination of the appropriate level of service intensity needed by a child or adolescent and their family.
American Society of Addiction Medicine (ASAM)	Guidelines for placement, continued stay, and transfer/discharge of patients with substance use and co-occurring disorders
Aetna Clinical Policy Bulletins	Aetna's proprietary medical necessity guidelines follow objective and credible sources, such as scientific literature, guidelines, consensus statements, and expert opinions.
Aetna Clinical Policy Council	Team of clinical experts and health care providers responsible for the review of new and emerging technology; this council also provides consultation to Aetna's medical directors

Evidence-based Decision Support Tool

Clinical UM staff uses nationally recognized, evidence-based guidelines and clinical review guidelines to drive consistency in decision-making. Guidelines represent best practices, reflect national standards, support medical necessity determinations, and meet the needs of individual enrollees.

Formal medical committees and ad hoc work groups advise and guide the development and adoption of guidelines. Aetna develops clinical policy bulletins using peer-reviewed medical literature, technology assessments, structured evidence reviews, evidence-based consensus statements, expert opinions of health care providers, and evidence-based guidelines from nationally recognized professional health care

organizations and public health agencies. Aetna reviews clinical criteria policies annually or more frequently based on knowledge of relevant new medical literature, guidelines, and regulatory action notices.

Aetna's Clinical Policy Council Committee and external practicing clinicians with expertise in providing the types of services in the clinical criteria policies conduct a comprehensive review process of both new and revised policies. A recent example is revision to the criteria used in decision-making for enrollees with asthma. We revised the criteria to read that exhaled breath nitric oxide testing is medically necessary for evaluation of asthma and for monitoring response to long-term control therapy for enrollees aged 5 years and older. This test is a quick and simple way to determine if enrollees are exhibiting signs of ongoing allergic inflammation. **Aetna's change resulted in ready utilization of this tool by providers**.

In alignment with the **Model Contract**, we adopt clinical practice guidelines for the following behavioral health conditions: schizophrenia, attention-deficit/hyperactivity disorder, depression, generalized anxiety disorder, post-traumatic stress disorder, suicidal behavior, oppositional defiant disorder, bipolar disorder, and substance use disorders. Aetna will also coordinate the development of specialized behavioral health clinical practice guidelines with other LDH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.

Determining Appropriateness of Treatment and Site of Treatment

UM staff applies guidelines to determine appropriate levels of care and identify competent providers for co-occurring conditions. We use UM guidelines consistently as a guide, but enrollees who may need a higher level of care to avoid imminent relapse receive continued stay authorization to bridge to the next level of care. We consider each person's circumstances individually in concert with available resources.

To increase access to crucial services, Aetna does not require prior authorization for the ASAM 3.1 lower intensity level of residential substance use treatment or multisystemic therapy. We pay for certain (in-lieu-of) services that are not part of the Medicaid benefit structure to ensure continuity of care, treatment at the appropriate level, and better health outcomes for our enrollees. In particular, the ASAM 3.1 level of care is crucial to supporting an enrollee's recovery in the community and their ability to be self-sufficient. This level of care represents a bridge between higher-cost, more intensive care, and community living. Enrollees also receive support with employment and housing at this level of care, which are significant social determinants of health in a person's recovery from substance abuse. Authorizing and paying for services outside the Medicaid benefit package ensures continuity of care, treatment at the appropriate level, and better health outcomes for our enrollees.

Inter-rater Reliability Program

To promote consistency in decision-making, we employ licensed clinical professionals who receive comprehensive training upon hire and annually. Through our inter-rater reliability (IRR) program, we conduct quarterly quality chart review audits to assess consistency in decision-making related to applying medical necessity criteria. We administer IRR testing annually to all UM staff, including pharmacy technicians, pharmacists, and medical directors. Staff scoring below the 85 percent threshold complete additional training and retake the exam twice. If staff still does not meet the standard, we implement additional performance measures and corrective action plans. We also audit all denials daily to guarantee compliance with NCQA denial notification standards. **Table 2.10.10-3** shows our aggregate IRR scores for medical and behavioral health UM in 2018.

Table 2.10.10-3: Aetna's UM Staff Exceed IRR Benchmarks

UM Staff	Physical Health Average Score	Behavioral Health Average Score
Medical Director	98.45%	98.67%
Prior Authorization and Appeals	100%	98.75%

UM Staff	Physical Health Average Score	Behavioral Health Average Score
Concurrent Review and Appeals	96.56%	98.10%
Average	**98.59%**	**98.80%**

In 2018, pharmacy IRR scores exceeded the minimum compliance 85 percent threshold:

- Clinical pharmacists: 97.8 percent for 18 pharmacists
- Medical director: 95.0 percent for two medical directors
- Pharmacy technicians: 95.0 percent for 12 technicians

Monitoring and Addressing High ED Utilization (2.10.10.2.2.)

Aetna's proprietary risk tool, Consolidated Outreach and Risk Evaluation (CORE™), increases the opportunity to stratify enrollees, identify special populations as early as possible, and provide services that address high ED utilization. Proprietary and evidence-based, CORE is a stratification tool that uses time-tested analytic methods honed for more than 10 years. Aetna's inpatient and ED models, based on CORE, provide enrollee-specific scores indicating the likelihood that the enrollee will visit the ED or experience an inpatient admission in the next 12 months. We run the model for our entire population monthly. Care Management teams review the results to identify enrollee contact and intervention opportunities.

CORE predictive modeling identifies enrollees who are candidates for intensive and supportive care management and enrollees who are candidates for high- and low-risk chronic condition management. Our predictive modeling shows that our highest-risk enrollees have multiple physical health conditions—70 percent to 90 percent had comorbid behavioral health conditions. CORE generates scores from internally developed algorithms based on Medicaid population data and our clinical and informatics expertise. Inputs to the algorithms include enrollee demographics, along with medical, behavioral, and pharmacy claims data.

We know that complexity is more important than diagnosis when identifying enrollees who are at high risk. Enrollees with complex needs benefit from our integrated care management model (Tiers 2 and 3) designed to support whole-person health. The tool predicts the likelihood of integrated care management making an impact and ranks all plan enrollees from highest to lowest risk.

CORE's analysis is based on three risk metrics:

- **Predictive model general risk score:** We consider enrollees who are in the top 1 percent of the population based on highest general risk score as high risk.
- **Emergency department risk score:** We identify enrollees with an 80 percent or greater risk score as high risk of an ED visit during the next 12 months.
- **Inpatient admission risk score:** We identify enrollees with a 70 percent or greater risk score as high risk of a physical or behavioral inpatient admit during the next 12 months.

We produce our ED and inpatient risk scores using logistical regression models to predict the probability of an occurrence within the next 12 months. Indicators include prior year ED, inpatient, and specialist utilization, comorbidities, and pharmacy complexity. Specific behavioral health risk indicators include behavioral health admissions and readmissions, presence of serious emotional disturbance, poly-prescriber, and poly-pharmacy activity for behavioral health medications, and concurrent use of multiple medications from one behavioral health therapy class.

In addition, we monitor for high utilization through the following:

- **Admission, discharge, and transfer (ADT) feeds:** We currently receive ADT feeds from 71 percent of Louisiana's reporting hospitals (104 total) daily via connection from Louisiana's Health Information Exchange LaHIE, the Greater New Orleans (GNO) HIE. **We are in the process of**

executing a contract with the hospital-sponsored health information exchange, the Louisiana Health Information Network Encounter Notification Service (LHIN-ENS), which will give us ADT feeds from most every hospital in the state.

- **Elli:** Starting in 2019, Aetna will be able to leverage our unique relationship with HMS, a leading health care technology company, to enhance our ability to analyze and use claims data. As a first adopter of Elli in Louisiana, Aetna will gain access to four years of claims data collected from all MCOs across the state. The data will be available to us on day one of an individual's enrollment. The data analysis provides an additional risk stratification that Aetna will consider in concert with our CORE predictive modeling risk stratification results. We will leverage Elli, in particular, when we enroll a new individual, enabling us to engage the enrollee in appropriate tier of care management immediately.
- **Direct referrals from hospitals and providers:** We receive information and referrals directly from our hospital and provider partners through Care Management and UM staff.

Addressing High ED Utilization

Aetna coordinates a variety of strategies to reduce high ED utilization. These include the following:

- **ED diversion coordinators:** Aetna employs ED coordinators who work under the umbrella of the Care Management team. The ED coordinators establish relationships with hospital staff throughout the state, engage enrollees with high ED utilization, and provide telephonic outreach to at-risk enrollees. ED coordinators also attend collaborative provider meetings, discuss the needs of the enrollees that need extra support during Aetna integrated rounds, and engage enrollees through face-to-face and telephonic outreach.
- **Community health workers and peer support services:** Aetna's community health workers coordinate with community-based organizations to refer enrollees to appropriate services to resolve social needs that can worsen health or increase avoidable ED visits. Aetna connects enrollees to peer support services through assertive community treatment and permanent supportive housing program teams; the HIV/AIDS Alliance for Region Two, Inc.; the Extra Mile of Monroe; Mental Health Association of Greater Baton Rouge; National Alliance on Mental Illness New Orleans; and the Metropolitan Human Services District.
- **Ready Responders:** Ready Responders, our community paramedic program, offers an alternative to seeking ED services for non-urgent medical needs. Ready Responders provides mobile non-emergency medical care to Aetna enrollees through licensed nurses, community paramedics, and physicians.
- **Schumacher Clinical Partners:** Aetna has a letter of intent from Schumacher Clinical Partners to leverage their innovative post-acute care coordination services across the state. This program will address repeat ED visits, readmissions, and observation stays by coordinating and monitoring post-acute services for Aetna enrollees.
- **Health Information line:** Aetna enrollees have 24/7/365 access to our Health Information line (Nurse Line) and Behavioral Health Services hotline. Through these resources, enrollees receive recommendations, in the language of their preference, on their health care issues. Nurses who staff the Health Information line instruct enrollees on self-care options, refer them to their primary care providers (PCPs) for follow-up, or recommend a visit to urgent care, helping to prevent avoidable ED visits.

Aetna successfully decreases ED and inpatient utilization year-over-year. We achieved the following in 2018 vs. 2017:

- **4.98% decrease** in ED visits/1,000
- **4.3% decrease** in per member per month (PMPM) for inpatient admissions
- **7.1% decrease** in physical health admissions/1,000
- **11.1% decrease** in behavioral health admissions/1,000
- **10.5% decrease** in physical health readmissions/1,000
- **36.2% decrease** in behavioral health readmissions/1,000

- **Telemedicine:** As part of our comprehensive network offering, we support enrollees in their homes and communities by offering telemedicine services through our existing network in place with MDLIVE® for behavioral health services and Teladoc for physical health services. MDLIVE offers a web-based solution, enabling enrollees to access outpatient services from the convenience of their community.
- **CVS Health MinuteClinics:** Aetna is working to expand access to appropriate levels of care throughout the communities we serve via our urgent care network and CVS Health Minute Clinics. **We are prepared, upon award and in collaboration with the State, to expand MinuteClinic access in at least one existing CVS store and as many as three existing CVS stores. We will assess the regions of the state where there are a high number of potentially preventable emergency room visits for feasibility of Clinic placement, overall timing, and staging for the new clinic(s).** We already have six MinuteClinics across the state in Metairie, Baton Rouge (two locations), Slidell, Covington, and New Orleans.

In addition, **Aetna addresses high ED utilization through value-based purchasing**. Aetna has a value-based contract with St. Martin Hospital to address high utilization and medical trends. This acute hospital pay-for-quality program provides the hospital incentive payments if they can reduce the readmission and ED utilization rate of their population using their ED diversion clinic. In addition, our in-home ED diversion performance-based incentive program incents participating providers who provide in-home care and disease management services to enrollees who are frequent utilizers of the ED with the opportunity to earn an incentive payment. Providers earn the payment when their ambulatory ED rate per 1,000 enrollees is less than that population's historical ambulatory ED rate per 1,000 enrollees and is at-risk for having their fee-for-service rates decreased for not meeting the performance targets.

Conducting Preadmission Screening and Concurrent Reviews (2.10.10.2.3)

Aetna's UM clinicians conduct preadmission screening and concurrent review to ensure enrollees are getting the right level and type of care for their medical and behavioral health needs.

Pre-screening for Psychiatric Residential Treatment Facilities

When Aetna receives a referral for psychiatric residential treatment facility (PRTF) admission for an enrollee, we perform an initial screen that includes review of records and current clinical information to determine whether PRTF is an appropriate level of care, or if alternate community-based services could meet the needs of the enrollee. We complete this screen within 24 hours of receipt of the referral and make the proper determination. The purpose of the prior authorization and concurrent review function for PRTF include the following:

- Compliance with the requirements set forth at **42 C.F.R. §441 Subpart D**
- Review of the certificate of need (CON)
- Rule out other community-based options
- Ensure the team has knowledge of the ambulatory resources available to the youth

If approved, we will notify the enrollee and/or guardian if applicable and, with consent, the referring party requesting PRTF services. We provide written notification of the approval within 48 hours. We then generate a proper authorization for each PRTF, again within 48 hours of completion of the screen. Together, with the enrollee, the enrollee's guardian and referring party, and with support from the enrollee's integrated care management team, we locate a PRTF provider available and appropriate to meet the enrollee's needs.

When the initial screen results in a determination that the enrollee needs PRTF care, Aetna secures admission to an appropriate PRTF for the enrollee within the timeframe stated in the CON, and in compliance with access and availability standards for this level of care. Aetna will authorize out-of-state

placement if an in-state option is not available within the required timeframe. In the rare occasion Aetna denies the referral, we will immediately notify the enrollee and/or guardian, and with consent, the referring party requesting PRTF services; within 24 hours, we provide written notification of the denial. Our notification of denial includes information on alternative services to ensure health and safety, including information on providers of those services, referral to care management, and the right of the enrollee to appeal the denial and the process to do so. In addition, for youth pending release from a secure setting for whom a PRTF is being requested, we complete the screen prior to the youth's release if the youth may be relinked to Aetna following release.

To expedite the PRTF placement process, **Aetna maintains near real-time bed utilization/availability for network PRTFs** and out-of-network replacements through weekly communication with our dedicated UM reviewer assigned to PRTFs. This staff person is a child and adolescent specialist who monitors placement availability and works on behalf of enrollees and families.

Concurrent Review

Our UM staff conduct concurrent reviews, as described previously. Aetna completes service authorization and concurrent review for inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out of the state, or state hospitals. A licensed mental health professional completes inpatient psychiatric hospital and concurrent utilization reviews for each enrollee referred for psychiatric admissions to general hospitals. We also work with State and community partners to provide needed UM services to enrollees. For example, we conduct UM functions for the coordinated system of care (CSoC) population in accordance with **Section 2.12.1.21 of the Model Contract**.

Complying with Mental Health Parity Requirements (2.10.10.2.4)

Aetna puts the enrollee and their unique behavioral and physical health needs at the center of all we do and works to increase health equity and parity. We integrate Mental Health Parity and Addiction Equity Act (MHPAEA) compliance into our UM program, from how we authorize services to how we evaluate and monitor compliance. Our program is fully compliant with all requirements outlined in **Section 2.3.11 of the Model Contract** and we ensure our material subcontractors are compliant as well. In addition to ongoing regular review of policies, Aetna employs the following strategies to assure parity compliance:

- We make sure any quantitative treatment limitations applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits.
- We do not impose non-quantitative treatment limitations (NQTL) for behavioral health benefits in any classification unless any factors used in applying the NQTLs to behavioral health benefits in a classification are comparable to and applied no more stringently than factors used in applying the NQTLs for medical/surgical benefits in the classification.
- We make behavioral health medical necessity criteria available to any enrollee, potential enrollee, or contracting provider upon request.
- We use LDH's drug formulary.
- We communicate the reason for behavioral health denials to the enrollee.
- We conduct parity analysis on behalf of LDH for plans offering both medical/surgical and behavioral health services.
- We provide out-of-network coverage for behavioral health when available for medical services.
- Our utilization grids are mental health parity-compliant.

Our Aetna Medicaid UM Steering Committee evaluates and measures compliance by reviewing our list of services that require authorization at least annually. We apply evidence-based medical necessity criteria and conduct IRR studies for both physical health and behavioral health services at least annually. The chief medical officer oversees this process and reports results to the Quality Management Oversight Committee (QMOC). The QMOC annually reviews and approves policies on UM practices, pharmacy,

appeals, and peer reviews. **All Aetna staff, including non-clinical and non-UM staff, completed training in mental health first aid**, which teaches compassion and skills for supporting those with mental health conditions and substance use disorders. Furthermore, Aetna adheres to the requirements outlined in **MHPAEA 42 C.F.R. 438.3(e)(1)(ii) and 438.910(b)-(d)**.

Identifying and Mitigating Over-utilization (2.10.10.2.5)

Aetna's Quality Management, Provider Experience, and Special Investigations Unit (SIU) teams work with the UM team to identify, track, and address over-and under-utilization, and to identify solutions with the provider community. To identify and mitigate over-utilization, Aetna uses the following:

- **Provider profiling:** We profile our PCPs and specialized behavioral health providers (including substance use disorder treatment, mental health, and residential providers) and we analyze utilization data to identify utilization and/or quality of care issues.
- **UM performance dashboards:** We use nine UM dashboards, which provide data reports on readmissions, observations versus one- to two-day stays, ED utilization, neonatal intensive care unit (NICU) admission patterns, outpatient urine drug testing patterns, medical claims trends, authorization trends, outpatient utilization trends, and inpatient performance targets: .
- **Demographic distribution for ED utilization dashboard:** This dashboard allows users to review ED utilization data through a demographic and health equity lens. The dashboard sorts and filters enrollee ED utilization data to identify possible demographic-related disparities related to race, ethnicity, language, geography, or adverse incidents.
- **Pharmacy data analysis**: We conduct retrospective drug utilization reviews (RetroDUR) to detect pharmacy over-utilization.

Aetna applies RetroDUR to assess drug over- and under-utilization patterns to drive the development of interventions and/or educational activities. We implement or refine interventions to improve prescribing and utilization patterns and control costs further. Interventions include the following:

- Identifying prescribing patterns of specific practitioners that warrant outreach and/or education
- Referrals to the Administrative Lock-In Review Committee to evaluate identified enrollees' utilization to determine whether they are candidates for pharmacy/prescriber lock-in
- Referrals to the SIU and/or Office of the Inspector General for investigation
- Identification and referral of enrollees to care management for outreach and engagement

Aetna's Safety RetroDUR program identified 203 enrollees with drug safety concerns in 2018. Enrollees identified were engaged in care management or had their issue resolved by pharmacist communication with the prescriber. This effort resulted in cost savings of $52,726 ($18.15 PMPM) in 2018.

Historical Experience with UM of Comparable Populations (2.10.10.3)

Our unique 30 years of national Medicaid experience and dedicated local leadership demonstrate our ability to improve our enrollees' lives while reducing complexity and administrative burden and serving as responsible stewards of State resources. We have served Louisiana under the Medicaid Managed Care program since 2015. We detail our significant experience providing UM services to comparable populations in the next section.

Challenges Identified with High Utilization and Increasing Medical Trends (2.10.10.3.1)

Aetna proactively addresses challenges associated with high utilization and increasing medical trends. For example, our focus on high-risk pregnancy and babies admitted to a NICU is essential as prevention and early intervention can dramatically reduce the number of children exposed to trauma. Aetna, in alignment with LDH, coordinated a systematic approach to decreasing health risks and costs associated with babies admitted to the NICU. Our approach, which includes intensive care management, discharge navigation, collaboration with system partners, and a targeted enrollee education campaign, has resulted in increased health outcomes and cost savings—**we saved $3,386,923 in 2017, a 19 percent increase from 2016**. In

addition, we reduced the average length of stay in the NICU from 18.4 days in 2017 to 13.2 days in 2018, and bed days/1,000 from 78.1 in 2017 to 67.7 in 2018.

Aetna maintains a strong commitment to identifying increasing medical trends and high utilization. Identification of these trends may indicate fraud, waste, or abuse activity (FWA). We detect and prevent Medicaid program violations and possible FWA overpayments through data matching; trending; statistical analysis; monitoring service billing patterns and claims edits; and other data mining techniques.

Other medical trends Aetna addresses include addressing inappropriate use of PSR and CPST; inpatient psychiatric recidivism, which we address through increasing community supports and our comprehensive Transitional Care Management program; and increasing costs of certain treatments such as anti-viral medications and hepatitis-C treatments, which we manage through our pharmacy program. **From June 2018-December 2018, the community tenure for enrollees with high behavioral health utilization increased by 12% for adults and 27% for children.**

Initiatives Managing High Utilization (2.10.10.3.2)

Avoiding high utilization rates, potentially preventable events, ED visits, and hospital admissions begins with the enrollee's connection with the PCP and care management support. Aetna recognizes that 51 percent of the enrollees with potentially preventable events are considered healthy. Therefore, we educate enrollees on the appropriate use of ED services in all enrollee-facing departments and via their PCP.

Our enterprise-wide System of Care model supports our local care management model to reduce high utilization. The System of Care model is a collection of integrated services grounded in trauma-informed care and trauma-informed approaches, culturally and linguistically appropriate services, and recovery principles and guides our care management service delivery model. Aetna case managers educate enrollees and their caregivers on specific physical and behavioral health disorders and the appropriate use of emergency services, including when and how to contact their PCP, and the importance of preventive care. Aetna's program addressing high utilization is a collaborative endeavor between the UM, Care Management, and System of Care teams, focusing on individualized treatment planning based on root cause analysis. **Since implementation in the third quarter of 2018, we have seen a 26 percent decrease in admissions and a 37 percent decrease in length of stay for our enrollees with high behavioral health service utilization.**

In addition to the strategies we use to reduce ED utilization described previously, Aetna deploys multiple strategies to reduce high utilization of services including community-based solutions, technology-based solutions, and provider-based solutions.

Community-based Solutions:

- **Addressing social determinants of health and community-level interventions:** As part of our integrated care model, case managers address enrollees' whole-person needs to address barriers to achieving optimal health and to utilize community supports and services to close gaps in care. For example, our case managers use Aunt Bertha (an internet resource with search and referral functions to provide access to comprehensive, localized listings) to identify community supports. Aunt Bertha is also available to enrollees via our website.
- **Discharge planning:** We identify real-time hospital admissions and ED visits and begin analyzing the cause of the admission and discharge planning needs on day one. During an acute stay, the integrated care team examines medical, behavioral, social determinants, and health literacy indicators for readmission and begins to address the root cause of the primary admission.

Technology-based solutions:

- **Remote patient monitoring**: We offer remote patient monitoring (RPM) to enrollees with conditions such as asthma and high-risk pregnancies via a contract with Care Innovations®. RPM facilitates near-

real time data to maximize appropriate care strategies and empowers enrollees to manage their health proactively.

- **Wellpass (text messaging):** Wellpass is a technology that allows Aetna Care Management staff to communicate with enrollees through text message regarding their ED utilization and health needs.
- **ED reminder phone calls:** The interactive voice response system calls enrollees monthly to identify reasons for obtaining ED services, assess if they have a PCP or need help obtaining one, provide education about urgent care centers and when to use, and to further address any care needs they may have after discharge. During the call, the platform links the enrollee directly to Enrollee Services or Care Management, as needed.

Aetna's integrated care management of highest-risk enrollees achieved **$1,949,899 in cost savings** in 2017**.**

Our efforts to reduce NICU average length of stays through pediatrician education saved 37% over the baseline NICU expense in 2017.

Our enhanced network of urgent care centers and increased enrollee awareness of urgent cares reduced ED utilization on a PMPM basis by 3.7% across all lines of business in 2018.

Provider-based Solutions:

- **CVS Health MinuteClinics:** We are prepared, upon award and in collaboration with the State, to expand MinuteClinic access in at least one existing CVS store and as many as three existing CVS stores. We will assess the regions of the state where there are a high number of potentially preventable emergency room visits, feasibility of Clinic placement and overall timing, and staging for the new clinic(s).
  - **Collaboration:** Aetna works with our high-volume ED facilities and PCPs to support facility case managers to identify duplicated services and prioritize interventions.
  - **Hospital Readmission Reduction Program:** Clinical pharmacists perform medication reconciliation and review when enrollees return home after an inpatient stay.
  - **Urgent care network:** Aetna continues to expand access to urgent care centers to make sure enrollees have access to care in convenient settings in their community—a key factor in preventing avoidable ED visits. **We have increased our number of urgent care locations by 15% since 2016.**
  - **Alternative payment models:** Aetna's alternative payment models incentivize providers to offer after-hours care to our enrollees by paying enhanced rates, decreasing avoidable ED visits.

Since its launch in 2017, Aetna's Enterprise Wide Opioid Taskforce has supported the advancement of Aetna's clinical strategy to combat the opioid overdose crisis and the high utilization of services associated with the opioid crisis. In the first year since announcing our five-year enterprise goals, we have seen the following results:

- A **60 percent increase in the rate of treatment** with non-opioid in enrollees with chronic pain
- A **50 percent decrease in opioid prescriptions** written for seven or more days after an acute injury
- **A nearly 30 percent increase in the rate of medication-assisted treatment** or other evidence-based treatments utilized.

Initiatives Addressing Use of Low-value Care (2.10.10.3.3)

Aetna detects and addresses under-utilization of high-value services and over-utilization of low-value services, as guided by LDH's Quality Management Strategy. We will continue to work collaboratively with LDH to improve high-quality, evidence-based, cost-effective care for enrollees. For example, Aetna supports the following evidence-based practices for high-utilizing individuals with serious mental illness, and we work to identify and provide access to providers of these services and practices in Louisiana: assertive community treatment, targeted case management, psychiatric rehabilitation process model, and dialectical behavior therapy.

In alignment with LDH's Mental Health Reform, Aetna collaborates with LDH to address inappropriate utilization of low-value services. Aetna requires prior authorization for CPST and PSR to ensure proper utilization of these services. This supports efforts to eliminate FWA and directs service utilization to evidence-based strategies. **Despite a reduction in units authorized for CPST/PSR in the last 6 months of 2018, we have seen a decrease in behavioral health admits/1,000 and readmits/1,000.**

Initiatives Addressing Long-term Stays in the ED (2.10.10.3.4)

Aetna actively addresses the long-term stay of enrollees in EDs based on limited availability for necessary behavioral health services. Our strategies include the following:

- Working to develop additional crisis stabilization beds for children
- Conducting analysis of use of the ED for behavioral health services, including at a minimum, reason for ED visit, length of stay, inpatient admissions and/or referral to follow-up care, difficulty in accessing follow-up services, and developing recommendations for reducing long-term stays in the ED
- Educating enrollees and providers regarding appropriate utilization of the ED
- Educating ED staff on availability of community behavioral health resources
- Telemedicine through MDLIVE to increase enrollee access to psychiatrists

Aetna identifies resources in the community, supports those organizations to build capacity, and coordinates care to reduce ED stays and drive care to local providers. Aetna supports several pilot programs aimed at leveraging community-based supports to reduce ED stays. These programs include Compass Behavioral Health's rapid crisis stabilization program; Jefferson Parish Human Services Authority's crisis respite and connection to care management and community-based resources program; and Safe Haven's crisis intervention center in St. Tammany Parish.

Supporting Providers with High Prior Authorization Denial Rates (2.10.10.3.5)

Aetna provides quality care to our enrollees and diligently works to support providers and reduce administrative burden, while avoiding the risks associated with overuse, underuse, and misuse of health care. Our initial provider orientation offers training on UM processes and prior authorization. We offer ongoing support via our Provider Relations team and through the provider portal. Through our Provider Advisory Committee, we review providers who are outliers for denial rates for enhanced provider education regarding prior authorization policies and procedures. We identify providers in need of support through authorization data reviewed in our Quality Management/Utilization Management Committee.

Aetna creates efficient and effective processes for providers who request services. We support providers not accustomed to managed care practices, and **employ multiple strategies designed to minimize their administrative burden and enhance their experience**, including the following:

- Assuring providers can access crucial data on rising-risk enrollees and gaps in care
- Using the standard LDH unified prior authorization form
- Review of appeals related to denials; Aetna has a significantly lower appeal rate per 1,000 enrollees compared to all other MCOs in Louisiana.
- Streamlining processes using trends identified by UM, Quality, and Provider Relations
- Promoting the use of evidence-based clinical guidelines and care paths
- Conducting annual evaluation of practitioner performance and health care professional education that targets appropriate and cost-effective use of health care resources
- Conducting quarterly site visits to facilities to collaborate on reduction of denials

We encourage providers to use the web portal for direct authorizations, educate them about our prior authorization process, and instruct them to provide all the necessary clinical information to facilitate rapid authorization for the right services. The provider portal includes requirements for prior authorization, how to request a copy of medical necessity criteria, and how to access to the provider prior authorization tool. This application allows providers to verify that a service is a covered benefit and to determine whether it requires prior authorization.

Workflow

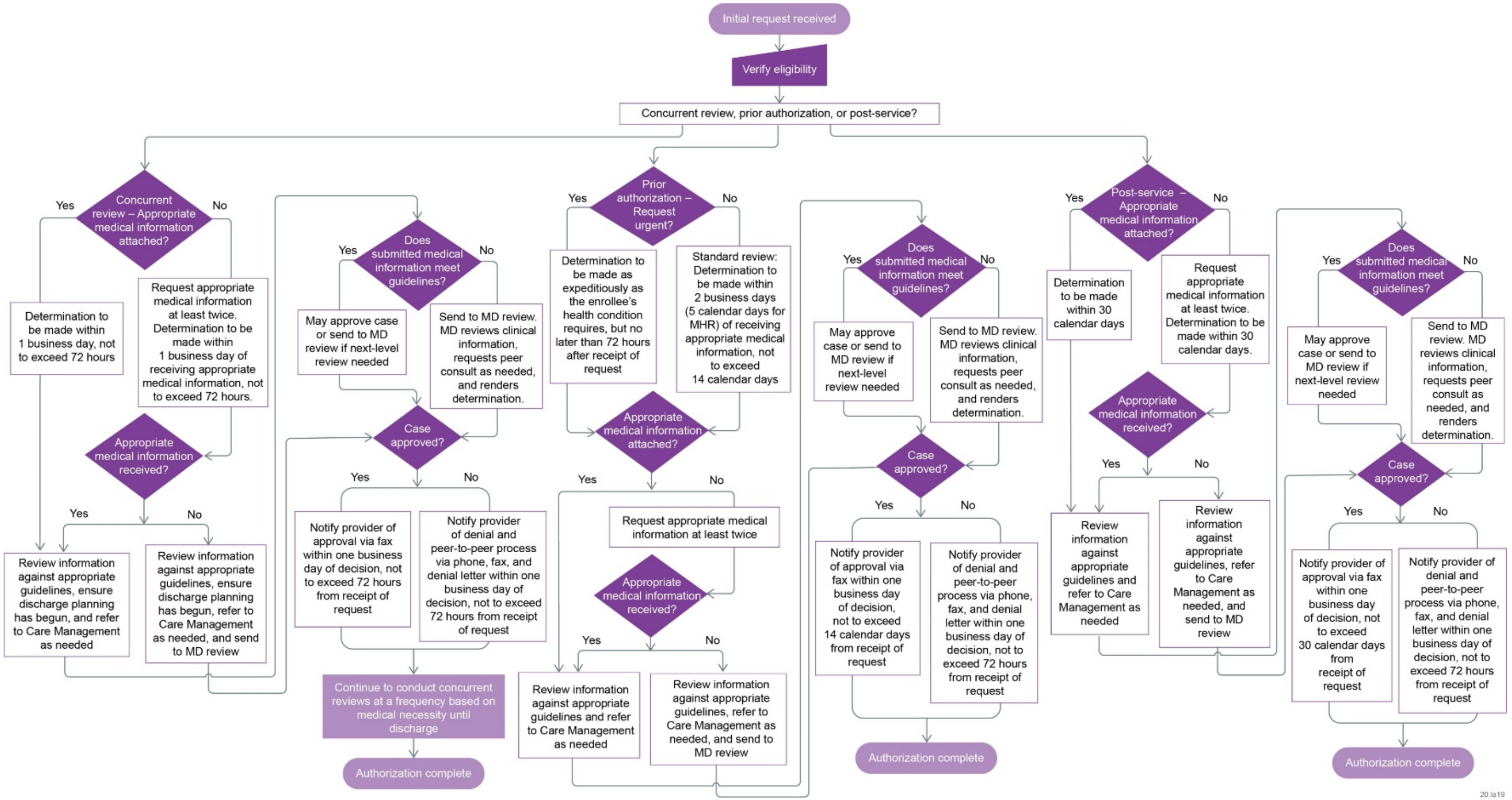

Figure 2.10.10-1: Aetna's Utilization Management Workflow

Aetna's UM workflow, from initial request to final disposition, including the workflow for expedited authorizations.

2.10.11 Quality

As an avid supporter of afterschool activities for children of all ages, Aetna routinely partners with the Boys & Girls Clubs of America to celebrate and recognize all of the hard work the Clubs do throughout the school year. Aetna CEO Rick Born is a board member of the Baton Rouge Boys & Girls Club and supports several programs for school-aged youth focused on academics, health, and character.

2.10.11 Quality

Improving the health of Louisianans and setting the bar for higher quality and cost-efficient care is Aetna's top priority. We are committed to quality, ready access, and innovation to maximize enrollee health, advance health equity, and address social determinants of health within a flexible value-based approach.

Aetna's Commitment to Quality Improvement (2.10.11.1)

Aetna brings the full complement of our local and national quality improvement infrastructure and resources in alignment with the **Louisiana Medicaid Quality Strategy** in achieving the **Triple Aim** to promote better health with better care at a lower cost. Our **substantial improvement trajectory** surpassed all other plans within Louisiana on the Healthcare Effectiveness Data and Information Set (HEDIS), LDH performance, Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Child with Chronic Condition (CCC) CAHPS survey measures, including meeting the 75th percentile for the following:

- Antidepressant medication management acute phase
- Antidepressant medication management continuation phase
- Chlamydia screening in women aged 16 to 24 years
- Adult CAHPS and CCC CAHPS survey: how well doctors communicate

Aetna ranked #1 in Louisiana compared to other plans for the following HEDIS 2018 measures:

- Well-child visits in the first 15 months of life
- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with upper respiratory infection
- Diabetes screening for people with schizophrenia or bipolar disorder

We will continue to increase our capabilities, resources, and programs to continue our improvement trajectory to meet or exceed the HEDIS 75th percentile across all measures identified in **Attachment G**. We are committed to fully engaging enrollees and providers in quality initiatives through increased staffing and face-to-face interactions targeting Louisiana communities experiencing health disparities. We will promote alternative treatment options, including telemedicine and mobile services in underserved parishes, and utilize community health workers (CHWs) to address each enrollee's unique needs. Our organizational commitment is evident by our year-over-year incline as shown in **Table 2.10.11-1**.

Table 2.10.11-1: Quality Measures Demonstrating Significant Improvements in Louisiana, 2016 to 2018

Performance Measure	HEDIS 2016	HEDIS 2017	HEDIS 2018	2017 Change	2018 Change
Childhood immunizations, combo 10	11.90%	14.81%	28.71%	↑2.91%	↑16.81%
Adult access to preventive/ambulatory health services	70.15%	77.57%	85.61%	↑7.42%	↑15.46%
Adolescent well-child visits	31.71%	42.82%	46.72%	↑11.11%	↑15.01%
Postpartum care	58.28%	63.08%	63.50%	↑4.80%	↑5.22%
Well-child visits 3 to 6 years	41.94%	53.94%	59.12%	↑12.00%	↑17.18%
WCC–body mass index (BMI) measurement	41.18%	42.59%	52.31%	↑1.41%	↑11.13%
Child and adolescent access to primary care (CAP) 12 to 24 months	76.58%	92.45%	93.77%	↑15.87%	↑17.19%
CAP 25 months to 6 years	68.04%	75.26%	81.27%	↑7.22%	↑13.23%
CAP 7 to 11 years	20.00%	76.22%	81.79%	↑56.22%	↑61.79%
CAP 12 to 19 years	50.00%	75.28%	81.46%	↑25.28%	↑31.46%
Comprehensive diabetes care eye exams	39.07%	47.02%	48.91%	↑7.95%	↑9.84%

Overall Quality Approach

As a National Committee for Quality Assurance (NCQA)-accredited organization, our innovative continuous quality improvement (CQI) approach encompasses an extensive array of activities to improve the experience of our enrollees and the care delivered by our providers. **We use an integrated and collaborative approach**, involving each department within Aetna; input from primary care providers (PCPs), specialists, and enrollees; and partnerships with organizations such as the Office of Public Health (OPH), Taking Aim at Cancer in Louisiana, March of Dimes, Well-Ahead School Health, the Louisiana Healthy Schools Collaborative, and other community resources.

Specific Strategies

We employ a comprehensive, multifaceted approach to identify and address unique characteristics of subpopulations for all measures in **Attachment G** in alignment with the **Louisiana Medicaid Quality Strategy**, including but not limited to quality measures #27, #35, #37, and #50. All of our quality improvement activities roll up to and are coordinated under our Quality Assessment and Performance Improvement (QAPI) program. All strategies related to quality measures #27, #35, #37, and #50 will include coordination with stakeholders and enrollee representation of the condition (new mother, cervical and colon cancer survivor, and individual with experience in overcoming alcohol and/or drug use) in our Enrollee Advisory and QAPI committees. We will highlight their stories in our enrollee newsletter as motivation and inspiration to our affected populations.

Childhood Immunization Status (#27)

Aetna ranked second of all managed care organizations (MCOs) in Louisiana for childhood immunization status (CIS) combination 10 vaccinations for HEDIS 2018. Our rates substantially improved from 11.9 percent in HEDIS 2016 to 28.7 percent in HEDIS 2018 secondary to coordinated upload of LINKS supplemental data, modification of our chase logic in the HEDIS data platform, extensive abstraction training, over-read during HEDIS audits, and local education at contracted federally qualified health centers (FQHCs). **Table 2.10.11-2** identifies our multimodality strategies and activities per Aetna functional area to continue our improvement trajectory as we expand our engagement of enrollees and providers.

Table 2.10.11-2: Specific Strategies to Address Childhood Immunization Status Quality Measure (#27)

Department	Strategies and Activities
Quality Management	• Enrollee outreach calls by a live person to schedule visits with the physician for wellness visits and immunizations • Hot Shots Kid's Club program for enrollees from birth to 2 years of age; the parent receives a certificate of completion and a special prize (e.g., puzzles, blocks, toy) is awarded to the child • Reminder mailers and text messages to the parent to complete the annual wellness visit and keep current in their immunizations • Baby book to new mothers detailing information about the well-baby visit schedule and immunization frequency • Enrollee education in newsletter articles on the importance of vaccinating their child and maintaining the immunization record • Health fairs and meetings in churches and schools promoting the need for childhood vaccinations • Pediatrician and PCPs assigned to the QAPI Committee to identify barriers faced by physicians • $20 gift card incentive for completion of annual wellness visits
Provider Relations	Provider Relations educates the pediatrician and provides them with the well-child HEDIS tips sheets and HEDIS value set billing codes and demonstrates how to access our web-based provider portal to review enrollee open gaps in care and current HEDIS rates.
Care Management (CM)	All pregnant mothers are enrolled into the CM Promise Program, which teaches them what to do after the baby is born, frequency of well-baby visits, and importance of vaccinations. We plan to have a home health agency conduct a well-baby visit and provide a welcome baby package and education.
Population Health Mgmt. (PHM)/CHW	CHWs outreach to new mothers to make certain they have the necessary skills, equipment, and food to keep their babies healthy. They reinforce the importance of vaccinations and assist in scheduling visits and transportation to the doctor's office or to OPH within their parish.

Department	Strategies and Activities
Health Care Equities/SDOH	The Health Care Equities department runs reports to identify health disparities and social determinant of health (SDOH) barriers and assists in planning interventions and/or initiatives for targeted areas and regions.
Value-based Payment (VBP)	VBP arrangements for completion of at least six wellness visits from birth to the age of 15 months; if completed, and immunizations are provided at each doctor's visit, the child will receive their full immunization series.

Cervical Cancer Screening (#35)

Aetna collaborates with the Cervical Cancer Free Louisiana initiative, Take Aim at Cancer in Louisiana, and the Louisiana Vaccination Coalition to increase awareness of cervical cancer prevention programs, increase rates of Pap testing and follow-up care, and improve human papillomavirus (HPV) vaccinations among adolescents for prevention. We promote collection of all sexually transmitted disease (STD) screenings during the annual Pap test, including HIV and hepatitis-C screenings, and work collaboratively with OPH to obtain administrative supplemental data. Utilizing continuous quality improvement (CQI) and the Plan-Do-Study-Act (PDSA) cycle, we identified an opportunity to increase vaccination rates and reduce over-screening for cervical cancer. **Aetna met the 90th percentile for HEDIS 2018 for non-recommended cervical screening rates at 3.30 percent and the 75th percentile at 30.17 percent for HPV screening.** Our cervical cancer screen rates showed strong improvement from 30.77 percent in HEDIS 2016 to 44.28 percent in HEDIS 2018. **Table 2.10.11-3** identifies our multimodality strategies and activities per Aetna functional area to produce continued improvement.

Table 2.10.11-3: Specific Strategies to Address Cervical Cancer Screening Quality Measure (35)

Department	Strategies and Activities
Quality Management	• Enrollee education includes reminder birthday flyers and annual cervical cancer newsletter article on the importance of getting their Pap test completed • Reminders in our enrollee handbook to get a Pap test done; text message reminders to enrollees who have not had screenings • Scheduled well-woman clinic days; enrollees receive an Aetna teal-colored T-shirt and/or free underwear gift card for participating • Health fairs around Mother's Day to promote women's health and preventive screenings with free Aetna Cares shirts • Assigned gynecologist QAPI Committee member to identify barriers physicians face • HEDIS education webinars and HEDIS liaison onsite provider education, to include prevention of over-testing, completion of STD screenings at the time of Pap, and point-of-care HIV and hepatitis-C lab finger-stick testing • $15 gift card given to women when they complete their Pap test; we also offer gift cards to a local merchandise store to purchase female underwear upon completion of their screening test
Enrollee Services	Every time an enrollee calls in, our Enrollee Services staff members receive an electronic alert to close any open gaps in care, including the need for a cervical cancer screening. Staff members schedule the appointment and arrange for transportation as needed.
Utilization Management (UM)	UM generates provider profile reports of under- or over-utilization of cervical cancer screening services. Specific providers receive education on evidence-based practices and required timeframes for completing Pap tests.
Provider Relations	Provider Relations staff members provide women's health tip sheets to PCPs and gynecologists including HEDIS value set billing codes; they collaborate with FQHCs to use evidence-based interventions to increase HPV vaccination and cervical cancer screenings.
Network Management	Recognizing a barrier of lack of female providers in rural areas, we plan to set up popup clinics and incentivize female practitioners to complete well-woman examinations within identified parishes.
Care Management	Electronic care management platform alerts prompt the CM of enrollees' needed tests and services; CM conducts education and assists in scheduling appointments, including arranging transportation as needed.
PHM/CHW	CORA, our innovative medical clinic on wheels, travels to high-density areas with low access; we collaborate with FQHCs and community health centers to make certain enrollees obtain their Pap and needed STD screening tests and discuss the importance of condom use in the prevention of STDs.

Department	Strategies and Activities
Health Care Equities/SDOH	We recognize African-American women in Louisiana are particularly at risk for cervical cancer, with a 25% higher incidence rate of cervical cancer compared to Caucasian women. We utilize data visualization software to map Louisiana cancer data to focus resources and identify areas for early detection interventions.
Value-based Payment	VBP arrangements with PCPs and gynecologists for enrollee completion of the cervical cancer screening test, with or without HPV. We incentivize providers for adherence to evidence-based guidelines and reduction of over-screening.

Colorectal Cancer Screening (#37)

Louisiana has the fourth-highest incidence and third-highest death (mortality) rate of colorectal cancer in the United States. We collaborate with Screen for Life: National Colorectal Cancer Action Campaign, the Louisiana Cancer Prevention and Control Programs, Taking Aim at Cancer in Louisiana, and the Office of Minority Health to address the needs of this population. **Table 2.10.1-4** identifies our multimodality strategies and activities per Aetna functional area.

Table 2.10.11-4: Specific Strategies to Address Colorectal Cancer Screening (#37)

Department	Strategies and Activities
Quality Management	• Education to enrollees 50 -75 years of age, including flyers on needed screening tests and how to obtain services, including flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double-contrast barium enema every 5 years, guaiac-based fecal occult blood test every year, and fecal immunochemical test (FIT) every year • Promote FIT-First and Flu-FIT campaigns to providers within the FQHC system to provide an annual, low-cost FIT test to enrollees • In collaboration with the provider, a FIT kit is mailed to the enrollee annually, with live call follow-up to remind them to send it back; the results are analyzed and sent to the provider for discussion of the results and recommended next steps if positive • Participating in health fairs, local community meetings, handing out free FIT kits, and promoting National Colorectal Cancer Awareness Month in March through our newsletter and mailers • HEDIS liaison onsite education and hand delivery of free FIT kits at provider offices for Aetna enrollee use • Adding a gastroenterologist to our QAPI Committee to identify the best ways to fight colon cancer • Incentive of $50 gift card for completion of colonoscopy • Partnership with National Colorectal Cancer Roundtable Initiative in 2019 to have more than 80% of targeted enrollees screened
Utilization Management	Utilize the Louisiana Colorectal Cancer Roundtable in recommending changes and additions of non-invasive DNA screening test every three years and computed tomography colonography every five years to the fee schedule to improve completion rates.
Provider Relations	Provider Relations staff members educate PCPs and gastroenterologists about recommended screening tests. FIT kits are hand-delivered free of charge to providers for Aetna enrollee use.
Network Management	Develop open access endoscopy systems centered on the enrollee's medical home at the FQHC as part of a committed medical neighborhood.
Care Management	CM conducts education and assists the enrollee to schedule their appointment, including transportation. CM enrolls enrollees with positive cancer diagnosis in the CM program and develops care plans.
PHM/ CHW	The PHM team outreaches to large provider groups, reviews HEDIS rates, and discusses closure of gaps, including demonstrations and discussions by vendors on FIT kits, importance of testing, and how to obtain free FIT kits. CHWs hand-deliver FIT kits and provide instruction within the home and recommend colonoscopy every 10 years.
Health Care Equities/SDOH	Use of data visualization software to map Louisiana cancer data to identify areas for early detection and incidence, targeting enrollees with screening rates and late-stage diagnosis rates less than 55%, with stratification by race and gender.
Value-based Payment	Develop competition among PCPs and gastroenterologists through VBP arrangements and collaborate with FQHCs to use evidence-based interventions

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (#50)

Aetna met the 2018 HEDIS 75th percentile for total initiation of Alcohol and Other Drugs (AOD) treatment, met the 50th percentile for 2018 HEDIS total engagement of AOD treatment, and exceeded the

2018 Quality Compass South Central rates and 2018 Quality Compass National rates for all performance indicators except for total engagement alcohol abuse and dependence. Within our enrollee population in Louisiana, there are 18,698 enrollees with a confirmed diagnosis of substance abuse disorder (opioid or other drug) and alcohol abuse disorder, equating to 16.47 percent of our total population. Aetna has identified opportunities to improve health outcomes to our enrollees due to the prevalence of alcohol, opioid, or other drug abuse or dependence as identified in **Table 2.10.11-5**.

Table 2.10.11-5: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment(#50)

Department	Strategies and Activities
Quality Management	• Qualified project manager hired with Lean Six Sigma Black Belt for oversight of initiation and engagement of alcohol and other drug abuse or dependence treatment (IET) performance improvement project • Enrollee flyers on treatment programs, CM and enrollee services, behavioral health (BH) telemedicine and teletherapy options, and available transportation • Enrollee newsletter articles on alcohol and drug use, tobacco cessation, and depression • Educational health fairs at homeless shelters with provision of resources, treating providers, telemedicine/teletherapy options, and availability of transportation vendors • Outreach to enrollees through interactive voice response (IVR)calls to encourage engagement in treatment, including a prompt for initiation of treatment if they have alcohol or drug use concerns • Enrollee focus surveys on reasons for non-participation • Completion of Screening, Brief Intervention and Referral to Treatment training by first-line providers (primary care, urgent care, obstetrics/gynecology [OB/GYN], pain management, and emergency department [ED] settings), and medication-assisted treatment (MAT) training workshops at no cost • Completion of hospital ED practitioner training of MAT certification for initiation of buprenorphine treatment • Maternal, Infant, and Early Childhood Home Visiting program for families impacted by opioid use and neonatal abstinence syndrome to decrease infant morbidity and mortality
Enrollee Services	The Enrollee Services team receives annual training on alcohol and substance abuse disorders, how to recognize them, available resources for enrollees, and how enrollees can self-refer to treatment
Pharmacy Management	• Enrollee restriction program to identify enrollees misusing, abusing and/or diverting controlled substances, in collaboration with LDH of restricting enrollee to a specific practitioner/pharmacy • Medication lockbox program • Restriction of amount prescribed and order frequency to prevent over-use and dependence • Promotion of use of oral lozenges, gum, and patches to enrollees for cessation of tobacco/nicotine use
Provider Relations	• HEDIS tip sheets on billing codes for IET measure • Handouts of available trainings to first-line providers and available treatment centers for enrollee referrals
Network Management	• BH telemedicine/teletherapy vendor contracts Quarterly reports of available outpatient services and treatment programs within each parish/region
Care Management	• CM assessments for depression screenings, American Society of Addiction Medicine (ASAM) evaluation, and support system • CM training annually on substance abuse disorders prevalence and treatment, motivational interviewing techniques, ASAM 6 evaluations, depression screening, stages of change, available substance abuse providers and resources, and tobacco cessation • Development of communication flowchart to map existing and enhanced communication processes between the hospital and UM and CM staff to ensure appropriate placement post-discharge
PHM/ CHW	• Use of peer support specialists with known prior history of drug/alcohol abuse who maintain sobriety • CHW enrollee home visits to encourage them to remain sober and continue with ongoing treatment • •Engagement of support system in treatment plan
Health Care Equities/SDOH	• Identified top coexisting conditions of tobacco/nicotine addiction, depression, and pain • Aetna interventions include a tobacco cessation program for this subpopulation; advising smokers and tobacco users to quit and discussing cessation medications and strategies

- Focused interventions on enrollee referral to alcohol reduction programs; medication management for enrollees prescribed antidepressant therapy coordinated by the CM department

Assessment, Incentives, and Evidence-based Interventions (2.10.11.2.1)

Aetna aligns financial incentives for providers and builds shared capacity to improve health care quality through data and collaboration. We integrate a range of data sources, systems, care sites, and domains to identify enrollee populations and subpopulations, understand their care needs, and operate programs designed to meet those needs. Enrollment data received from LDH is integrated with medical, pharmacy, utilization reports, provider profiling, and lab claims. Together, these data sources, as well as survey and SDOH information, make up the key data elements necessary to identify enrollee risks, and pinpoint subpopulations and opportunities to improve services. We maintain the integrity, accuracy, and consistency in all data reported, and we conduct ongoing validation audits.

Available Data Sources

Aetna's assessment of utilization rates and potential for improvement is supported by sophisticated technology, databases, and tools, as described in **Table 2.10.11-6.**

Table 2.10.11-6: Available Data Sources

Data Source Type	Description
Claims Management System	Collection of medical claims for inpatient, outpatient, professional, and transportation services
HEDIS NCQA-certified Data Platform	For generation of annual HEDIS and non-standard HEDIS rates, creation of monthly trend reports, and provider gap-in-care lists
Elli/HMS Data System	Population management solution to drive risk intelligence and care management activities by providing a 360-degree view of the enrollee's four-year claims use prior to their current enrollment
Hotspot Analytics	Identification of enrollee penetration by gender, race, ethnicity, culture, HEDIS and non-standard performance indicators, and by region and parish
PHM Platform	Identifies enrollee health risk factors and social determinant of health indicators; alerts care manager of gaps in services, ED disparity dashboard, and health equity dashboard
Surveys/Assessments	Annual and post-call surveys and enrollee and provider surveys to measure their satisfaction and experience with our programs and services, social determinants, and care needs
Medical Record Audits	Provider adherence to medical record, HEDIS standards, and clinical practice guidelines
Grievances and Appeals Data Platform	Collection and tracking of enrollee and provider satisfaction with the plan and services rendered
Quality Data Platform	Tracking of provider preventable conditions, health care-acquired conditions, and potential quality of care concerns

Assessment of Utilization Rates and Potential for Improvement

Understanding utilization rates is foundational to improving enrollee health outcomes, ensuring closing gaps in care, and decreasing health care costs. Aetna formally assesses utilization rates through our Quality Management/Utilization Management Committee (QM/UM), including review of historic and current performance data for over-utilization of low-value care and under-utilization of high-value care. We produce monthly reports showing aggregate performance rates, predictive rates, and encounter data to identify enrollees needing care or outreach. Hotspot drilled-down reports show enrollee characteristics, race, ethnicity, specific gaps by parish, SDOH, and other variables to identify need for intervention based on region. We use the PDSA cycle and perform multiple analyses, including root-cause analysis, flow and run charting, Ishikawa diagrams, Pareto charts, and the 5 Whys. We create driver diagrams to show areas for potential improvement and take actions as guided by our QM/UM.

As one example of our assessment and improvement of appropriate utilization, during a review of community psychiatric support and treatment (CPST) facilities and psychosocial rehabilitation skills (PSR) training utilization reports, we found a sharp incline in service utilization and identified increased claim submission. We reviewed the current process of payment and noted that no prior authorization was required. We modified the process to require prior authorization for CPST/PSR services and submitted suspicious claims to Fraud, Waste, and Abuse for investigation for fraud, waste, or abuse and potential recoupment of monies. As a result, we will recoup an estimated $1.758 million dollars in 2019.

Provider and Enrollee Incentives (2.10.11.2.2)

Aetna leads the Louisiana Medicaid market in provider incentives through VBP arrangements to incentivize delivery of the right care in the right place at the right time. From January 1 to September 30, 2018, 51 percent of Aetna's provider payments in Louisiana were tied to VBP programs. Eighty-five percent of Aetna PCPs take part in a VBP arrangement benefitting 76 percent of enrollees. We have VBP arrangements with many of the largest systems in Louisiana, such as Franciscan Missionaries of Our Lady, Willis-Knighton Health System, Baton Rouge General, Seaside Health Systems, Acadia Healthcare, and Brentwood Hospital. We continue to add VBP providers. We use a variety of models, including pay-for-quality, pay-for-performance and shared savings for PCPs, patient-centered medical homes, BH hospitals, BH outpatient clinics, and acute hospitals. Providers earn incentives for meeting benchmarks, including closing gaps in care, and achieving the HEDIS 50th percentile or equivalent.

We recognize the most successful **enrollee incentives** are those specifically targeted to the individual's preventive, acute, and chronic health care needs. **Incentives are an opportunity for us to engage our enrollees in their care, and communicate the importance of visits, tests, screenings, and healthy behaviors**. Aetna's Quality and Data Analytics teams assess the efficacy of our incentives in closing gaps in care in a fiscally responsible manner, making modifications based on outcomes. In addition to committing to all six optional value-added enrollee benefits, we incorporate enrollee incentives to support the delivery of the right care in the right place at the right time, including those described in **Table 2.10.11-7**.

Table 2.10.11-7: Examples of Enrollee Incentives Programs

Program	Incentive Offered	Highlights of Improvements
Healthy Moms and Babies	$25 first prenatal visit, $10 each consecutive visit, $50 postpartum visit (PPC), $50 one 17P shot, over-the-counter benefits of diaper rash ointment, and condoms	• PPC: NCQA 50th percentile • 17P: ↑Increase by 8.20 points in 1 year
Healthy Milestones, Ages 0-20	$20 gift card for completion of wellness visits	• W15: NCQA 50th percentile • W34: ↑ 17.18 points in 2 years, Adolescent Well Care: NCQA 50th percentile
Ted E. Bear, M.D. Club™, Ages 0-20	Participants receive $15 first visit, $20 second visit, and $30 third visit for meeting with their physician or registered dietician to discuss weight loss goals	• WCC BMI: ↑ 11.13 points in 2 years • Physical activity:↑ 11.90 points in 2 years • Nutrition: ↑ 13.39 points in 2 years
Cancer Screening Program	$15 for breast cancer screening (BCS) women, ages 21 and older, $15 for cervical cancer screening, women ages 21-64, $50 colon cancer screening, enrollees ages 50 and older	BCS: NCQA 50th percentile
Asthma Screening Program	$15 gift card for completion of a follow-up visit after asthma-related ED visit	Asthma Medication Ratio 51-64 ratio: ↑25 points in 1 year
Chlamydia Screening	$10 gift card for enrollees 16 to 24 years for chlamydia screening (CHL)	CHL: ↑2.23 points in 2 years

Program	Incentive Offered	Highlights of Improvements
Diabetes Program	$10 gift card retinal eye exam, $10 gift card A1C testing, over-the-counter benefit of blood pressure (BP) cuff, sharps containers, and diabetic socks	• A1C: ↑5.20 points in 2 years • A1C <8: ↑23.33 points in 2 years • Retinal Eye Exam: ↑9.84 points in 2 years

Evidence-based Interventions (2.10.11.2.3)

Our evidence-based interventions targeting super-utilizers (classified as enrollees with 6 or more ED visits in the past 12 months) and reducing potentially preventable events include but are not limited to Care Management ED Diversion, CVS Health MinuteClinics, Hospital ED Diversion, and the Ready Responders community-based program as described in **Table 2.10.11-8.**

Table 2.10.11-8: Examples of Aetna Evidence-based Interventions and Strategies

Intervention	Description
Care Management ED Diversion[1]	This program follows National Center for Biotechnology Information guidelines for reducing frequent visits to the ED. We generate a regular report from our analytics platform of non-emergent ED visits by enrollee. CM ED coordinators establish relationships with the enrollee and develop care plans to guide them to use outpatient services, urgent care centers, and telemedicine.
CVS Health MinuteClinics[2]	Walk-in clinics can significantly reduce adult enrollee presentations to the ED department by improving access to care. We have six CVS Health MinuteClinics in Louisiana: Baton Rouge (two), Covington, Metairie, New Orleans, and Slidell. CVS Health MinuteClinics offer treatment of minor illnesses and injuries, screenings, vaccinations, injections, and wellness and physical examinations on a no-appointment basis seven days a week. We are prepared, upon award and in collaboration with the State, to expand MinuteClinic access in at least one existing CVS store and as many as three existing CVS stores. We will assess the regions of the state where there are a high number of potentially preventable emergency room visits, feasibility of Clinic placement and overall timing, and staging for the new clinic(s).
Hospital ED Diversion Program[3]	Aetna entered into VBP arrangements with the Natchitoches Regional Medical Center (NRMC) and St. Martin Hospital to reduce enrollee preventable emergency visits. We collaborated with LDH and NRMC to develop a VBP model to address PCP access issues and high non-emergent ED use. NRMC will use patient navigators for post-visit ED visits to assess enrollee needs and provide education on symptom management, community resources, urgent care locations, and transportation. St. Martin is a hospital in Breaux Bridge experiencing PCP challenges due to being in a rural environment. They built an urgent care center to improve enrollee PCP access and reduce non-emergent ED usage. We created a VBP arrangement with them to align incentives to provide them higher reimbursement for the urgent care center and shared savings on ED utilization.
Ready Responders Community-Based Program[4]	The Ready Responders community-based program in the Orleans and Jefferson parishes uses community paramedics for the management of urgent, low-acuity illnesses and injuries. Using data reports, we identify at-risk enrollees with CM high-risk scores, frequent ED usage, multiple hospital admissions, and lack of physician engagement. Each enrollee receives a minimum of five scheduled visits a month by a paramedic with completion of a full assessment, screenings, and tests, and development of a self-management plan. Usual participation is 60 to 90 days with extension based on health status or lack of progress. Measures impacted include plan all-cause readmission, potentially preventable ED visits, potentially preventable readmission, and reduction in ambulatory care ED visits.

1 Soril, Leslie, Leggett, Laura, Lorenzetti, Diane, Noseworthy, Tom, Clement, Fiona, "Reducing Frequent Visits to the Emergency Department: A Systematic Review of Interventions," PLoS ONE, 10(4) (2015): accessed March 30, 2019; https://doi.org/10.1371/journal.pone.0123660.

[2] Morley, Claire, Unwin, Maria, Peterson, Gregory, Stankovich, Jim, and Kinsman Leigh, "Emergency department crowding: A systematic review of causes, consequences and solutions," PLoS ONE, 13(8) (2018): accessed March 30, 2019; https://www.ncbi.nlm.nih.gov/pubmed/30161242.

[3] Natale-Pereira, Ana, Enard, Kimberly, Nevarez, Lucinda, Jones, Lovell, "The Role of Patient Navigators in Eliminating Health Disparities," Cancer (117) 3541–3550 (2011): accessed March 25, 2019; https://doi.org/10.1002/cncr.26264.

[4] Bigham, Blair, Kennedy, Sioban, Drennan, Ian and Morrison, Laurie, "Expanding Paramedic Scope of Practice in the Community: A Systematic Review of the Literature," Journal of Prehospital Emergency Care, 17 (3), 361-372 (2013): accessed March 23, 2019; https://www.tandfonline.com/doi/abs/10.3109/10903127.2013.792890.

Quality Assessment and Performance Improvement Program (2.10.11.3)

Aetna has a well-established QAPI program to direct organization-wide initiatives for continuously improving the health status of covered populations in compliance with the **Model Contract Section 2.16** and **42 C.F.R. 438.330(a)(1)**. We integrate a governance model with responsibilities and accountabilities of leadership and the board of directors. Our chief medical officer (CMO) and quality management coordinator are accountable for the management of the QAPI program, in collaboration with enrollees and key stakeholders, locally and nationally.

Analyzing Gaps in Service Delivery and Quality of Care (2.10.11.3.1)

Aetna integrates a range of data sources, systems, care sites, and domains to identify enrollee populations and subpopulations, understand their care needs, and operate programs designed to meet those needs.

Analyzing Gaps in Delivery of Services

Identifying, analyzing, and closing gaps in delivery of services is a multifunctional endeavor including information technology (IT), QM, CM, PHM, VBP, and enrollee services. Our data collection for identifying, measuring, and reporting gaps in service delivery includes information from enrollee and provider surveys, HEDIS and LDH performance metrics, and administrative data. We analyze results in workgroups with key leaders, providers, and enrollees comparing prior years and target goals by conducting the 5 Whys, Ishikawa diagrams, barrier analysis, and root-cause analysis to find opportunities for action plans to address gaps; we regularly conduct reevaluations of key data points based on findings.

Our Enrollee Services closed 6,155 identified gaps in care in 2018 by acting on electronic alerts in every enrollee interaction to schedule needed screenings, tests, and wellness visits.

In 2018, we conducted more than 24 in-depth and focused analyses, including examination of information from provider satisfaction, enrollee experience with services including BH, and all LDH performance and HEDIS measures that fell below the 50th percentile, or did not improve at least 2 percent. We acted on gaps by entering into contract negotiations with mobile enrollee engagement service providers to complete annual wellness exams, BMI measurements, chlamydia screens, and diabetic care (including A1C testing and retinal eye exams) and hired HEDIS liaisons to perform onsite training for lower-performing providers.

Analyzing Gaps in Quality of Care

Aetna's integrated quality review process makes certain that issues involving quality of care or service, safety, complaints, or other areas of dissatisfaction are systematically evaluated, tracked, and entered into the quality data platform for investigation. Potential quality of care concerns (PQOCs) are reported by internal Aetna personnel, or received directly from an enrollee or care provider. Documentation is collected and reviewed to determine if a PQOC exists.

Aetna's National Quality Oversight Committee (QOC) evaluates PQOCs related to facilities and vendors to make a determination; if a quality of care issue is found, the committee recommends appropriate action. The QOC sends case files to the Aetna Credentialing and Performance Committee for tracking and trending. Actions taken by the committee include peer-to-peer discussion, practitioner corrective action plan, financial penalties, suspension of privileges, termination of contract, and other follow-up determined necessary by peer review. PQOC data is aggregated monthly and reported to the QM/UM and Quality Management Oversight Committee (QMOC). If the termination results in a material change in the network, Aetna supplies written notice to LDH and/or the Office of Behavioral Health.

Areas for Improved Management of Chronic and Selected Acute Diseases or Conditions

We deploy a proactive year-round **prevention and wellness** strategy that aligns with evidence-based guidelines to determine best practice in the management of preventive, acute, and/or chronic conditions. We use a risk stratification model that integrates demographic, claims/encounter data, and results from health appraisals to stratify enrollees to appropriate programs based on score, from lowest risk (population health management), medium and rising risk (supportive care management), and high risk (intensive care management). Our care management program emphasizes early identification of symptomology to prevent an enrollee's decline in medical or mental condition.

Our electronic care management platform is crafted to alert care managers with up-to-date, enrollee-needed services, tests, and screenings to identify enrollees at risk for hospitalization, at risk for a premature birth or complications during delivery, and/or those that may require counseling for an existing medical or BH condition. We can track and evaluate CM interventions through customized reports of gap closure rates for acute and/or chronic conditions by population/region, and drill down to each assigned care manager. CM, UM, QM, and our Louisiana CMO review these reports monthly for trends.

As one example, through our reviews we identified 8.91 percent of our enrollees were diagnosed with diabetes at a total cost of $21,441,430 in 2018. To improve the care and health outcomes of our enrollees with diabetes, our care managers completed training to become certified diabetes educators knowledgeable in the latest clinical trends/practices to work collaboratively with enrollees, providers, and community agencies in development of education programs, health fairs, and other focused activities. We also developed provider incentives through VBP arrangements as well as enrollee incentives to increase and support the enrollee level of self-management.

Reduction in Disparities in Health Outcomes

Aetna is committed to reducing disparities for underserved enrollees with the goal of health care equity for all enrollees. We do this by stratifying key quality measures to narrow any health care disparities that exist through use of data visualization software to map data to identify areas for early detection and incidence. Using the initial health needs assessment and data collected through our population health data platform and data visualization software, we identify enrollee characteristics by region and parish, age, sex, race/ethnicity distribution, language preferences, and cultural diversity to develop and apply specific interventions by lowest-performing regions and parishes, and respective lower-performing clinics where we need to focus more energy and resources.

For each region, parish, and clinic, we set annual goals for improvement based on prior performance in comparison to all other clinics within their community, with financial incentives defined for reaching goals. The VBP, PHM, QM, and Provider Services teams coordinate their work with clinic managers and providers to tailor interventions based on their unique population and organizational structure. Our fully integrated, locally based UM/CM model promotes proactive and chronic care management visits at low-performing clinics within each parish. We promote rural community use of our mobile mammogram and lab services, telemedicine, and teletherapy options to those underserved populations.

Using geo-accessibility software, we can identify our practitioner availability by parish/region, race, and gender. For parishes/regions identified with enrollee access issues, we will provide incentives to practitioners to participate in popup clinics and work with FQHCs to host clinic days and have those specialists come in during normal business hours, extended hours, and on weekends. We will enhance reimbursement for those specialists who would agree to travel to underserved areas to practice one to two days per month. For example, we identified the need for female practitioners to conduct cervical cancer screenings in Region 3 Saint Charles Parish, Region 4 Evangeline Parish, Region 6 Avoyelles, Concordia, La Salle, and Rapides parishes, Region 7 Red River and Natchitoches parishes, and Region 8 Caldwell,

Lincoln, and Morehouse parishes. As such, we will contract with female practitioners to be available for clinic days to our female population within each region.

Identifying Underlying Reasons for Variations in Provision of Care (2.10.11.3.2)

In identifying reasons for variations in provision of care and evaluating practice variation, we assess the effectiveness of care rendered, adherence to evidence-based guidelines, treatment options chosen, and frequency of use of clinical activities as it relates to the capacity of our health care system, such as doctor visits, diagnostic tests, and hospital admissions. Inappropriate variation occurs when non-evidence-based care is provided, or the care lacks wide acceptance, and the high level of variation cannot be supported on a quality or outcomes basis, which can lead to disparate outcomes for enrollees, higher utilization, costs, and waste. We analyze data reports, provider patterns of over-and-under utilization of services, regional and provider demographic variations, complaints and appeals, quality of care events, and results of our onsite medical record audits to identify variation in care and low-performing practices. Our focus is to ensure enrollees get the right care, at the right time, and at the right place.

In 2017, Aetna implemented a national project across all markets to improve breast-screening rates and optimized outreach to enrollees to gain a better understanding of their motivation and barriers to care, including being too far, too sick, or too busy. We also tested the effectiveness of different types of messages (‘do it for yourself’ and ‘do it for your family’). A machine learning model was used to predict correctly 93 percent of the time which enrollees would receive or not receive a mammogram, and this informed our tests of different messages and outreach channels used. The recipients of the different outreach efforts showed breast cancer screening rates 28 percent higher than a randomized control group. In Louisiana, we also identified challenges of enrollee knowledge deficit and access to service issues. We reprioritized our live calls, emails and IVRs, and contracted with Louisiana State University to enhance mobile mammogram services with extended clinic hours to rural communities to the subset of enrollees most likely to not complete their screenings. Aetna ranked second in the LDH amongst current MCOs, and we met the NCQA 50th percentile at 58.21 percent.

Implementing Improvement Strategies Based on Analytical Findings (2.10.11.3.3)

All of the analytical findings gathered through the two functions described previously are discussed and addressed through our QMOC and QM/UM committees. During committee review, we establish a workgroup with an assigned project manager and/or champion to oversee the project, with key business leads, community partners, stakeholders, and enrollee participation. We conduct brainstorming sessions to identify areas of improvement and select multiple interventions to address identified gaps and generate action plans, which include project goal, measurement, and impact of change. We examine any social determinants or disparity prevalence and cost-ratios, incorporating outreach activities and care management strategies to engage enrollees with chronic and acute diseases.

We check progress using tools like Gantt charts and drive accountability through routine meetings and setting target dates for task completion. We use pilot studies first to evaluate feasibility, time, cost, and adverse variations to the proposed action plan. Data and information are collected, and results of the implementation are assessed and interpreted by reviewing measurement results to the goal, demonstrating the success or failure of the project. This provides valuable insight and cost feasibility of the project to make certain the change will provide desired results. If there is a positive impact, we implement network-wide change collaboratively within our internal departments, external vendors, and stakeholders.

One example of Aetna’s implementation of improvement strategies based on analytical findings is our well-child visit initiative. Recognizing a gap in care for our child enrollees not receiving well-child visits, we determined that underlying root causes included enrollee and provider knowledge deficits and inadequate outreach and engagement of enrollees and providers regarding the importance of visits and

corresponding HEDIS measures as well as access challenges. We changed our process to increase education, outreach, and engagement. We added a $20 incentive message to our birthday mailers, sent text message reminders, and started IVR call reminders. We tripled the content of our enrollee newsletter to focus on prevention and wellness. Our Enrollee Services staff members attended a four-hour intensive HEDIS training, and successfully closed 6,155 gaps in care within a one-year period. We developed additional VBP arrangements with providers; our PHM team followed up monthly to ensure they achieved the goal of the NCQA 50th percentile. Within a two-year period, we saw a significant improvement in parent engagement and participation in self-management of their child's care as identified in **Table 2.10.11-9**.

Table 2.10.11-9: Improvement in Performance Measures HEDIS 2016 to 2018

Performance Measures	HEDIS 2016	HEDIS 2017	HEDIS 2018	LDH Goal	Rate Change
Adolescent Well Care	31.71%	42.82%	46.72%	40.69%	15.01%
Well-child 15 months (6 visits)	N/A	53.94%	63.99%	62.06%	10.05%
Well-child 3 to 6years	41.94%	53.94%	59.12%	72.45%	17.18%

Data-driven Clinical Initiative in the Past 24 Months

Within the past 24 months across all nine regions of Louisiana, we implemented a data-driven clinical initiative targeting the administration of 17P, a progesterone medicine to prevent preterm birth. We examined gaps from data collected via claims, stratified it by subpopulation (race/ethnicity/region), and examined enrollee social-economic issues (e.g., childcare, transportation, distance to provider) to look for health disparities. We completed flow charting, run charts, Ishikawa diagrams, Pareto charts, and 5 Whys, and focused enrollee surveys to identify reasons for variations in provision of care and interventions needed. We implemented a strategic plan to increase the total number of pregnant enrollees receiving at least one inoculation of 17P between the 16th and 24th weeks of pregnancy. Despite our outreach attempts, we were initially unsuccessful in improving our rates. We then conducted an enrollee survey to better understand the underlying reasons for variations in provision of care and found a high percentage of African-American enrollees considered high-risk for preterm births that lacked transportation and were without childcare for children at home. We identified a breakdown in the referral process and communication flow between CM team and the treating physician, as well as CM knowledge deficits.

We accomplished an increase of 8.20 percentage points from 10.81 percent in HEDIS 2017 to 19.01 percent in the HEDIS 2018 measure for Initiation of Injectable Progesterone for Preterm Birth Prevention (PTB) through the following actions: modification of outreach material targeted to African-American females, changes to our referral process to include an eligibility list being faxed directly to the home health agency every two weeks, 17P inoculation provided by specialized home health agency in coordination with the ordering physician, and addition of a new transportation vendor which allowed for parent-child transport. Care management training was conducted to ensure provision of 17P education to enrollees identified at high risk for delivery of a preterm birth, including newsletters, baby books, flyers, mailers, phone calls, and text messages. Care managers receive a weekly list of enrollees at risk for high-risk pregnancies. Using this list, they conduct five outreach attempts to enroll them into the program. The benefits of progesterone were fully explained to the enrollee during every contact and they were made aware of availability of home health services and transportation benefits. Care managers, home health agency representatives, and the treating physician meet biweekly to identify gaps and coordinate care. Due to the added education and awareness of this initiative, we also realized improvements in screenings during pregnancy including chlamydia (14 percent), HIV (10 percent), and syphilis (57 percent).

Quality Management and Quality Improvement Approach (2.10.11.4)

Aetna clearly defines quality management and quality improvement (QM/QI) guiding principles, structures, and processes and assigns responsibility to the right individuals for implementation and monitoring through our QAPI program in compliance with all applicable provisions of **42 C.F.R. Part 438**.

QAPI Plan Description, Goals, Quality Committees, and Schedule (2.10.11.4.1)

Aetna's QAPI program achieves the following primary goals:

- Implement a QM/QI program that effectively promotes and builds quality into the organizational structure and processes throughout the plan to meet and surpass LDH target goals
- Conduct continuous monitoring and assessment of the physical and behavioral health services provided throughout our network to make certain they adhere to evidence-based practice standards
- Improve under-utilization of high-value services and over-utilization of low-value services
- Identify and analyze opportunities for improvement with implementation of action plan as indicated
- Set expectations around safety with enrollee-centered rights and choices
- Outline our Provider Support Plan to include how Aetna will support activities related to improvement in specific outcomes, including data sharing and metrics

QM/QI activities that support the goals and objectives of the QAPI program are coordinated on an annual basis through our structured framework described in **Table 2.10.11-10.**

Table 2.10.11-10: QAPI Program Components

QAPI Components	Description
QAPI Program Description	Outlines the strategic plan and goals to meet or exceed the LDH's quality strategy, quality plan, and other requirements. We modify our QAPI Program Description annually based on our findings, changes to contract, NCQA accreditation standards, and LDH and federal guidelines.
QAPI Work Plan	A Louisiana-specific activity-tracking tool reviewed quarterly at the QMOC and QM/UM meetings to facilitate achievement of goals identified internally by LDH, enrollees, and providers. It is a dynamic document with specific interventions and activities to drive the implementation of clinical and service quality improvement outcomes related to contractual performance measures, HEDIS measures, performance improvement projects, medical and treatment record audits, enrollee and provider surveys, and NCQA standards. It names staff members responsible for each activity and the periods for completion. Continuous progress is reflected, and activities, barriers, and outcomes are measured, trended, and compared to defined targets or the industry benchmarks, with the most stringent measure being used.
QAPI Program Evaluation	An annual evaluation of the QAPI program assesses the overall effectiveness of our QI program and reflects an assessment of completed and ongoing activities in the QAPI Work Plan. It addresses barriers from the previous year and provides recommended interventions for overcoming issues and barriers identified. Opportunities for improvement identified in the evaluation or articulated by LDH regulators, or from provider or enrollee feedback, drive the development of our goals and objectives.

Quality Committees

A formal committee structure allows for oversight of the QAPI program and for the flow of information to and from the board of directors and LDH. Formal committees, subcommittees, and ad hoc work groups advise and guide the QAPI process. The committees foster collaborative partnerships and integrate provider and enrollee feedback into development of operational policies and our decision-making. We encourage external stakeholders and community agencies to take part in our committees, presenting their programs and initiatives as topics for discussion. We incorporate information gleaned from our participation in LDH Quality Committee and activities into our committee discussions and goals.

Board of Directors

The board of directors has ultimate accountability for the QAPI program and related processes, activities, and systems, including the QAPI program description and any subsequent revisions, annual evaluation of the previous year QAPI activities, summary reports, data, outcomes of studies, and credentialing activities.

Quality Management Oversight Bodies and Schedule of QM Activities

Our QAPI process is guided by committees, subcommittees, and ad hoc work groups as outlined in **Table 2.10.11-11.** All meetings are recorded and minutes or summaries (based on confidentiality restrictions) are provided to the QMOC and LDH as requested. Meeting frequency is increased as needed.

Table 2.10.11-11: QAPI Committees and Schedule of Activities

QAPI Committee	Description	Meeting Frequency
Quality Management Oversight Committee (QMOC) – fulfills requirements of QAPI Committee	Chaired by the CMO with cross-functional representation, as well as medical and BH providers, enrollees, and LDH; integrates QM and performance improvement activities throughout the plan and provider network; provides executive oversight of the QAPI program and makes recommendations to the board of directors	Quarterly
Quality Management/Utilization Management Committee (QM/UM Committee)	Chaired by the CMO with active participation from the behavioral health medical director with cross-functional representation and network providers, including PCPs/medical homes, specialists, pediatrics, OB/GYNs, and BH; advises and makes recommendations regarding the quality of care and service provided to enrollees	Quarterly
Delegation Oversight Committee	Chaired by the director/manager of network management with cross-functional representation; advises the QMOC about delegated relationships	Quarterly
Committee for Service Improvement	Chaired by the director of operations with cross-functional representation; advises the QMOC and/or management about enrollee and provider issues	Quarterly
Member Advisory Committee (MAC) – fulfills requirements of Enrollee Advisory Council	Chaired by the manager of enrollee services as delegated by the chief executive officer with cross-functional representation and enrollee representatives; provides feedback regarding strategies for improving enrollee care and services including health education and other enrollee materials	Quarterly
Compliance Committee	Chaired by the compliance officer with cross-functional representation; reviews, monitors, and assesses the effectiveness of the compliance plan	Quarterly
Policy and Procedure Committee	Chaired by the compliance officer with cross-functional representation; development, implementation, approval, and communication of all policies	Quarterly
Grievance and Appeals (G&A) Committee	Chaired by the G&A manager, with cross-functional representation and at least one enrollee advocate; reviews trends, resolves issues, and renders decisions	Quarterly
Pharmacy and Therapeutics Committee	Chaired by the director of pharmacy with participation from the CMO, clinical liaison, BH prescribers, Aetna Medicaid organization medical directors, and network pharmacists and physicians; responsible for oversight of drug over- and under-utilization patterns and formulary.	Quarterly
Provider Advisory Council (new)	Will be comprised of enrollees and providers; provides expert council to the plan to improve access, provider satisfaction, and assistance with connecting with specialty providers; reviews satisfaction survey results and provides feedback and input on policies and programs	Quarterly
Hospital Advisory Committee (new)	Will consist of medical and BH hospitals, clinics, health centers, and key advocacy groups; provides feedback on new quality improvement initiatives and insight into local population health concerns	Monthly

Our QAPI program is also supported by national Aetna committees including the National Drug Utilization Review, Credentialing and Performance, Practitioner Appeal, and the National Quality Oversight Committee. Key plan staff members take part in these committees to represent Louisiana and incorporate the best practices found nationally across markets into our local initiatives.

Organizational Chart of QAPI Program (2.10.11.4.2)

Figure 2.10.11-1 depicts the organizational chart of our QAPI program reporting to our board of directors.

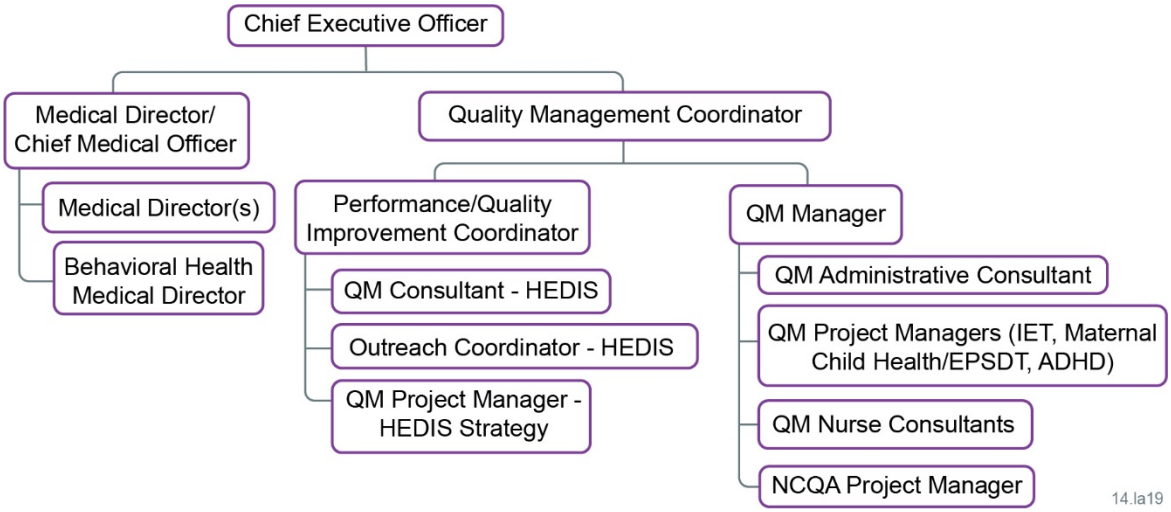

Figure 2.10.11-1: Quality Management Organizational Chart

Aetna is committed to significant investment in Quality staff to meet the goals of the Triple Aim.

As led by our medical director/CMO and our quality management coordinator, our QM program staff members described in **Table 2.10.11-12** are dedicated to maximizing health outcomes with additional support and guidance from the Aetna national team.

Table 2.10.11-12: QM Staff and Responsibilities

Title	Responsibilities
Medical Director/Chief Medical Officer	Full-time board-certified physician with current unencumbered license with at least three years of medical specialty training and five years post-training in providing clinical services; leads and implements the clinical direction for the organization and QAPI program
Medical Directors (BH and non-BH)	Full-time board-certified physicians with current unencumbered license with at least three years of medical specialty training and five years post-training; act as administrators providing oversight to the medical and BH programs and a minimum of one psychiatrist
Quality Management Coordinator (Quality Director)	Full-time, Louisiana-licensed registered nurse (RN), physician, physician assistant (PA), or certified professional in healthcare quality (CPHQ); responsible for developing, implementing, and monitoring quality management, performance improvement projects and initiatives, population health, prevention and wellness programs, and policies and procedures
Performance/Quality Improvement Coordinator	Full-time certified professional to focus organization efforts on improving HEDIS performance measures; manages all aspects of the annual HEDIS submission
QM Project Manager–HEDIS Strategy	Full-time CPHQ or Lean Six Sigma-certified project manager providing oversight of all aspects of the provider and enrollee marketing materials, budget accountability, and implementation
QM Consultants (4)	Full-time associates collect medical records from provider offices; performs administrative and office support activities related to QM essential business functions
NCQA Project Manager	Full-time CPHQ or Lean-Six Sigma certified project manager responsible for oversight of accreditation activities and compliance, including maintaining an accreditation work plan, oversight of workgroups, and conducting mock audits
QM Nurse Consultants (2)	Full-time QM nurse consultants to oversee surveys and delegation oversight

Title	Responsibilities
Quality Manager	Full-time Louisiana-licensed RN or has master's degree in health care administration with minimum of five years' QI experience; responsible for staff oversight; performs professional administrative duties related to NCQA process and compliance to contractual obligations
IET Performance Improvement Project (PIP) Manager	Full-time licensed mental health professional, Green Belt-preferred, that ensures enrollee receipt of alcohol and substance abuse services, arranging provider trainings, and promoting enrollee engagement in treatment and preventive health strategies
Maternal Child Health/EPSDT Coordinator	Full-time Louisiana licensed RN, physician, or PA, or with a master's degree in public health or health care administration; coordinates maternal/child health and EPSDT services, promoting preventive health strategies
Attention-Deficit/Hyperactivity Disorder (ADHD) PIP Manager	Full-time project manager with minimum three years of QI experience, preferred Yellow Belt Lean Six Sigma certification; ensures project management of ADHD services, promoting preventive health strategies, and identifying and coordinating assistance
Outreach Coordinator – HEDIS (5)	Full-time HEDIS abstractor professional coder assists in the review of medical records to highlight HEDIS and medical record review opportunities for the medical staff

HEDIS Performance Measurement and Reporting (2.10.11.4.3)

Aetna has proven capacity to participate in the LDH's annual HEDIS and non-HEDIS performance measurement and reporting initiative as evidenced by our timely submission in Louisiana to NCQA and State regulatory agencies for HEDIS 2016, 2017, and 2018. At the close of each review cycle, our contracted NCQA auditor validates our HEDIS data files. We validate the accuracy of our reports in collaboration with the national team to ensure no data integrity issues. We fully cooperate with external review organizations. **Table 2.10.11-13** describes our local and national resources committed to performance measurement, reporting, and data-driven initiatives.

Table 2.10.11-13: Resources Dedicated to HEDIS and Other Measurement and Data-driven Initiatives

Resource	Description
Aetna Medicaid Organization IT Team	Identifies, connects, manages, and verifies all data sources used for HEDIS measurement, and is comprised of over 200 individuals, with over 20 associates dedicated to data management
Shared Services Informatics Team	Performs HEDIS system oversight, data management, and quality reporting, as well as provider and value-based reporting that includes both HEDIS and utilization measures
Aetna Medicaid Organization QM Team	Support the Louisiana team by reviewing HEDIS trends, developing and evaluating new approaches to provider and enrollee engagement, and supporting scalable programs to test approaches through our work with industry-leading technology, analytics, software, and service companies (e.g., Elli)
Utilization Management	Monitors performance metrics, trends in outpatient, inpatient, and ED utilization patterns, and generates provider profile reports of over-/under-utilization
Care Management	Engages enrollees for closure of HEDIS and non-HEDIS performance measures, and coordinates care
Provider Services	Facilitates interactions between providers and Aetna and coordinates the ongoing HEDIS and non-HEDIS education of network providers and provision of gap-in-care reports
Value-based Payment	VBP arrangements incentivize providers to engage fully with the enrollee, provide needed services, and prevent over-/under-utilization of services
Population Health Management	The PHM team outreaches to large provider groups, reviews HEDIS rates, and discusses closure of gaps using our electronic population health management platform. Community health workers and peer support specialists provide enrollee education and link them to the services, tests, and screenings needed.

Recent Successful Quality Improvement Activity Example (2.10.11.4.4)

Childhood obesity is an epidemic in Louisiana with approximately one in three children being overweight or obese, leading to serious physical and behavioral health repercussions including diabetes, hypertension, anxiety, and depression. Our recent successful quality improvement activity is the **Ted E. Bear, M.D.**

Club initiative, aimed at improving health outcomes of our child and adolescent enrollees through completion of well-child visits with their PCPs, including a BMI measurement and physical and nutritional counseling. Our Louisiana Care Management team outreaches directly to enrollees with a BMI above the 85th percentile for participation and communicates directly to the practitioner, nutritionist, and school partner to promote improved health status. The enrollee receives a $15 gift card for completion of their first visit with their doctor or registered dietician, a $25 gift card for their second visit, and a $30 gift card third for their visit. Through this initiative, we have seen a significant improvement year-to-year for HEDIS measurements as outlined in **Table 2.10.11-14.**

Table 2.10.11-14: Results Achieved from Ted E. Bear, M.D. Club Quality Improvement Activity

Measure	HEDIS 2016	HEDIS 2017	HEDIS 2018	Improvement 2016 to 2018
Weight assessment counseling (WCC): BMI total	41.18%	42.59%	52.31%	11.13 points
WCC: physical activity total	27.76%	23.61%	39.66%	11.90 points
WCC: nutrition total	39.53%	34.26%	49.39%	9.86 points
Adolescent Well Care	31.71%	42.82%	46.72%	15.01 points/6.03 points above 50th percentile

Aetna also took part in 76 local health and wellness fairs throughout 2018 to provide screenings, physical activity demonstrations, cooking and nutrition education demonstrations, gift giveaways, special door prizes, and a healthy meal and/or snack. To promote healthy eating and access to healthy food options, we identified locations to plant six new community gardens in identified food deserts throughout South Baton Rouge. In partnership with the Baton Rouge Garden Alliance, our programming consists of education from a licensed horticulturalist with 10 years of sustainable community and school garden implementation. Children will be taught how to plant and grow fruits and vegetables, as well as how to prepare healthy meals using their ingredients with recipe cards we distribute at the site.

Quality Improvement Plans and Projects (2.10.11.4.5)

Continuous quality improvement is core to the success of Aetna's quality programs. Aetna identifies quality improvement plans and projects to put in place from the outcomes of our current initiatives, annual evaluations, HEDIS measures, enrollee and provider surveys, and internal monitoring results. Our ongoing monitoring includes provider profiling, utilization management reviews, gaps-in-care reports, trends, audit findings, annual assessments, and focus groups to look for opportunities to improve quality outcomes. We conduct a root-cause analysis and develop data-driven initiatives to address identified opportunities for improvement.

Potential Topics

We identified hypertension, diabetes, and cardiovascular disease as potential topics for quality improvement plans and projects—23.26 percent of our enrollees have a diagnosis of hypertension with a total cost of $37,280,292 in 2017, and 8.91 percent of our enrollees are diagnosed with diabetes with a cost of $21,441,430. Coronary artery disease affects 9.94 percent of our enrollees with a cost of $10,528,328. Through our root-cause analyses, we identified the following contributing factors: lack of enrollee engagement in self-management plans and CM programs, enrollee knowledge deficits, ineffective medication protocols, practitioner non-adherence to evidence-based guidelines, racial disparities, and lack of PCP or CM follow-up to make certain the enrollee is adherent to their treatment plan.

Monitoring of Implementation and Outcomes

Aetna monitors implementation and outcomes of all our quality improvement plans through our QAPI program. Each project has an assigned project manager to implement a project plan to identify goals, project tasks, defined roles and responsibilities, and outline budget and necessary resources needed.

Hypertension

Our plan is to implement a hypertension quality improvement project as guided by the American College of Cardiology 2017 guideline[5] for the prevention, detection, evaluation, and management of high blood pressure (BP) in adults. We will conduct a pilot study to evaluate feasibility, time, cost, and challenges/barriers, and improve upon the study design prior to full-scale project implementation. For our enrollees diagnosed with hypertension, we found 48.72 percent of those diagnosed are African American. Based on this prevalence, our focus is African-American females with BP rates greater than 140/90. Our data software will provide an accurate listing by parish of numerator noncompliant enrollees by race and ethnicity, and by practitioner. We will outreach and partner with each provider and get their agreement to participate in the study. Each enrollee identified will be sent a letter requesting their participation, including a special offer of a free pedicure or manicure upon each visit.

Meeting the enrollee where they are, we will co-locate at a local nail salon weekly, manned by a pharmacist, care manager, and CHW. The enrollee will be provided with a BP kit and education on how to monitor their BP at home, take their weight daily, modify their diet, and take medications as prescribed. The pharmacist will review the medication for efficacy and coordinate medication changes with their doctor. The enrollee will be scheduled to return every three to four weeks and taught to record their weight and BP in a tracking log, which they must bring at their next visit. We will also educate the aestheticians to provide ongoing education to enrollees between visits, and the CHW and care manager will follow up with the enrollee to validate their understanding of education provided.

For outcome monitoring, we will use HEDIS controlling BP technical specifications and value set codes to derive our eligible subpopulation and setting target goals. Baseline data will be collected, and all interactions will be documented in our data platform. We will calculate the current HEDIS controlling BP rate for the selected enrollees and compare it to the BP results calculated at each visit, for a time period not to exceed four months. We derive the final rate for this subset population and the effectiveness of our project over time. The project manager will conduct weekly meetings with the team to discuss progress.

Diabetes

Diabetes ranked second for cost utilization for our enrollees in 2017. Upon review of our HEDIS measures, we identified that although our A1C testing, A1C control less than 8.0, and retinal eye exam were increasing over a three-year trend from 2016-2018, (A1C by 7.82 percent, A1C control rate by 17.07 percent, and retinal eye exam 9.04 percent), the majority of our enrollees were not self-managing their blood sugar. We conducted an Ishikawa analysis to identify the challenges our enrollees faced. The major challenges were poverty, transportation issues, knowledge deficit, and access to care especially in rural areas. Our plan is to increase compliance with HbA1c testing for enrollees with diabetes targeting parishes identified with the highest propensity of adults with elevated HbA1c. Aetna is partnering with diagnostic labs/mobile services to schedule home visits to take their BP, height, and weight; draw their blood for A1C testing; obtain a urine sample; and perform a retinal eye exam that will be read by a board-certified ophthalmologist. These services are offered at no cost to the enrollee during the daytime, evening hours, or weekends. All results are sent to the enrollee's doctor and reviewed by our Care Management team. The team discusses the results with the enrollee to establish a self-management plan. Additionally, we utilize remote patient monitoring for diabetic patients as well for the rural communities to increase their compliance and improved health. We will utilize the CVS Health pharmacy bag messaging to provide reminders to enrollees. We will monitor to ensure enrollees with A1C control less

[5] Whelton Paul and Carey, Robert, "Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines," Journal of the American College of Cardiology, 71 (19) 127-248 (2018): accessed March 30, 2019; DOI: 10.1016/j.jacc.2017.11.006.

than 8.0 receive an A1C test every six months, and we will offer gift cards to the enrollee for their participation. Our CHWs and care managers will conduct home visits to provide education about diet and exercise and check their progress with their self-management plans. We will track effectiveness in closing gaps in care monthly, and assess our HEDIS final rates for A1C testing, A1C control less than 8.0, retinal eye exam, and nephropathy screening annually.

Cardiovascular Disease/Tobacco Cessation

Using claims data, we identified that nicotine dependence ranked as the number one primary diagnosis among our enrollees with alcohol and substance abuse disorders. Upon review of Adult CAHPS survey summary rates, we identified a three-year downward trend from 74.26 percent in 2016, to 68.83 percent in 2017, and to 68.70 percent in 2018 for how often medication was recommended or discussed by a provider. Our plan is to implement a tobacco cessation project to improve provider adherence to evidence-based guidelines, increase education, and decrease enrollee cigarette use in alignment with the Louisiana Cancer Prevention program. We will partner with community resources including FQHCs and school-based health centers to promote engagement with Quitline, the Smoking Cessation Trust, and the Tobacco Control Initiative programs. These programs offer free counseling, cessation medication, online support and tools, telephone support, individual and group counseling sessions, and specialized services for pregnant enrollees. Our CHWs and care managers will visit the enrollee in their home or work to assess their progress. They will deliver cessation medication to the visit and link them to local resources for support, including churches and recreational centers. They will communicate openly to the doctor, with enrollee permission, about the successes and challenges faced and work together in development of the enrollee cessation plan. We will monitor outcomes through CAHPS rates and by aggregate data obtained of the total number of enrollees successfully completing a tobacco cessation program as reported by CM, CHWs, and Enrollee Services.

Clinical Practice Guidelines (2.10.11.5)

Aetna is committed to supporting providers in the adoption of clinical practice guidelines (CPGs) to implement interventions to provide the right care, in the right place, at the right time.

List of CPGs Relevant to the LDH's Medicaid Population and Sample CPG

Our comprehensive list of medical, behavioral, and preventive CPGs relevant to LDH's Medicaid population are highlighted in **Table 2.10.11-15.** They are available at any time on our website at www.aetnabetterhealth.com/louisiana/providers/guidelines. **Attachment E** contains our chosen sample of the attention-deficit disorder CPG for review.

Table 2.10.11-15: Aetna Louisiana CPGs

CPG Category	CPG Topic
Medical Health	Asthma, chronic kidney disease, chronic obstructive pulmonary disease, chronic pain, contraceptive practice, coronary artery disease, diabetes, heart failure, hepatitis C, HIV/AIDS, hypertension, low back pain, sickle cell disease
Behavioral Health	Acute and post-traumatic stress disorders, attention-deficit disorder, alcohol use, bipolar disorder, trauma, disruptive behavior, eating disorders, major depressive disorder, obsessive-compulsive disorder, general anxiety disorder and panic, schizophrenia, substance use disorders, and suicidal behaviors
Preventive Health	U.S. Preventive Services Task Force A and B recommendations, vaccine recommendations, pediatric periodicity schedule, vaccines for pregnant women

Developing and Disseminating CPGs (2.10.11.5.1)

Aetna uses national policies and processes for adopting and updating CPGs and preventive health guidelines from recognized sources and in compliance with **42 CFR 438.236** and NCQA standards. We collaborate with LDH, other Louisiana MCOs, and providers to select physical, behavioral, and

preventive CPGs to be used across the system to decrease provider administrative burden in compliance with **Model Contract Section 2.12.1.4**. Our quality management coordinator brings all guidelines to our QM/UM committee for review, input, and adoption. Modifications to the guidelines are made by consensus with each CPG being formally approved by our QMOC.

We support **widespread dissemination of CPGs to our providers** through our website, web portal, provider manual, onsite visits, trainings, newsletter, and fax blasts. Providers receive a customized orientation within 30 days of the provider's effective date with the plan with ongoing training on best practices and CPGs. Our Provider Services liaisons conduct onsite education, including hand-delivering of select CPGs. From October 2018 through January 2019, our Provider Services liaisons and ADHD PIP project manager provided education and supplied the ADHD CPG toolkit to 352 targeted providers throughout all 9 regions. We emailed the availability of guidelines to all providers and will continue to outreach until we reach a closure rate of 100 percent. Our CPGs are available to our **enrollees** at any time through our website; we regularly analyze the web traffic data to make certain they are beings accessed. We recognize CPGs are written in academic, scientific language that may not be easily understood. We take the key messages out of the CPG (e.g., screening schedules, symptoms, and treatment options) and push them out through our mobile app, handbook, newsletter, on CVS Health pharmacy bag messaging, and through texts from Aetna. We have staff available to provide explanation to the enrollee in a culturally and linguistically appropriate manner.

Incorporating Evidence and Opinions into CPGs (2.10.11.5.2)

We select nationally recognized CPGs based on scientific evidence, national standards, and expert consensus. We encourage provider and enrollee participation in the selection and adoption of the CPGs through our QM/UM and QMOC committees, as well as through our regular regional Joint Operating Committees. If we do not have a corresponding specialist to the topic within our network, we obtain the opinion of an expert out of network. We make modifications to the guidelines to incorporate input from providers and enrollees as approved through QM/UM and QMOC.

Evaluation of Adherence to CPGs (2.10.11.5.3)

We check adherence to CPGs through corresponding clinical indicators and performance measures to examine enrollee behavior and provider habits for acute and chronic conditions, including but not limited to comprehensive diabetes care, COPD pharmacotherapy management and admission rates, well-child visits, attention-deficit disorder medication management, and prenatal and postpartum care. While many MCOs conduct remote desktop reviews of medical records to assess adherence to CPGs, Aetna has committed to completing **onsite medical record reviews** as an intervention to facilitate immediate feedback and education to support provider adherence. Through our VBP program, we offer multiple models for providers to earn financial incentives as well as non-financial incentives for adherence, including our tiered preferred provider performance program as well as free point-of-care kits for HIV and A1C testing and aid in obtaining Clinical Laboratory Improvement Amendments certification, if the practice is not currently certified.

Updating and Revising CPGs (2.10.11.5.4)

We review research annually and ongoing for changes to CPGs to ensure consistency with current medical practice standards. When a revision is needed, we work with LDH, MCOs, and providers across all nine regions to review, approve, and adopt the CPG. All CPGs are approved by our QM/UM and QMOC committees no less than every two years or as often as new information is available.

Quality Response Template (2.10.11.6)

Aetna has submitted the completed Quality Response Template for our NCQA Health Insurance Plan Ratings (2018-2019) for all of our Medicaid managed care contracts with full NCQA accreditation in **Attachment E.**

2.10.12 Value-Based Payment

Building partnerships between Aetna and Louisiana community-based organizations is a fundamental objective of promoting physical activity and improved nutrition to create healthier cities. Aetna participates in festivals to promote health screenings as part of community prevention programs, and the integration of health components into cultural events and activities.

2.10.12 Value-Based Payment

Aetna acknowledges, understands, and will comply with all the requirements of the RFP and the **Model Contract**.

Value-Based Payment (2.10.12)

Aetna is the leader in implementing value-based payment (VBP) arrangements that provide better health, better care, and lower costs among all Medicaid plans in Louisiana despite our overall higher risk population. The *2017 Healthy Louisiana Value-based Report* showed our VBP spend at 34 percent of provider payments compared to the statewide Medicaid health plan weighted average of just 16 percent. We do not rest on our laurels; Aetna has further increased the percent of provider payments tied to VBP to 51 percent in 2018. **Currently, 76 percent of Aetna Louisiana enrollees are served by a value-based primary care provider (PCP) and 85 percent of Aetna-contracted PCPs are participating in a VBP program.**

Aetna Meets and Exceeds LDH's VBP Goals

As of January 1, 2019, Aetna already meets several of LDH's VBP thresholds for managed care organizations (MCOs). We already exceed Contract Year 3 (2022) thresholds for the percent of provider payments and total amount of potential incentive payments made through VBP arrangements.

National VBP Expertise Informs Louisiana Efforts and Success

The Aetna enterprise has developed over 1,900 VBP arrangements including 350 arrangements with accountable care organizations (ACOs) and over 7 million enrollees in various VBP arrangements across all lines of business. Through **Aetna Better Value**, our Medicaid suite of VBP solutions, our VBP strategy supports delivery system reform and practice transformation. **Aetna Better Value** currently has over 10,000 individual providers and over 550,000 enrollees across the country participating in multiple Health Care Payment-Learning Action Network (HCP-LAN) alternative payment method (APM) categories. Aetna has been highly successful building on a national record of success in payment reform. As providers evolve along the HCP-LAN APM continuum, we link more provider payments and incentives to value and realize improved quality, reduced costs, and increased enrollee satisfaction and engagement. We also leverage our national and Louisiana commercial and Medicare enrollment to encourage providers delivering care to all product lines to accept VBP arrangements.

VBP Strategic Plan and Goals over the Life of the Contract

Aetna's goals over the life of the contract are as identified in **Table 2.10.12-1** and align with the **Model Contract Section 2.17.2**. These goals list by contract year our projected total percent of provider payments, projected provider incentive payments, number of anticipated implemented ACO arrangements, and the accompanying enrollee participation rates with the assigned PCP and supported specialized behavioral health enrollees.

Louisiana Strategic Plan Initiatives: Aetna's mission to build a healthier world centers on our commitment to transforming the health care delivery system through analytics, payment reform, and provider support. Aetna continues to construct and implement flexible, unique, and innovative VBP arrangements supporting our strategic plan and our goals over the life of the new contract to achieve the Triple Aim. Additionally, these VBP arrangements align with the goals and objectives of LDH, as we seek to maximize enrollee health, advance health equity, and address social determinants of health (SDOH), while supporting innovation and a culture of continuous quality improvement.

Table 2.10.12-1: Aetna's Goals by Contract Year for Incentive Payments, ACOs, and Enrollee Assignment

Contract Year	% of Total Provider Payments	Projected Provider Incentive Payments[1]	Number of Implemented ACOs	PCP Assignment/Behavioral Health-supported Enrollees Participation Rate
2019	51%	$2,801,601	0	76%
2020	60%	$9,542,657	1	80%
2021	70%	$10,974,056	2	85%
2022	75%	$12,620,164	3	90%

Building on our approved State Fiscal Year 2019 VBP Strategic Plan for the next contracting period, we will do the following:

- Evolve and expand APMs and arrangements focused on specialty provider types to include all HCP-LAN APM categories
- Enhance region- and provider-specific APMs and arrangement approaches based on the community's health care needs and provider capabilities
- Facilitate rural provider participation in APMs
- Target under-performing providers for improvement of population health through practice transformation and VBP arrangements
- Introduce VBP arrangements that advance and integrate behavioral health, SDOH, populations with special needs, and maternal health
- Develop and implement ACO arrangements that meet **Section 2.17.14 of the Model Contract**[2] requirements
- Promote provider input in APM design
- Collaborate with LDH on the development of other payer approaches to optimize provider success in VBP arrangements
- Improve our administrative and clinical outcome measures
- Provide tailored support, including but not limited to data exchange, collaboration on closing care gaps, and timely reporting to successfully impact delivery system reform

> *"Aetna has been a committed and innovative partner in working with St. Martin Hospital to develop a value-based approach to further advance the hospital's efforts to ensure enrollees in our community are seeking care in the most appropriate setting."*
>
> **—Karen Wyble**
> **CEO, St. Martin Hospital**

Aetna's VBP Approach

Our VBP arrangements are data-driven, based upon improvement opportunities via an analysis of claims, quality outcomes, SDOH, public health, and disparities data for each provider and model type. These VBP arrangements align with the HCP-LAN APM framework of 2(a), 2(b), 2(c), 3, and 4 with direct linkage to the provider-specific and applicable quality performance measures from **Attachment G of the Model Contract**. Aetna's VBP approach for various provider types includes primary care and specialty care (including behavioral health and hospital-based care) and expands into other treatment venues, such as community mental health centers, federally qualified health centers (FQHCs), rural health clinics, and non-traditional providers. Our unique approach with these providers increases improvement in the health of Louisianans through innovative, whole-person care and well-coordinated systems of care addressing

[1] Our projected provider incentive payments show a significant increase between 2019 and 2020 in **Table 2.10.12-1** in **Section 2.10.12**, due to the increase in enrollees from our current enrollment of 120,000 to the proposal enrollment of 375,000.
[2] We have letters of intent for an ACO model with Franciscan Missionaries of Our Lady Health System's Health Leaders Network and Aledade, currently representing 7,100 enrollees and expecting to grow to at least 22,500 enrollees based upon 375,000 enrollees with implementation by 2021.

medical and non-medical drivers of health. For example, in 2019 we developed a VBP arrangement called the Community Care program with Ready Responders, a community-based organization providing in-home education to enrollees with high utilization of the emergency department (ED). Education of these enrollees includes appropriate use of the ED, helping them manage any chronic conditions at home, close gaps in care, and assess their SDOH conditions that contribute to potentially preventable ED visits. Ready Responders' VBP arrangement (3B) includes downside risk for their fee-for-service reimbursement if they are unsuccessful in meeting the VBP performance targets. Another example of an innovative VBP arrangement is our planned initiative with Schumacher Clinical Partners, an ED group with a post-acute services program. The post-acute services program seeks to reduce repeat ED utilizers of potentially preventable ED visits, facilitate follow-up care to the enrollee's PCP, and identify SDOH that may trigger these potentially preventable ED visits. As a final example, we have a letter of intent with Woman's Hospital in Baton Rouge to develop a VBP arrangement focused on maternal health with incentive-based quality measures of elective or early induction delivery without medical indication, cesarean rate for low-risk first-birth mothers, and percentage of low birthweight births.

We have collaborated with the provider community to advance LDH's vision for better health, better care, and lower cost with a focus on rural hospital engagement in a VBP approach. As an example, we address potentially preventable ED visits through an ED diversion program with St. Martin Hospital with support from health information technology to advance health equity and address SDOHs.

Aetna Better Value's Specific Models, VBP Arrangements, and Expected Impacts

Aetna Better Value's VBP arrangements are custom-designed and align financial incentives with improved quality, cost, utilization, and outcomes through shared financial accountability. In alignment with our strategic plan, the following list in **Table 2.10.12-2** provides a comprehensive description of the specific types of VBP arrangements and their associated HCP-LAN APM category Aetna has and will utilize throughout the contract term.

Table 2.10.12-2: Aetna Better Value VBP Programs

VBP Program/APMs	Description	Measure Goals	Status
CMS Comprehensive Primary Care+ Program—Primary Care Providers—Patient-Centered Medical Home (PCMH) (2A)/Shared Savings (2C)	Providers receive an enhanced care coordination fee to assist with practice transformation in providing care in a payer agnostic manner. Providers also may receive a share of savings for any demonstrated reduction in historical cost and utilization.	HEDIS 50th Percentile	Currently implemented
Patient-Centered Medical Home (2A/2C)	PCPs receive a monthly care coordination fee (annually adjusted based on performance) for the practice's assigned enrollee panel to invest in infrastructure and care coordination. The practice is evaluated on five mutually agreed upon quality/utilization measures.	HEDIS 50th Percentile	Currently implemented
Virtual ACO (2A, 2C, 3A, 3B, and 4)	VBP arrangements within an Aetna-administered ACO designed to assist unaffiliated small and rural providers that provide care to the same cohort of enrollees to participate in APMs.	Medical Loss Ratio and/or HEDIS 50th Percentile	1st Quarter 2020
Social Determinants of Health Incentive Program (2B)	Community-based organizations and PCPs that report their enrollees' SDOH using billing the Z-codes receive quarterly incentive payments. The initial program focus is on homeless enrollees and women with high-risk pregnancies.	Z-codes used for over 50% of enrollees	3rd Quarter 2019

VBP Program/APMs	Description	Measure Goals	Status
Acute Hospitals P4Q Program—P4P (2C)	Providers may receive an incentive payment equal to a percentage of their previous year's claim spend based on performance in utilization and/or quality measures targets.	HEDIS 50th Percentile	Currently implemented
Behavioral Health (BH) Hospital P4Q Program—P4P (2C)	Providers may earn an incentive payment equal to a percentage of their previous years' claim spend based on performance in utilization and/or quality measures targets	HEDIS 50th Percentile	Currently implemented
Behavioral Health Outpatient Clinic P4Q Program—P4P (2C)	Providers may earn an incentive per behavioral health gap in care closed by the provider and improving their attributed population's historical utilization rate.	HEDIS 50th Percentile	Currently implemented
OB/GYN P4Q Program—Pay for Performance (2C)	Providers may earn incentive payments per maternity care closed gaps in care, by improving upon their previous C-section rate, and other maternity-related quality measures.	HEDIS 50th Percentile	3rd Quarter 2019
Primary Care Providers Pay for Quality (P4Q) Program—Pay for Performance (P4P) (2C)	Providers may earn an annual incentive for the provider's performance on select utilization and quality.	HEDIS 50th Percentile	Currently implemented
School-based Health Center P4Q Program—P4P (2C)	Providers may earn incentive payments per wellness screening closed by the provider.	HEDIS 50th Percentile	3rd Quarter 2019
Urgent Care Quality Program—P4P (2C)	Urgent care providers may earn incentive payments for closing wellness gaps in care and successfully coordinates follow-up care while the enrollees have an urgent care visit.	HEDIS 50th Percentile	2nd Quarter 2019
Shared Savings—Primary Care Providers—(3A)	Providers receive a financial budget to manage their attributed enrollee's health care cost below a medical benefit ratio or per member per month (PMPM) total cost of care target. If the provider's medical expenses are below the specified target, then the provider is eligible to receive a share of the surplus achieved for each quality performance target met.	Medical benefit ratio target or historical PMPM cost of care target and HEDIS 50th percentile	Currently implemented
In-home ED Diversion Performance-based Incentive—Community Paramedicine Providers—Shared Savings (3B**)**	Participating providers deliver in-home care and disease management services to referred Aetna enrollees who are frequent ED utilizers. Providers may earn incentive payments if they demonstrate improved ED rates.	Improved ED rate per 1,000 enrollees	Currently implemented
Physical Health (PH)/BH Integration Program—Primary Care Providers and Behavioral Health Professionals—Population-based-Payment Model (4A)	Providers with both BH and PH co-located providers receive a monthly capitation payment reflecting the PMPM cost for providing services related to treatment of dual-diagnosed enrollees with a specified chronic medical diagnosis (e.g., diabetes, hypertension) and behavioral health diagnosis (e.g., anxiety, depression, substance abuse disorder).	Performance targets on quality and utilization measures	1st Quarter 2020

Table 2.10.12-3 illustrates (from 2017 through 2019 YTD) that we have increased the number and types of VBP arrangements by HCP-LAN APM. This occurred as providers advance through the HCP-LAN APM continuum from our entry-level pay-for-quality program to more advanced HCP-LAN APMs. With several years' experience in adopting APMs across 16 states, we are fully committed to the APM framework and LDH's vision of the advancement of and comprehensive quality improvement. Aetna expanded PCMH arrangements in Louisiana from zero to 19 from 2017 to 2019.

Table 2.10.12-3: Aetna's 2017-2019 VBP Arrangements in Louisiana

Programs (APM)	2017	2018	2019	PCP Count	Enrollment Assigned	% Provider Payments (Jan–Sept 2018)
PCMH (2A, 2C)	0	13	19	245	5,305	1.16%
Pay-for-Quality (PCP) (2C)	839	820	813	1,081	49,074	18.09%
Pay-for-Quality (Acute Hosp.) (2C)	0	1	2	N/A	N/A	1.13%
Pay-for-Quality (BH Hosp.) (2C)	2	4	6	N/A	N/A	1.19%
Pay-for-Quality (BH Opt.) (2C)	0	0	1	N/A	N/A	N/A
Comprehensive Primary Care Plus (CPC+) (2A, 3A)		1	1	5	315	0.01%
In-home ED Diversion Performance Based Incentive (3B)	0	0	1	N/A	N/A	N/A
Shared Savings (3A)	5	10	11	1,205	35,355	29.01%
Totals						
VBS	846	849	854	2,536	90,049	50.59%
Plan					118,504	100%
Percentage				85%	76%	

Aetna is in discussion with many providers in each region across Louisiana to bolster participation in VBP arrangements. We identify providers for potential VBP arrangements based upon their historical quality and cost performance, provider payment volume, enrollment panel size, region, and their unique value of services they provide to our enrollees. **Table 2.10.12-4** summarizes, by region, some of the providers with which we are exploring potential APMs and the associated HCP-LAN APM category. We will emphasize adding hospitals, obstetrics and gynecology (OB/GYNs), behavioral health, and non-traditional providers such as nursing facilities, home- and community-based providers, tribal providers, and transportation and housing providers. Our VBP Strategic Plan ensures that we will continue to be the leader in delivering value-based care in Louisiana.

Table 2.10.12-4: Aetna's Targeted 2019 and 2020 New VBP Arrangements

Region	Provider	HCP-LAN APM Category	HCP-LAN APM Category
Statewide	Aledade ACO	Shared Savings/PCMH	3A
Statewide	Hulin Health Urgent Care	Urgent Care Quality Incentive Program	2C
Statewide	Louisiana Breast and Cervical Cancer	SDOH Incentive Program	2B
1	Pediatric Clinic Westbank	PCMH	2A/2C
1	Kinsley House	SDOH Incentive Program	2B
1	Crescent City Physicians	CPC+	3A
1	Louisiana Children's Medical Center	Shared Savings/PCMH	3A
2	Mays Clinic	PCMH	2A/2C
2	Patient Plus Urgent Care	Urgent Care Quality Incentive Program	2C
2	Health Centers in Schools	SBHC P4Q	2C
2	Health Leaders Network CIN/ACO	Shared Savings/PCMH	3A

Region	Provider	HCP-LAN APM Category	HCP-LAN APM Category
3	Family Medicine Clinic of Reserve	PCMH	2A/2C
3	Louisiana Physicians ACO	Shared Savings	3A
4	Abbeville General Hospital	PCMH/Acute Hospital P4Q	2A/2C
4	Acadiana Practitioners	PCMH	2A/2C
4	Women's Clinic of Acadiana	OB/GYN P4Q	2C
5	Lake Charles Memorial Hospital	PCMH/Acute Hospital P4Q	2A/2C
5	West Calcasieu Cameron Hospital	Acute Hospital P4Q/ED Diversion P4Q	2C
6	Rapides Medical Center/Group	Acute Hospital P4Q/ Shared Savings	2C/3A
7	Bossier Family Medical Clinic	PCMH	2A/2C
7	North Caddo Medical Center	PCMH/Acute Hospital P4Q	2A/2C
7	Natchitoches Regional Medical Center	Acute Hospital P4Q/ED Diversion P4Q	2C
7	Pediatric Providers of Louisiana	PCMH	2A/2C
7	CHRISTUS Physician Group	Shared Savings/PCMH	3A
8	Internal Medicine of the Twin Cities	PCMH	2A/2C
8	Rehabilitation Services of Louisiana	PH/BH Integration Program	4A
9	North Oaks and North Oaks Medical Group	Shared Savings	3A

Solutions for Rural Providers

Aetna engages providers across the care and geographical spectrum, including those in rural areas with processes to assure equity in VBP programming. Our strategy provides incentives to our providers with various Healthcare Effectiveness Data and Information Set (HEDIS) and non-HEDIS measures, tailored to the enrollee population and in alignment with **Attachment G of the Model Contract**. This helps us accurately evaluate differences in rural and urban provider adoption of VBP. For example, we monitor and compare VBP adoption in rural areas versus urban areas.

The VBP team will approach small PCPs in rural areas to encourage enrollee care coordination and aggregation of enrollee data with other specialists and hospitals. The VBP team invites them to participate in a **Virtual ACO** with support from Aetna's electronic population health management and analytics platforms. Payments received from participation in the VBP arrangements within the Virtual ACO assist providers to build their internal information technology infrastructure or improve functionality of their electronic health record (EHR) and care coordination capacity.

It is important to engage rural non-traditional providers in VBP arrangements—those providers beyond primary care, such as nursing facilities, home- and community-based providers, tribal providers, and transportation and housing providers. These provider discussions help us understand their unique capabilities and challenges to shape VBP arrangements creating flexible, customized solutions.

Impact of APMs on Potential Incentive Earnings

For both 2016 and 2017, we made provider payouts and anticipate paying out additional incentives for 2018 and 2019. We project increases in provider incentive payments as more providers engage in VBP arrangements and continue advancement in care coordination. As of January 1, 2019, Aetna already meets several of LDH's VBP goals for MCOs. For example, **we already exceed Contract Year 3 requirements for the percent of provider payments made through VBP arrangements as described**

in Section 2.17.2. As illustrated in **Table 2.10.12-5**, for contract year 2020, we project expected and maximum payment amounts that contracted and targeted providers are eligible to earn, and if applicable, the expected and maximum downside risk or penalties from the provider for each VBP arrangement.

Table 2.10.12-5: VBP Projected Provider Incentive Earnings 2020

APM Categories	Projected VBP Provider Potential Incentive Earnings during Contract Year 2020			
	Expected Incentive	Maximum Incentive	Expected Risk/Penalty	Maximum Risk/Penalty
Category 2A Models	$659,016	$868,770	$50,877	$137,754
Category 2B Models	$1,084,702	$1,643,487	N/A	N/A
Category 2C Models	$1,631,990	$3,549,054	N/A	N/A
Category 3A/3B Models	$4,490,699	$9,904,805	$388,536	$777,072
Category 4 Models	$1,676,250	$1,760,063	$0	$83,813
Total	$9,542,657	$17,726,179	$439,413	$998,639
Plan Projected Enrollment	375,000			

Quantitative, Measurable, Clinical Outcomes Sought (2.10.12.2)

While the **Aetna Better Value VBP arrangements** may vary as to the degree of financial risk assumed, each of the models include quality, utilization, and clinical outcome measures tied to provider payments and include several measures aligned with LDH's goals. We tailor these measures to primary care, specialty care, hospital-based, and non-traditional provider types. Through our collaborative VBP approach with providers, we select relevant outcome measures that align with the practice's goals and set achievable targets to maximize program success.

Creating Measurable VBP Results

Aetna uses the following quality, cost, and utilization measures in our VBP arrangements as described in **Table 2.10.12-6.** Each current and future customized VBP arrangement as required by LDH must include a link to at least one of the 61 LDH incentive measures identified in **Attachment G**. As the program matures, the targets are reset to align financial incentives and accountability with continuous improvement. In addition, Aetna will collaborate with LDH and seek approval to identify and implement VBP arrangements with measures that are not LDH quality performance measures to achieve similar Triple Aim results prior to implementing.

Table 2.10.12-6: Quality/Utilization/Cost Measures and Benchmarks for VBP Arrangements

Quality/Cost Measure	LDH Quality Performance Measures	Target	VBP Arrangements
Adolescent Well Care Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life, Well Child Visits in the First 15 Months of Life, including Immunization Status	Yes	HEDIS 50th Percentile	Shared Savings, PCMH, P4Q, SBHC P4Q, CPC+, Urgent Care Quality Program
Postpartum Care, Timeliness of Prenatal Care, Elective Delivery Rate, and Initiation of Injectable Progesterone for Preterm Births, Cervical Cancer Screening	Yes	HEDIS 50th Percentile	OB/GYN P4Q

Quality/Cost Measure	LDH Quality Performance Measures	Target	VBP Arrangements
Colorectal Cancer Screening	Yes	HEDIS 50th Percentile	PCMH, P4Q, CPC+, Shared Savings
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Yes	HEDIS 50th Percentile	PCMH, P4Q, CPC+, Shared Savings
Ambulatory ED Rate Per 1,000 enrollees	Yes	HEDIS 50th Percentile	Shared Savings, PCMH, P4Q, Acute Hospital P4Q, In-home ED Diversion
Comprehensive Diabetes Care-HbA1c Control < 8.0	Yes	HEDIS 50th Percentile	Shared Savings, PCMH, P4Q, BH/PH Integration
Counseling for Nutrition & Physical Activity	Yes	HEDIS 50th Percentile	Shared Savings, PCMH, P4Q, SBHC P4Q, CPC+
Comprehensive Diabetes Care-**Hba1c** Testing	Yes	HEDIS 50th Percentile	Shared Savings, PCMH, P4Q, CPC+, Urgent Care Quality Program
Breast Cancer Screening	Yes	HEDIS 50th Percentile	Shared Savings, PCMH, OB/GYN P4Q, CPC+, Urgent Care Quality Program
Follow-up After Hospitalization for Mental Illness—Within 7 and 30 Days of Discharge (FUH)	Yes	HEDIS 50th Percentile	BH Hospital P4Q, BH Outpatient Clinic P4Q, Shared Savings, PCMH, CPC+
Plan All Cause Readmissions	Yes	HEDIS 50th Percentile	Shared Savings, Acute Hospital P4Q, CPC+
Follow-up after ED Visit for Alcohol and Other Drug Abuse or Dependence	Yes	HEDIS 50th Percentile	BH Outpatient Clinic P4Q, BH/PH Integration
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	Yes	HEDIS 50th Percentile	BH Outpatient Clinic P4Q, BH PH Integration
Cultural Competency Provider Training	No	Aetna-verified completion of provider training	Shared Savings, PCMH, CPC+
Trauma-informed Care Provider Training	No	Aetna-verified completion of provider training	Shared Savings, PCMH, OB/GYN P4Q, CPC+
Controlling High Blood Pressure	Yes	HEDIS 50th Percentile	Shared Savings, PCMH, P4Q, BH/PH Integration, CPC+
Antidepressant Medication Management	Yes	HEDIS 50th Percentile	BH/PH Integration, CPC+

Louisiana HEDIS Improvements

Aetna had 83% and, preliminarily, 71% of their HEDIS measures increase year-over-year from HEDIS 2017 to 2018 and 2018 to 2019, respectively. As an example of success within a provider group, Access Health achieved a 12% reduction in inpatient admissions, 9% improvement in the follow-up after an inpatient mental health hospital stay within 30 days, and over 8% improvement in the follow-up hospital/mental health visit with 7 days. This illustrates the true impact of our value-based payment programs.

Demonstrated VBP Results

Our VBP arrangements have the primary goal of ensuring enrollees experience better health and receive better care at a lower cost. Aetna has demonstrated results on improving readmission rate and ED visits per 1,000 enrollees as highlighted in **Table 2.10.12-7**. The providers identified below have achieved year-over-year **better care** success through participation in our shared savings program in reducing potentially preventable events (PPE) for utilization measures.

Table 2.10.12-7: Admissions, Readmission Rates, and ED Visits for Shared Savings Providers, 2015-2018

Provider	Admits/1000			Readmission Percent			ED Visits/1000		
	2015	2018	% Change	2015	2018	% Change	2015	2018	% Change
St. Thomas Community Health Center	46.1	16.2	-64.8%	27.3%	20.0%	-26.7%	193.5	79.4	-59.0%
Provider HealthLink	31.6	15.7	-50.3%	50.0%	12.9%	-74.2%	120.3	92.0	-23.5%
Access Health	23.3	14	-39.9%	15.5%	12.2%	-21.1%	100.8	79.0	-21.7%

Improvements in HEDIS measures from 2017 to 2018 show the impact VBP provider incentives, collaboration with our population health specialists, and reporting have had resulting in improved quality performance for **better health** as illustrated within the Reddy Family Medical practice, as shown in **Table 2.10.12-8**.

Table 2.10.12-8: Reddy Family Medical Clinic Performance

Measure Name	2017 Rate	HEDIS Target	2018 Rate	HEDIS Target
Adult BMI	85%	84.54%	100%	86.24%
Adolescent Well Care	0%	48.41%	40%	50.12%
Cervical Cancer Screening	41%	55.94%	64%	58.48%
Diabetes Care A1C testing	87%	87.83%	100%	87.10%
Diabetes Care Nephropathy Monitoring	93%	90.51%	90%	90.27%

Finally, Aetna's value-based providers have had success with lowering the **total cost of care** for their population. For example, in 2017, our Louisiana provider partners in shared savings VBP arrangements, representing 15 percent of the total plan's enrollment, had an overall 33 percent lower PMPM cost of care than the overall health plan's enrollment. These same provider partners' high-risk enrollees, representing 22 percent of the total plan's high-risk enrollees, had a 12 percent lower PMPM cost of care than the overall health plan's high-risk enrollees. These examples confirm our ability to achieve the Triple Aim of better care, better health, and lower costs through VBP arrangements with our provider partners.

Expansion of VBP Arrangements within First Three Years of Contract (2.10.12.3)

Aetna already exceeds LDH's projected 2022 requirements for the percent of provider payments and total amount of potential provider incentive payments through VBP arrangements. In accordance with our strategic plan and continuing our high rate of VBP enrollee participation, we focus on expanding VBP arrangements along the HCP-LAN APM continuum and to new provider types. We work to advance providers toward VBP arrangements that emphasize quality improvement, incorporate upside shared savings payments, downside risk, and condition-specific population-based payments.

To assess a provider's VBP arrangement readiness or move to more advanced APMs, we use the **Aetna Better Value Provider Readiness Survey.** This comprehensive questionnaire helps to determine

collaboratively the provider's VBP arrangement path. This proprietary tool leverages extensive research on which capabilities a provider requires to promote VBP success. The tool consists of 20 questions and is the first step in creating a relationship between Aetna and providers to assess their current capabilities. During face-to-face readiness survey completion, this tool promotes dialogue, as opposed to simply completing and returning a survey without interaction. It captures details such as technological capabilities, whether there is a physician champion, care manager involvement, and innovative payment experience. This tool guides providers on their journey to value while prioritizing quality of care.

Collaborating with Providers in VBP Arrangement Design

In compliance with all **Model Contract** requirements, our strategic plan details our outreach and engagement efforts with providers over the contract period. We highlight our plan to engage rural and urban, as well as large and small providers across Louisiana.

Aetna solicits information from providers participating in VBP to learn about their experiences and gather insight on how to improve our VBP programming through the following efforts:

- **Value-based Hospital and Provider Advisory Committees:** The committee consists of at least one administrative and clinical lead from our VBP provider networks. This group meets biannually along with plan leadership to give insight on existing program design and provide recommendations to the plan evolving our value-based program design and strategy.
- **Joint Operating Committee (JOC):** During multidisciplinary JOC meetings, we receive recommendations from providers on enhancing VBP reporting that drive improvements through additional specificity.
- **Quality Management Operating Committee:** The committee's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and provider network; provide Quality Assessment Performance Improvement program executive oversight; and make recommendations to the board of directors.
- **Annual value-based partner forums:** The annual value-based quality forum will be an opportunity to discuss the health plan quality strategy with our value-based clinical leaders, conduct quality improvement panel discussions, and highlight and award quality performance achievement among the value-based provider system.

Leveraging Aetna's VBP team, we advance providers along the HCP-LAN APM continuum. This team collaborates directly with physicians and their staff to identify providers who are more likely to advance along the HCP-LAN APM continuum and show expertise to move to more advanced payment models, such as upside gainsharing with downside risk (HCP-LAN APM category 3B) and population-based payment (HCP-LAN APM category 4). Offering their expertise and background, the VBP team lends valuable technical assistance hand-in-hand, making real impact on the daily practice of care.

As an example of our interaction with specific providers in our expansion efforts, in 2019 we have secured a letter of intent with a clinically integrated ACO, Health Leaders Network (HLN). HLN represents a statewide collaboration of 850 independent and employed providers of Franciscan Missionaries of Our Lady Health System, focused on providing the communities they serve with high-quality and efficient health care. HLN's ACO network has participated in the Centers for Medicare & Medicaid Services (CMS) Medicare shared savings program and next-generation ACO model. Our intention is to contract with them as an ACO for 2020 in accordance with the **Model Contract 2.17.14**.

Timeline of VBP Advancement along the HCP-LAN APM Continuum

We emphasize moving providers toward HCP-LAN APM Categories 3 and 4, as illustrated in **Figure 2.10.12-1**, which include condition-specific population-based payments, upside gainsharing, upside gainsharing with downside risk, and other incentives. For example, Aetna increased its year-over-year

2017 to 2018 enrollment assigned and PCPs participating to the HCP-LAN APM Category 3 from 13 percent to 29 percent.

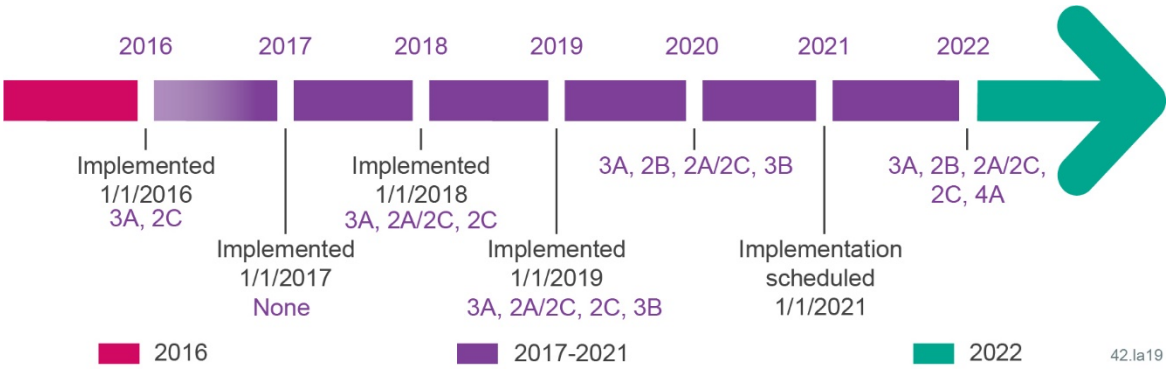

Figure 2.10.12-1: VBP Implementation Timeframe

Aetna's continual advancement of VBP arrangements across the timeframe from 2016 to the present, through the new contract period of 2020- 2022 from APM category 2 though categories 3 and 4.

Evolution of Providers: HCP-LAN APM Continuum

Aetna continuously seeks to engage new providers in VBP arrangements and advance those already participating within the APM framework with the goal of advancing to full-risk arrangements. **Table 2.10.12-9** demonstrates our proposed timeline for supporting the Louisiana PCPs and PCMHs currently in our VBP program toward more advanced APMs that include up to downside risk. We assess the ability to move along the continuum on the providers' enrollment panel size, the provider's historical success in their existing APMs, and resources and infrastructure in place to support advancement along the APM continuum in addition to criteria identified in the Aetna Provider Readiness Survey. For example, if a provider is not ready to undertake the next level of value-based arrangements, we assist them to close gaps in care with improved quality or assisting with enhancing their infrastructure through continuous care coordination infrastructure payments.

Table 2.10.12-9: Projected Timeframe for Movement along the APM Continuum with Louisiana PCPs/PCMHs

Provider	VBP Effective Date	Current HCP-LAN APM Category	2020 HCP-LAN APM Category	2021 HCP-LAN APM Category	2022 HCP-LAN APM Category
Access Health	1/1/2016	3A-Shared Savings	3A-Shared Savings	↑3B-Shared Risk	3B-Shared Risk
Bryan G. Sibley	8/1/2017	2A/2C-PCMH-P4Q	2A/2C-PCMH-P4Q	2A/2C-PCMH-P4Q	↑3A-Shared Savings
Children's International Medical Group	1/1/2018	3A-Shared Savings	↑3B-Shared Savings	↑3B-Shared Risk	3B-Shared Risk
Franciscan Missionaries of Our Lady Health System	1/1/2017	3A-Shared Savings	3A-Shared Savings	3A-Shared Savings	↑3B-Shared Risk
Jefferson Parish Human Services Authority	1/1/2018	2A/2C-PCMH	2A/2C-PCMH	↑3A-Shared Savings	↑4A-Population Based Payment
Ochsner-LSUHSC Physician Group	1/1/2018	2A/2C-PCMH-P4Q	↑3A-Shared Savings	3A-Shared Savings	↑3B-Shared Risk

Provider	VBP Effective Date	Current HCP-LAN APM Category	2020 HCP-LAN APM Category	2021 HCP-LAN APM Category	2022 HCP-LAN APM Category
Mansoor Pediatrics	1/1/2018	2A/2C-PCMH-P4Q	↑3A-Shared Savings	3A-Shared Savings	3A-Shared Savings
Provider HealthLink of Louisiana	1/1/2016	3A-Shared Savings	3A-Shared Savings	3A-Shared Savings	↑3B-Shared Risk
South Louisiana Medical Associates	1/1/2018	2A/2C-PCMH-P4Q	↑3A-Shared Savings	3A-Shared Savings	3A-Shared Savings
Willis-Knighton Physician Network	1/1/2018	3A-Shared Savings	↑3B-Shared Savings	↑3B-Shared Risk	3B-Shared Risk

We have developed strong relationships and built trust with our current provider partners and our contracts focus on responsibly increasing levels of risk as providers move along the APM continuum to categories 3 and 4 in a manageable timeframe. Our approach allows providers to decide what models are right for them and within the appropriate timeframe.

Based upon our experience, it can be challenging for providers to move to advanced APMs that include downside financial risk. Fifteen percent of our HCP-LAN APM Category 2 and 3 providers are FQHCs and are limited to the amount and type of downside risk they can accept. Our population health model addresses these concerns focusing on practice and delivery system transformation with a clinically integrated approach ensuring provider success with advanced payment models. In addition, we will add our Medicare and commercial enrollment to the VBP arrangements enabling providers to pool risk across a patient panel representing multiple populations rather than the singular Medicaid population. By creating a value-based ecosystem that includes all types of providers, Aetna partners with providers to start them in the most appropriate VBP arrangement and support them to move along the risk continuum in a responsible, timely, and quality-focused manner.

Supporting Providers in Delivery System Reform (2.10.12.4)

Aetna's VBP arrangements are the first step in driving successful delivery system reform. With our robust provider support, reporting tools, technical assistance, and data support including our electronic population health platform and data exchanges, we assist providers in improving health outcomes at the point of care and achieving system delivery reform. Our approach leverages strong payer-provider relationships built on trust and transparency supported by data, reporting, and connectivity—creating a valued partnership to advance delivery system reform.

Provider Support in System Delivery Reform

Through our robust provider support model, led by an assigned population health specialist, the Aetna VBP team assists providers in the pursuit of the Triple Aim of achieving better care, better health, and lower costs through shared savings arrangements. **We are the only Louisiana MCO assigning population health specialists (PHSs) to specific providers that focus on practice transformation.** Specifically**,** the VBP team assists providers in overall population health management, including providing a minimum of monthly reviews on all performance trends including total cost, quality, and utilization with guidance on actions to achieve targets, and supporting advanced care coordination. Through the provision of standard reports transmitted at least monthly, access to the electronic population health management (PHM) platform with near-real time enrollee utilization information, and direct claims data feeds into provider PHM systems, Aetna supports providers in transforming and improving care delivery with a 360-degree view of the enrollee's health activity. Aetna's VBP team engages providers with staff from the following departments to further assist the provider in system delivery reform:

- Population Health Management (including Louisiana-based population health specialists and community outreach coordinators)
- Provider Services, Care Management, Quality Management, Network Management, and Claims Management

"When comparing MCO platforms, Aetna's PHM platform stands out as one that is user-friendly…but provides great ability to identify and manage care gaps and high-risk enrollees and monitor group performance in improving the health of our patients."

—Ann Kay Logarbo, CMO, Children's International Medical Group

Our VBP team collaborated with and supported Franciscan Missionaries of Our Lady Health System in identifying enrollees who were frequent utilizers of the ED and had potentially preventable visits. The collaboration identified frequent utilizers, potentially preventable visits, and more appropriate venues of care over the course of a year, resulting in a 24 percent reduction in the ambulatory ED visits per 1,000 enrollee rate. We have also worked with Ready Responders using innovative interventions to reduce PPEs and low-value care, including reduced inpatient hospital readmissions, ED usage, and screening for cervical cancer. These are examples of how we assist providers in successful delivery system reform, including closing gaps in care and assessing and improving SDOH and health equity disparities.

Additionally, integrating behavioral and physical health within a VBP arrangement provides for movement toward successful delivery system reform. This includes appropriate placement post-hospital discharge and increasing co-located providers within our network. Our VBP team collaborates with providers to access, understand, and use data from a variety of reports and via Aetna's electronic PHM platform. Our data reports provide detail regarding our enrollee's medical, behavioral, functional, and social needs that assist in the advancement of delivery system reform. We integrate with providers and all components of the delivery system to assure achievement of reform.

Aetna Better Value Reporting

Table 2.10.12-10 describes standard performance reports Aetna distributes to providers in VBP arrangements to help identify quality, utilization, and cost trends and opportunities. For those providers who utilize their own population health platform, Aetna is willing to provide a data exchange of claims information to import into their platform. We have set up File Transfer Protocol sites to transfer files securely for providers in several states under full-risk agreements supporting them in gaining full reporting of claims data to allow for their own analytics to identify quality, utilization, site of service, and cost opportunities to achieve delivery system reform.

Table 2.10.12-10: Standard Reports Aetna Shares with VBP Providers

Report	Purpose	Aetna VBP Programs	Frequency
Quality	Insights on performance at the organizational, group, and individual provider level on enrollee-level gaps in care on HEDIS quality measures	P4Q, PCMH, Shared Savings	Monthly
Key Performance Indicator	Insights on performance at the organizational, group, and individual provider level on key utilization measures (ED visits, admissions, readmissions, and generic dispense rate) among their assigned enrollee panel	PCMH, Shared Savings	Monthly
Financial	Insights on performance at the organizational, group, and practitioner level on the medical benefit ratio among their assigned enrollee panel	Shared Savings	Quarterly

Through robust reporting and analytics, we measure providers' performance to make sure they are successful in meeting quality, utilization, satisfaction, and cost targets as they progress through the APM continuum and achieve delivery system reform. As providers succeed within their current APM, we

evaluate their capabilities to determine whether they exhibit readiness to assume additional risk, particularly as they become more capable and successful with a population-health reimbursement approach. For providers in a VBP program at level two of the HCP-LAN APM continuum, such as pay-for-quality, the Louisiana-based VBP director, along with Network, Quality, and PHSs, performs an annual determination of provider readiness to move to the next APM level. Movement along the APM continuum further enhances the VBP arrangements to influence delivery system reform.

Technical Assistance and Data Supporting System Delivery Reform

An example of how we assist providers in continuous process improvement and support is through our current Louisiana participation in the advancement of the CMS Comprehensive Primary Care Plus model—a national advanced primary care medical home model that strengthens primary care through regionally based multi-payer payment reform and care delivery transformation. Through collaborative multi-payer technical assistance, population health data access, and reporting, we help providers enhance services for enrollees in a payer agnostic manner. As an example, Aetna is collaboratively working other regional CPC+ payers to align performance measures in VBP programs to shared providers and develop provider-specific reporting inclusive of all payers. Through this initiative and others, we strengthen primary care by advancing EHR adoption and improved HEDIS performance outcomes.

Types of Technical Assistance

Types of technical assistance given include strategies for approaching performance measure improvement, education on HEDIS technical specifications for coding, closing gaps in care, and the use of our PHM platform. Technical assistance also includes supplemental data feeds to ensure upload to their data warehouse for calculation of HEDIS rates. Those that need ad hoc assistance can contact PHSs through secure messaging or can receive technical assistance 24/7/365 through our PHM platform.

Data Access through Population Health Platforms

Aetna's PHM platform provides a comprehensive tool to assist providers managing a VBP arrangement. The platform, shown in **(Figure 2.10.12-2)**, provides a single data-sharing tool empowering provider partners with near real-time access to complete enrollee profiles, fostering collaboration and quality improvement. The electronic population health management platform offers complete transparency, including the cost of care and promotes enrollee access, shared decision-making, proactive health management, coordinated care delivery, adherence to evidence-based guidelines, improved quality outcomes with an emphasis on closing gaps in care, improved operational performance, and decreased administrative burden for providers. Access to our electronic PHM platform is at no cost to the provider.

Providers who use the tool obtain data on hospital and ED admissions, readmissions, medication reconciliation, open care gaps, and care transitions. Our innovative platform includes transparency of cost of care with our providers, allowing a 360-degree view of enrollees' cost of care and care gaps. All of this creates a powerful system helping providers engage and manage their enrollees more closely without having to pay for additional resources. Our platform is available to primary care and specialty care physicians, hospitals, and facilities participating in our VBP arrangements. The platform also interfaces with Athena EMR as well as the following State health information exchanges:

- Greater New Orleans Health Information Exchange (GNOHIE)
- Louisiana Emergency Department Information Exchange (LaEDIE)
- Louisiana Health Information Exchange (LaHIE)
- Louisiana Health Information Network (LHIN)

Figure 2.10.12-2: Population Health Platform Screenshot

Aetna's electronic population health management platform provides comprehensive data and integrated tools to improve population health outcomes.

We educate and support new providers in accessing and adopting this platform. The platform offers an array of helpful, easy-to-use tools that ultimately serve as a feedback loop for the care team improving care delivery systems. All of this creates a powerful integrated system that helps providers engage and manage their patients more closely without having to pay for additional resources.

Aetna's comprehensive support for providers will lead to the achievement of better care, better health, and lower costs in alignment with our strategic plan and LDH's goals. Our comprehensive support empowers providers to transform the delivery system of care via improved population health outcomes.

Conclusion

We are committed to achieving our VBP Strategic Plan and related goals through the continued advancement of VBP arrangements by collaborating with providers to move them along the HCP-LAN APM continuum. With improvement of the quality performance measures and clinical outcomes, our enrollees achieve the Triple Aim of better care, better health, and lower costs through our support of providers aligning incentives for successful delivery system reform.

2.10.13 Claims Management and Systems and Technical Requirements

Providing health and prevention education to Louisiana communities is a top priority for Aetna. Through our partnerships and classroom curriculum, we connect students with opportunities and educational resources on health and wellness.

2.10.13 Claims Management and Systems and Technical Requirements

Aetna implemented our claims adjudication processes and other technical systems to promote LDH's objectives when we initiated the plan in 2015. Since that time, through transparent communication, responsible stewardship, and collaboration with LDH, we have operated and continuously improved our systems in alignment with LDH requirements. The Aetna Medicaid organization has over 30 years of experience managing the care of the medically vulnerable, supporting caregivers, and working closely with multiple states' departments of health and human services to achieve successful health care results and effective cost outcomes.

Aetna attests that we will adhere to all requirements of the Louisiana Medicaid Managed Care Organization related to this Request for Proposal including, but not limited, to the following:

- Model Contract Section 2.18, Claims Management
- Model Contract Section 2.19, Systems and Technical Requirements
- Model Contract Section 2.11 Provider Reimbursement and related sections of Part 4, Payment and Financial Provisions
- Louisiana Managed Care Organization Manual
- Louisiana System Companion Guide
- All applicable Louisiana State administrative rules and statutes
- All applicable federal requirements

Understanding of Rules and Statutes and Customization for Louisiana (2.10.13.1)

Aetna has been operating as a Healthy Louisiana plan since 2015 and understands all requirements of the Louisiana Medicaid program. We have customized the claims processing and encounter submission system to meet the unique requirements of LDH. This platform has the flexibility to respond quickly to the needs of LDH when off-cycle updates occur in health plan advisories, information bulletins, and ad hoc requests. We configure our systems in accordance with Louisiana fee schedules, covered services, and provider manual requirements.

Recently, the Applied Behavioral Analysis fee schedule was changed in relation to a specific population that receives careful oversight by the State due to legislative mandates. Aetna was able to facilitate this fee schedule change and have all systems updated and claims reprocessed within 15 days of the change—surpassing LDH's 45-day regulatory requirements to process changes and payment.

Our claims adjudication system properly supports and increases successful provider participation due to our ability to pay all submitted medical and pharmacy claims on a timely basis. Additionally, to avoid increased administration costs and to minimize provider burden, we bring a best-in-class claims payment process that maximizes first-pass auto-adjudication and minimizes incorrect payments or inappropriate denials. We have demonstrated strong performance for both medical and pharmacy claims in Louisiana, serving both traditional and non-traditional providers, and continue to be committed to meeting and exceeding LDH's targets for timeliness and accuracy of claims adjudication. In 2017 and 2018, Aetna paid pharmacies for prescriptions dispensed within 11 days (on average) from the date of fill, surpassing LDH's requirements of 15 days. Aetna also demonstrates strong performance with respect to medical encounter submissions. **Table 2.10.13-1** highlights these achievements.

Claims Adjudication Performance Metrics in Louisiana

- Electronic data interchange (EDI) rate (rolling 12-month): 93.9%
- Auto-adjudication rate (rolling 12-month): 92.2%
- Timeliness (new day claims 15 days) 2018 YTD: 97.39%
- Accuracy 2018 YTD: 99.47% (payment and financial)
- Denied claims average: 11%

Table 2.10.13-1: Aetna—Cumulative Encounter Completion Percentages (DOS 1/1/17-12/31/18)

Managed Care Organization (MCO)/Delegated Vendor	Cumulative Completion (%)
Entire Plan	97.89%
LogistiCare (non-emergency transportation)	99.22%
Superior Vision (vision services)	98.96%
DentaQuest (dental services)	97.90%
CaremarkPCS Health(pharmacy benefits)	99.77%
Aetna Non-vendor	97.18%

Over the past two years, we improved overall financial completeness by 2.61 percent and Aetna now consistently exceeds the financial encounter reconciliation rating of 95 percent. We participate in all encounter meetings/workshops hosted by LDH, and meet with LDH, Myers and Stauffer (auditing agency), and DXC Technology, the State's fiscal agent, on a regular basis to resolve any outstanding questions or issues related to encounters. We have applied continuous quality improvements, which resulted in a Myers and Stauffer report listing a decrease in complaints month-over-month.

Aetna is preparing for the upcoming changes in LDH's minimum performance standards for encounter submissions with the new contract term beginning in 2020. As part of our preparation, we are implementing a new encounter system, which will be completed prior to the start of the new contract term. In other states where we implemented this new encounter system, we achieved increases in our performance metrics related to encounter submissions. For example, in Kentucky and Florida we achieved a 1.79 percent and 2.26 percent increase in submission accuracy, respectively.

Moving to a New Encounter Management System

Rollout for Louisiana is enhanced by our vendor's development of Knowledge Packs, which are created directly from the State's encounter submission requirements and System Companion Guide. Turnaround time for rolling out this tool is greatly reduced, allowing us to move quickly and accurately to the deployment phase.

We achieve positive results with all Louisiana claims adjudication and encounter submission requirements through establishment and adherence to **customized** policies and procedures, configuration of **LDH-compliant** claims processing/encounter submission systems, and other tools tailored to support processing and payment within State requirements.

Policies and Procedures to Meet State Performance Standards and Prompt Payment

As a result of over 30 years of experience in Medicaid managed care programs, we have developed robust written policies and procedures (P&Ps) to support adherence to contractual, State, and federal requirements related to claims adjudication and encounter submission. We carefully monitor revised guidance, the provider manual, or policy notifications from LDH to customize our P&Ps to align with the needs of Louisiana. Our detailed procedures support our commitment to fiscal responsibility and foster the achievement of successful outcomes related to the timely and accurate payment of claims.

Automated Claims Adjudication System

Aetna views claims adjudication and encounter submission as an integrated set of end-to-end processes. Our claims adjudication system is a Health Insurance Portability and Accountability Act (HIPAA)-compliant, rules-based information processing system. It includes 28 integrated modules that maintain and process health care administration data, allowing us to increase administrative efficiency and improve the quality of care. The system contains every data element required for claims data adjudication. The provider module contains the unique provider identification number generated by the system, plus all

billing, tax, and State reporting information. The validation of provider data includes the ability to confirm the provider is enrolled as a provider in the Louisiana Medicaid program. If not, the claim is denied and returned to the provider. Aetna accepts claims through multiple channels and is capable of handling individual or a large volume of claims consistent with ASC X12 standards.

The claims module shows the date of receipt, history of actions taken on each claim, and date of payment, including the check number. The system accumulates claims by specific benefit limits and lifetime benefit rules. It scrubs and edits the claim data for accuracy during processing and payment. To maximize the quality and accuracy of our process, our system uses several embedded, configurable capabilities to review and edit claims data, including duplicate billing logic, coding accuracy, procedure code guidelines, procedure code definition policies, and technologies to detect questionable billing practices. We also have customized specific requests from LDH such as configuring to bypass explanation of benefits (EOB) requirements for our Chisholm members, allowing only one EOB per prior authorization. Our system's edits address all areas required within the **Louisiana Model Contract Section 2.18.8.** They include the following:

In 2018, Aetna's Medicaid organization processed over **46 million claims**. We processed **1.8 million medical claims in Louisiana** alone in 2018.

- Enrollee eligibility, enrollee name, and enrollee unique identification number
- Valid dates of service
- Medical necessity determination, prior authorization, and covered services
- Duplicate claims
- Provider validation
- Quantity of service

We use claim submission data to analyze our records and align our system provider data and State registry data. This continuous process improvement protocol improves accuracy of our claims payments and encounter submissions, thereby minimizing encounter rejections.

Potential Duplicate/Void Encounter Records in Louisiana

In 2017 over $4.4 million, or 1.32% of dollars in potential duplicates, were identified and removed from the cumulative financial completion rate. As a result of system enhancements and process improvement, potential duplicates have since been reduced by 97.81%, to $97,000.

In addition to managing claims for Medicaid managed care services, we possess operational and administrative capacity to efficiently and effectively process in lieu of services (ILOS), value-added services, and qualifying Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services claims. EPSDT, ILOS, and value-added services are assigned codes and are processed through our claims system and submitted through our encounter system as required by LDH.

Additional Tools to Support Compliance with Louisiana Claims Requirements

In addition to our P&Ps and a well-configured claims adjudication and encounter system, we utilize other tools and tasks to support our compliance with requirements.

Proactively Managing Claims Flow and Processing

Our standard and ad hoc claims reports proactively manage claims workflow to meet LDH's prompt pay requirements by alerting us to adverse trends. Based on this analysis, the Claims Operations department takes immediate action to address any trends that indicate a potential issue in areas such as turnaround times or inventory levels for aging claims. This approach enables us to identify the root cause of the problem and to develop and implement the appropriate action plan to ensure LDH's prompt pay requirements.

Robotic Processing Automation

To provide greater efficiency and accuracy of claims adjudication, we have deployed robotic processing automation (RPA) extensively within Aetna. RPA allows Aetna to remove manual processing and assists our team in providing additional data checks and data revisions. One such process deployed for Louisiana introduced supplemental checks to attach the appropriate provider to the appropriate claim using 10 different data points.

Supporting Providers in the Claims Submission Process

Aetna offers support, useful tools, and education to providers in their claims submission activities. Successful clean claims submission and accurate and timely payment upon initial submission allows providers to remain focused on their primary goal of maximizing the service delivery and health outcomes for Louisiana enrollees. We currently process check runs twice per week and will be moving to three-times-per-week frequency to support timely provider payments and enhance provider satisfaction.

Pharmacy Claims Adjudication and Compliance with Requirements

As Aetna's pharmacy benefits manager in Louisiana since 2015, CaremarkPCS Health brings the experience of a best-in-class pharmacy claims payment system that is used throughout the country. Serving the Medicaid population since 1988, CaremarkPCS Health currently supports 31 managed Medicaid health plans and more than 21 million covered members.

CaremarkPCS Health's pharmacy provider payment process is automated and it adheres to all State and federal prompt pay requirements. In the event a claim is paid beyond required timeframes, applicable interest is automatically calculated and paid. CaremarkPCS Health provides Aetna with monthly prompt pay reporting as a means to evidence compliance. CaremarkPCS Health has demonstrated exceptional processing outcomes. Additionally, the pharmacy claims processing system has been available 99.99 percent of its scheduled time during 24/7/365 operations; the system provides average response time of one second or less for all processed transactions calculated over a 12-month period.

Edits are used at the point of service and are designed to confirm pharmacy compliance with LDH's program parameters even before prescriptions are dispensed. A report is produced daily to check claims for inconsistencies in quantity, days' supply, etc., with the majority of these inconsistencies resulting from keying errors at the local pharmacy point of sale during the claim submission process. When errors are detected, an outreach is completed to the submitting network pharmacy to have them reverse the claim and submit a corrected claim with the appropriate data.

Management Information Systems Used and Compliance with Model Contract (2.10.13.2)

Aetna understands and complies with all systems and technology requirements of the Louisiana Medicaid program; we have been operating in compliance with these requirements since our entry into the program in 2015. Systems are designed, maintained, enhanced, or changed in alignment with requirements of the Louisiana Medicaid Managed Care Organization Model Contract, the Louisiana Managed Care Organization Manual, the Louisiana System Companion Guide, and all State and federal statutes and rules. We are proud of the robust and effective systems we have created, which minimize wasteful spending, abuse, and fraud and reduce complexity and administrative burden for providers and enrollees.

Length of Use and Brief Descriptions of all MIS Systems (2.10.13.2.1)

Over the past four years, we have successfully implemented numerous management information systems (MISs) in support of our health plan, assuring system stability. The systems listed in **Table 2.10.13-2** have been in use in Louisiana since plan implementation in December 2015, with the exception of the electronic population health management platform, which began in December 2016. **Table 2.10.13-2** identifies all MIS used in Louisiana.

Table 2.10.13-2: Aetna Management Information Systems Since Louisiana Implementation
December 2015

System	Description	System Implementation Date (Louisiana)[1]
Claims processing system	Suite of modules which include the books of record for claims processing, enrollment, customer service, utilization management/service authorization, and provider roster information	December 2015
Encounter data submission system	Industry-leading platform specifically designed around complexity and variation of State Medicaid encounter reporting requirements; upgraded system implementation scheduled for the second and third quarters of 2019	December 2015
Electronic care management platform	Clinical tools such as screenings, assessments, and care plan documents to be used in case management activities are stored and available to permitted members and providers	December 2015
Electronic population health management platform	A unified view of enrollee data for providers that shares data digitally and aggregates actionable data across member roster	December 2016
Enrollee and provider portals	Offers both members and providers extensive, interactive functionality and uses Aetna's rich data set to personalize the user experience	December 2015
Mobile application	App store-accessible platform that provides members access to the most widely sought functionality (e.g., find a provider, view ID card, check an authorization)	December 2015
Grievance and appeals	Tracks and monitors grievance and appeals records, provides workflows for service teams, and provides auto-letter generation using customized reporting templates for Louisiana	December 2015
Financial	Stores financial data and is utilized for production of reports and financial planning	December 2015

Hardware and System Architecture Specifications for All Systems Used (2.10.13.2.2)

Application/system: At the heart of our information systems are our rules-based eligibility, enrollment, customer service, and claims processing systems and our web-based case management application. The system is built on Microsoft's .NET architecture, which benefits LDH by providing a high degree of flexibility, scalability, and integration with other systems. **Figure 2.10.13-1** provides additional detail regarding application systems and interfaces.

Hardware: The Aetna Medicaid organization's databases run on our next-generation database platform. All databases reside on all-flash storage arrays from IBM. The arrays deliver orders of magnitude better throughout than prior-generation storage area networks, and they are replicated in near-real time (five-minute delay) to Aetna's standby data center for disaster recovery. The compute tier is comprised of Cisco's Unified Compute System rackmount servers, each containing 1TB of random access memory and Intel's v3 Chipset. The servers are combined into a VMWare, Inc. Elastic Sky X virtual cluster for superior maintenance, fault-tolerant, and scalability characteristics. Server maintenance can be performed in a round-robin fashion at the compute tier without downtime and in the event of node failure; the remaining servers in the cluster can take over for the failed node. Computing capacity can be seamlessly added to the cluster as well without downtime. Database workloads are segmented onto dedicated virtual machines that can be patched independently of each other.

Figure 2.10.13-2 provides additional detail regarding our MIS Network Hardware Configuration Design.

[1] Aetna's systems in Louisiana reflect the MIS deployed across the Aetna Medicaid organization, with the majority of the operational components in place nationally since at least 2007.

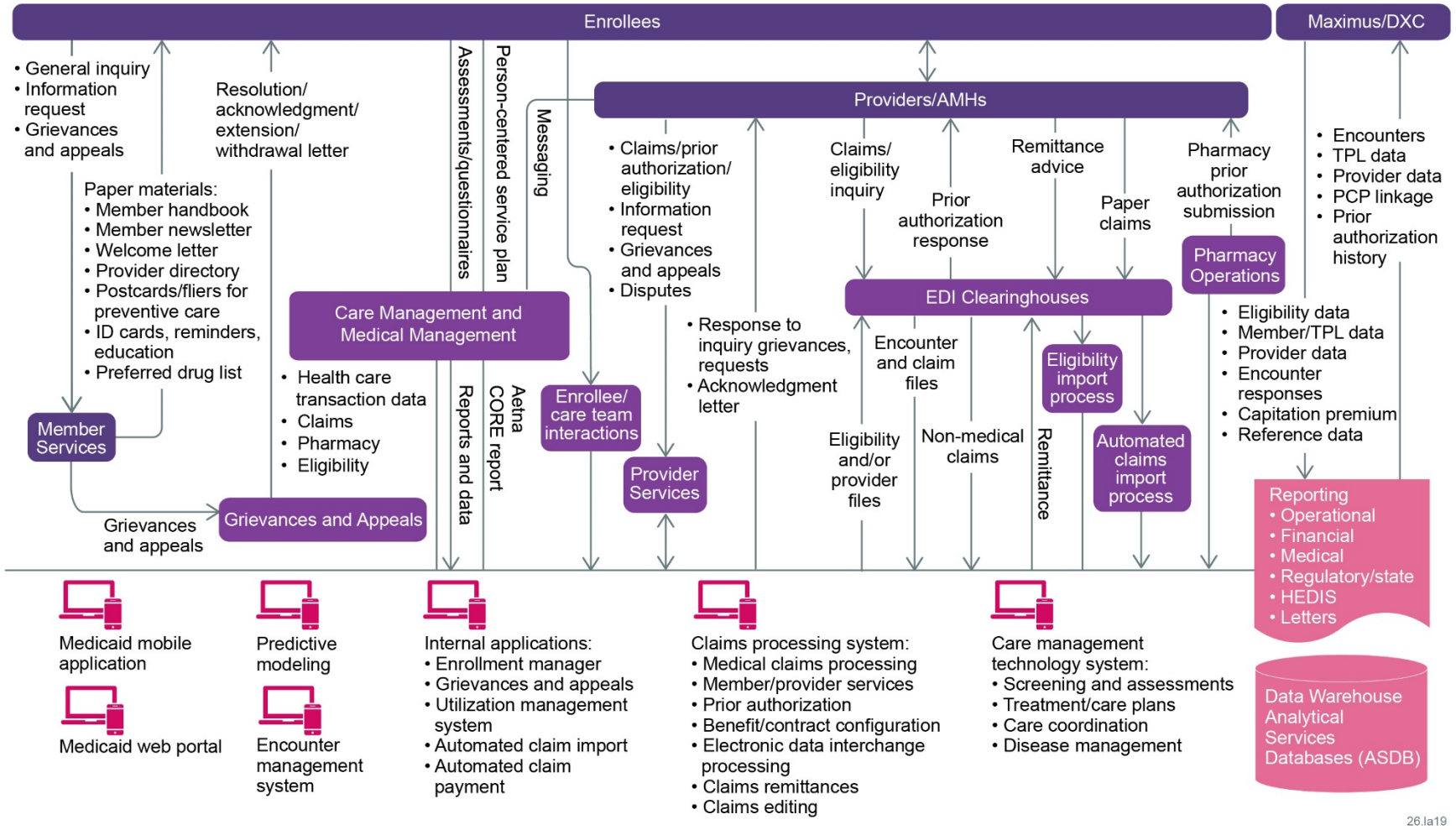

Figure 2.10.13-1: Aetna MIS Network Hardware Configuration Design

Aetna Application Systems and Interfaces Rules-based configuration provides flexibility, scalability, and integration across systems.

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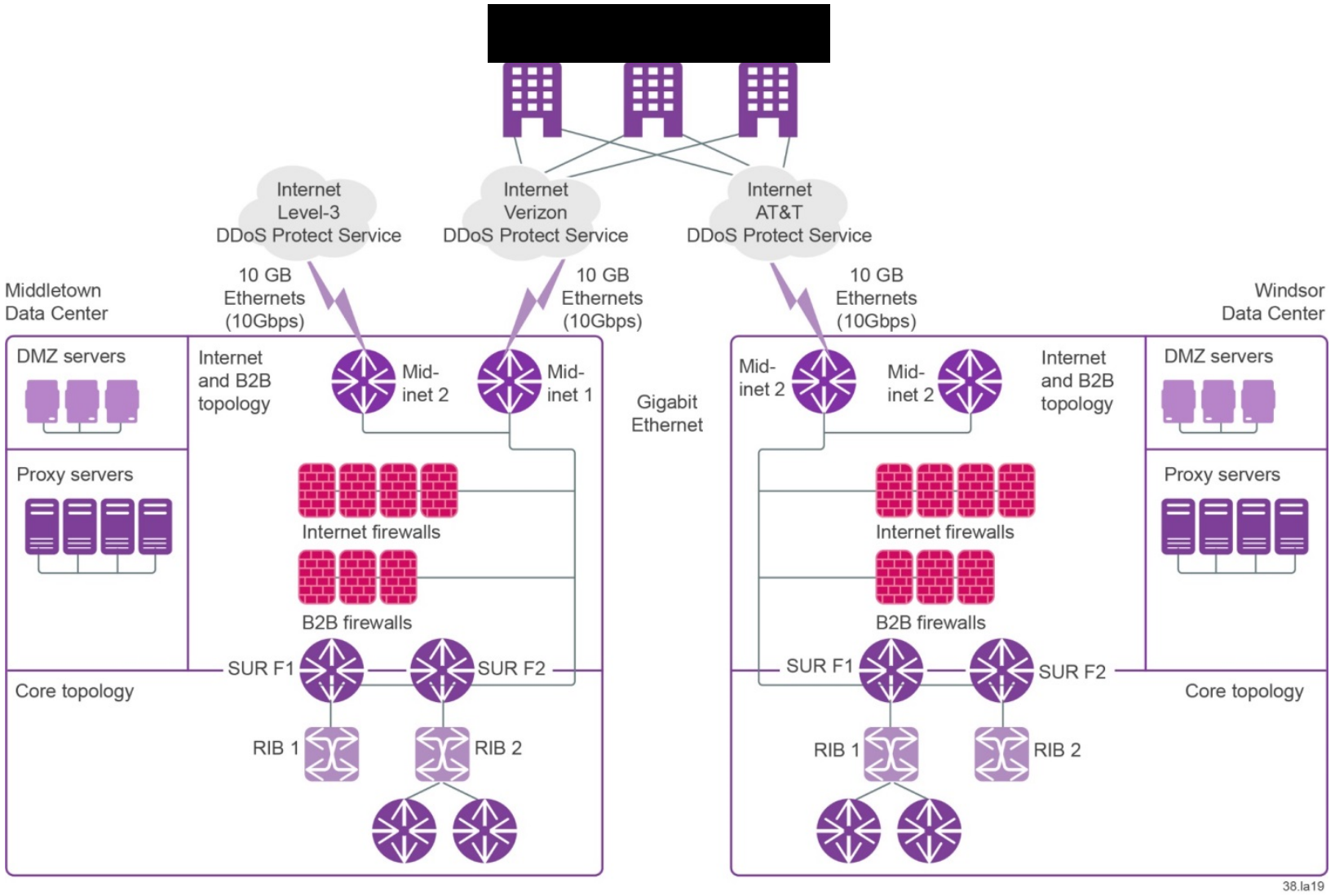

Figure 2.10.13-2: Aetna MIS Network Hardware Configuration System Design

Our resources and systems are fully integrated and scalable, supporting system changes or expansion.

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Database layer: Our database layer is powered by Microsoft SQL server, which uses a wide variety of applications to display, print, and analyze data and to produce both standardized and customized reports. We configure systems to capture the data elements needed to provide accurate and insightful reporting.

Network and telecommunications: Our network and telecommunications infrastructure consists of triple-redundant servers that enable us to connect phone calls if two of the three servers fail. Our key production and telecommunication systems include the following systems/applications: key information systems in mirrored hardened data centers in [redacted]. We also use triple redundancy for telecommunication services: AT&T-hosted cloud-based services, onsite call management servers, and application/data servers in [redacted]; and technical support services.

Interfaces: To validate compliance with HIPAA and seamless connectivity/minimal interruption of services provided by all vendors/subcontractors, Aetna is currently in compliance with the recently released Statement on Standards for Attestation Engagements No. 18 (SSAE 18), which has enhanced requirements for adequate control environments for vendors/subcontractors.

All Proposed Functions and Data Interfaces (2.10.13.2.3)

Our MIS offer robust functionality for Aetna staff and integrated tools for members and providers. **Figure 2.10.13-2** provides detail regarding data interfaces of our MIS. Next, we provide additional information regarding the functions of our MIS.

Claims Processing System

The claims processing system includes a suite of modules for claims processing, enrollment, customer service, utilization management/service authorization, and provider roster information. To meet the changing needs of the Claims Management department, we use a claims hierarchical rules engine. It was built with a feature-flagging design (rules for claims processing with a minimum disruption of services) to allow us to rapidly adjust the configuration to provide flexibility while minimizing downtime and providing greater platform responsiveness. Louisiana claims import rules have been programmed and the application is built to ease turning rules and configuration characteristics on and off as needed without affecting the entire system, further ensuring service continuity.

Enrollment files are received, processed, tracked, and stored in the enrollment management system. Enrollment update information from LDH and/or directly from the enrollee is incorporated in the enrollment files. Once we receive the 834 files, the enrollee records are compared to the existing data within our electronic claims management system. Each enrollee record is fed through our highly configurable rules processor, which identifies, matches, consolidates, and updates enrollee information to ensure proper updates to demographics, enrollment benefit plan assignments, primary care provider (PCP) assignments, member classifications, and other critical information. This system allows Aetna to monitor enrollment and identify enrollees requiring immediate services and/or service coordination. Therefore, we can identify opportunities to engage new enrollees and maintain continuity of care.

Enrollee Services System

Aetna offers automated functions for enrollees on our website, portal, mobile app, and through our integrated voice response (IVR) system. Our Enrollee Service representatives (ESRs) and IVR track every call in a member module; if a call is not immediately resolved, a follow-up tracker is set. Call tracking queues items to areas such as appeals or to case managers. ESRs are able to update an enrollee's PCP, review claims and previous interactions, update addresses and phone numbers, and issue replacement ID cards (data is securely sent to the ID card vendor daily for fulfillment). ESRs also have access to our pharmacy benefit manager's system to assist members with real-time pharmacy questions.

Utilization Management/Service Authorization Business Application

Aetna has processes to accurately and timely load updated prior authorization requirements. Aetna's utilization management/service authorization business application electronically stores and reports the time and dates for all service authorization requests received, decisions made regarding the service requests, clinical data to support the decision, and timeframes for notification to providers and enrollees of decisions. Aetna also loads new provider contracts, provider demographic information, changes in provider contract terms, and changes to the provider directory into the claims processing system in accordance with all requisite timelines.

Encounter Data Submission System

Our encounter management system is an integrated, HIPAA X12-compliant, single system for encounter management that consolidates submission and reconciliation processes. It performs comprehensive encounter validation through a coordinated set of edits and validation rules that comply with State-specific business rules, allowing us to proactively identify potential data issues and correct them at the earliest stage of the reporting process. A dedicated team monitors regulatory changes in the market and performs any needed product updates to meet State requirements and timelines. This helps to ensure accurate, consistent tracking, trending, process improvement, data collection, monitoring, validation, reporting, and error correction. The encounter management system validates encounter files received from all subcontracted vendors (such as vision and pharmacy) for compliance using standard HIPAA guidelines, SNIP levels 1-5. It performs multiple levels of validations including duplicate checks on the encounter information and provides comprehensive validation steps that ensure files are accurate and complete prior to submission.

Care Management System

The electronic care management platform allows staff to complete the health needs assessment (HNA), comprehensive assessment, specialized screenings, and the individual plan of care in electronic formats. These documents are also stored in the portal for accessibility by enrollees and their approved treatment team partners as described later in this section. The electronic care management platform has a built-in alert system to notify case managers when required assessment and plan-of-care updates are due. The platform has the ability to generate patient chronic illness education, stratify members' acuity (immediate upon assessment), and seamlessly move members along the continuum of case management tiers as outlined in the **Model Contract**. The platform also stores member additional info and preferences (social determinants of health, other demographics, and caregiver or family information).

Population Health System

Our proprietary electronic population health management platform allows Aetna's Utilization and Case Management staff, providers, and other treatment teams the ability to view real-time, actionable data about a member's admissions, discharges, and treatment needs. This platform collects data related to predictive modeling, enrollment files, HNAs, care plans, enrollee self-referral and provider referral demographics, cost/utilization reports, pharmacy data, workflows, gaps in care, and social determinants of health in a timely manner.

Through our robust provider support model, we provide the resource support for system integration, education, and training on the electronic population health management platform. In working with providers who are operating with different configurations of electronic health record (EHR) systems in the marketplace, we have found that many EHR systems are not able to connect easily to other systems. We offer our population health management platform solution to select providers as a complementary tool to round out their data set. Where possible, we will leverage tools and technologies like our population health management platform to support providers with expanding their health information technology and health information exchange (HIE) capabilities where appropriate and consistent with existing State and federal EHR incentive and expansion programs.

Enrollee and Provider Portals

For enrollees: Aetna's website has a variety of helpful sections that provide information to enrollees and aim to equip them to more actively manage their health care. Features of the enrollee area include access to the most current enrollee handbook, a comprehensive provider search function and directory, the formulary drug list, how to access translation and interpreter services, health promotion and education information, and much more. The enrollee website allows the enrollee to communicate directly with a plan representative as well. The website is compliant with the Americans with Disabilities Act of 1990 (ADA) and meets Web Content Accessibility Guidelines (WCAG), which ensures content accessibility by everyone, irrespective of disability or age.

Aetna's secure portal links provide enrollees with access to claims, health and wellness tools, and CaremarkPCS Health's member website and secure web portal services via a secured, single sign-on credential. The web portal allows individuals to determine their financial responsibility for a drug; order a refill for mail order prescription; locate a network pharmacy by ZIP code or name; determine potential drug-drug interactions, side effects, and significant risks of drugs; and determine the availability of generic products. Enrollees can also securely review drug history information and access diverse pharmacy tools, which includes the ability to complete both electronic and telephone inquiries about their pharmacy benefit and drug coverage.

For providers: Aetna offers access to the provider portal, which improves efficiencies and offers complete accessibility to provider and enrollee data and reports. The portal contains information on provider and enrollee records, claim or authorization status, electronic explanations of benefits outlining claim services payment or denials, dates of service, procedure codes, amount billed and allowed, and amount paid, as well as the status of grievances and appeals. Providers have the ability to submit prior authorizations (including pharmacy prior authorizations) and appeals and grievances through the provider portal. This web-based platform allows us to communicate enrollee health care information directly with providers in real time, inclusive of enrollee assessments and care plans.

Medicaid Mobile Application

Our mobile engagement application (app) leverages technology at the enrollee's fingertips through Android and iOS devices, using enrollees' at-the-moment activities and location to deliver access to care virtually anywhere. Our electronic care coordination platform capabilities include sharing directly with enrollees to improve information availability and care outcomes. Personalization enables services to enrollees that greatly enhance their ability to access services. With the Aetna mobile app, enrollees can get on-demand access to the tools they need to stay healthy. For example, they can find a doctor, request a member ID card, or change their PCP at any time, from anywhere. As the application evolves in preparation for the contract term in 2020, we will add functionalities to improve the enrollee experience and care. For example, we intend to add functionality that allows enrollees to complete the health needs assessment in the mobile app and store this information within the electronic care management platform. Additionally, the app will be enhanced to provide claim notification information to enrollees and will give enrollees the option to notify Aetna if they view a claim for a service they did not incur (potential fraud flag). The mobile app is compliant with the ADA and meets WCAG, which ensures content accessibility by everyone, irrespective of disability or age.

Grievance and Appeals

Our grievance and appeals application is integrated into our claims processing system and is highly customizable to capture, process, store, and retrieve detailed information on each complaint, grievance, or appeal received. We do not delegate grievances or appeals processing to any subcontractors. Aetna's comprehensive documentation allows us to maintain and track all cases from origination through resolution. The application is housed in a secure location with access limited to role-based authorities, which includes Aetna leadership, the compliance officer, data staff, and Grievance and Appeal department staff. The application is maintained by the Grievance and Appeal Oversight team.

Establishment of a system to document, process, track, and report complaint, grievance, and appeal data is State-mandated, and our system meets the criteria established by LDH.

Financial

Aetna uses a financial reporting and planning system that stores financial information including revenue and expenses for Aetna by line of business. The financial system is used for external and management reporting, and for internal financial planning purposes. The Business Information System/Informatics Finance group supports a variety of plan-based reports including Daily Claims, Weekly Claims, Speedometer, TAT Comparison, and Top 200 High Cost Members.

Data and Process Flows for all Key Business Processes (2.10.13.2.4)

Aetna's MIS infrastructure supports for the integrated, interdependent flow of data within and across systems. The following diagrams provide detail regarding data and process flows for customer service (**Figure 2.10.13-3**), enrollment (**Figure 2.10.13-4**), claims adjudication (**Figure 2.10.13-5**), care management (**Figure 2.10.13-6**), utilization management (**Figure 2.10.13-7**), and financial processes (**Figure 2.10.13-8**).

Proposed Resources Dedicated to MMIS Exchanges (2.10.13.2.5)

Medicaid Management Information System (MMIS) exchanges are handled by our national team, which works closely every day with our local health plan staff to ensure timely, fully compliant processing of all inbound and outbound files. Aetna Medicaid Information Technology (IT) takes a business-focused strategy for MIS delivery. Our team is an independent, fully dedicated organization, which serves the Medicaid quality, care, and delivery teams. Our vice president of program delivery, who has over 40 years of health care IT management experience, leads the Aetna Medicaid organization IT team and is supported by a diverse team comprised of over 250 individuals. The team is organized around specific business functions (digital innovations, enrollee and enrollment, provider experience, claims and encounters, clinical management, and finance and reporting), which allow IT to be nimble and flexible to address the needs of the local Aetna plan. Other dedicated teams are responsible for compliance, governance, infrastructure, global security, architecture, production support, and data and file management, which brings additional expertise to critical data-heavy functions like MMIS exchanges. These teams are fully versed in the latest data interoperability standard, including HL7 and the newer Fast Healthcare Interoperability Resources standards, and partners with the Medicaid Quality team and Aetna to identify appropriate market HIEs, electronic medical record data clearinghouses (i.e., Athena), and directly with large provider practices. The national team works in concert with a dedicated team of local Louisiana managers and support staff to ensure IT processes such as file transfers, enrollment, and claims processing, reporting, and all auxiliary systems are functioning properly and within State guidelines. Local staff works closely with the State's subject matter experts to assist in the delivery of solutions and turn the State's requirements into specific system or process designs for leading-edge solutions. The local team coordinates the integration of all of Aetna infrastructure support areas to ensure required IT resources are appropriately allocated to meet Louisiana's business objectives.

Availability of Data Elements to Produce Management Reports (2.10.13.3)

Aetna attests that all data elements needed to produce required management reports are available for inclusion in our report submissions to LDH. We adhere to the requirements of the **Managed Care Reporting Guide** and utilize the **MCO Manual** and **LDH's Managed Care Reporting Website** as additional sources of guidance. Additionally, our data capture mechanisms are adaptable and can be customized as needed to meet new requests related to reporting. Aetna's system supports reporting all requested data elements for even the most complex regulatory reports. We have a proven record of meeting regulatory requirements for new, ad hoc, and changing reporting needs. We work closely with LDH subject matter experts to understand their requests so that we report accurately and appropriately.

Proposed System Changes and Enhancements and Ensuring Continuity (2.10.13.4)

At this time, Aetna is not proposing material changes or enhancements to our enrollment, utilization management/service authorization, or care management/disease management systems during the term of the contract beginning in 2020. Aetna is working toward transitioning our Louisiana plan to a new encounter management system that has delivered an even higher performance outcome for encounter metrics in states where it has already been implemented. We have not yet set a firm transition date for Louisiana; however, the transition date will occur in 2019.

When we do make systems changes, we do so with utmost awareness to avoid or minimize disruption in day-to-day operations. Our processes protect and maintain system operations through all phases of change from implementation to completion through regular communication, coordination, testing, scheduling, and monitoring. Our staff includes individuals with Six Sigma training and project management certification. **Figure 2.10.13-9** demonstrates our standardized process for system changes or enhancements.

Interface with LDH, Providers, and Material Subcontractor Systems (2.10.13.5)

Aetna works closely with LDH, along with its agents, to achieve both successful health care results and effective cost outcomes. Aetna follows a secure and proven process for establishing and maintaining all EDI interfaces. We utilize industry-standard secure File Transfer Protocol servers to handle inbound and outbound file exchanges. When establishing a new EDI interface, we collaborate with the State and trading partners to exchange key information required to establish the secure connection for exchanging files on both sides. These connections enable the implementation of a wide range of data sharing, including all HIPAA X12 file exchanges; examples include enrollment (834), claim payment/advice (835), health care claim and encounter (837I/P/D), prior authorization (278), and capitation premium financial reconciliation (820). In addition, Aetna supports the exchange of custom file interfaces whenever required by LDH or other subcontractor systems.

Aetna also supports critical, real-time HIPAA transactions including eligibility inquiry and response (270/271) and claim inquiry and response (276/277). Additionally, Aetna continually promotes and adopts different transaction formats and protocols including HL7, the messaging standard that enables clinical applications to exchange data.

Aetna accepts and processes daily and weekly (and others as scheduled) enrollment files provided by LDH. We maintain a proprietary rules processing engine for loading 834 files and reconciling the data with our business application. Our rules-based engine is fully customizable to meet the specific requirements of LDH's enrollment file processing and produces comprehensive statistics reports allowing extensive reporting and monitoring by our Enrollment team.

Aetna's information system design uses powerful, reliable, and expandable data processing systems. The foundation of this platform is a redundant, high-speed local area network and wide area network, with clusters of servers with built-in redundancy. This scalability allows systems to match any escalation in demand associated with LDH's, network providers' and subcontractors' performance requirements, while at the same time maintaining system uptime and performance. Our Enrollee Services Call Center runs on a top industry-standard Internet Protocol switch, which maintains 20 percent extra capacity to cover any spikes and growth spurts.

We are also working toward enhanced data interface results through blockchain technology. **We are the only health care payer that is a founding member of two health care blockchain alliances.** In 2018, we joined the Synaptic Health Alliance, which is focused on data quality for provider directories. We are also a founding member of Health Unity Network, which focuses on reducing the friction, cost, and integration complexity between the various parties within the health care ecosystem.

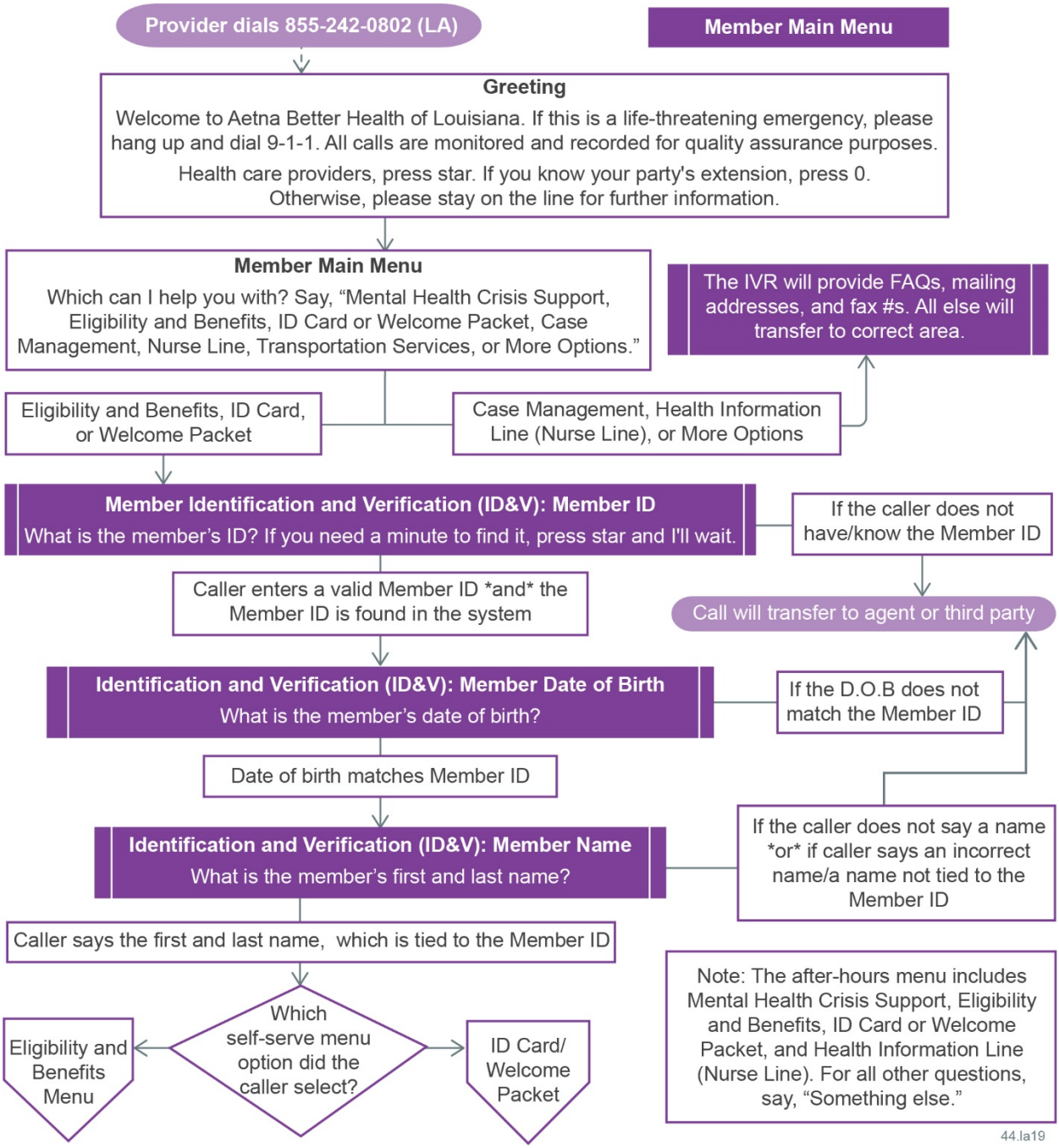

Figure 2.10.13-3: Customer Service Data and Process Flow

Our customer service system allows for documentation and verification of data related to general customer service, case management inquiry, and Health Information line (Nurse Line) activities.

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- Enrollment files are processed per the State's contract requirements
- Typically, daily enrollment files are processed within 1 day of file receipt from the regulator/enrollment broker and monthly reconciliation enrollment files on an average of 3-5 days of file receipt

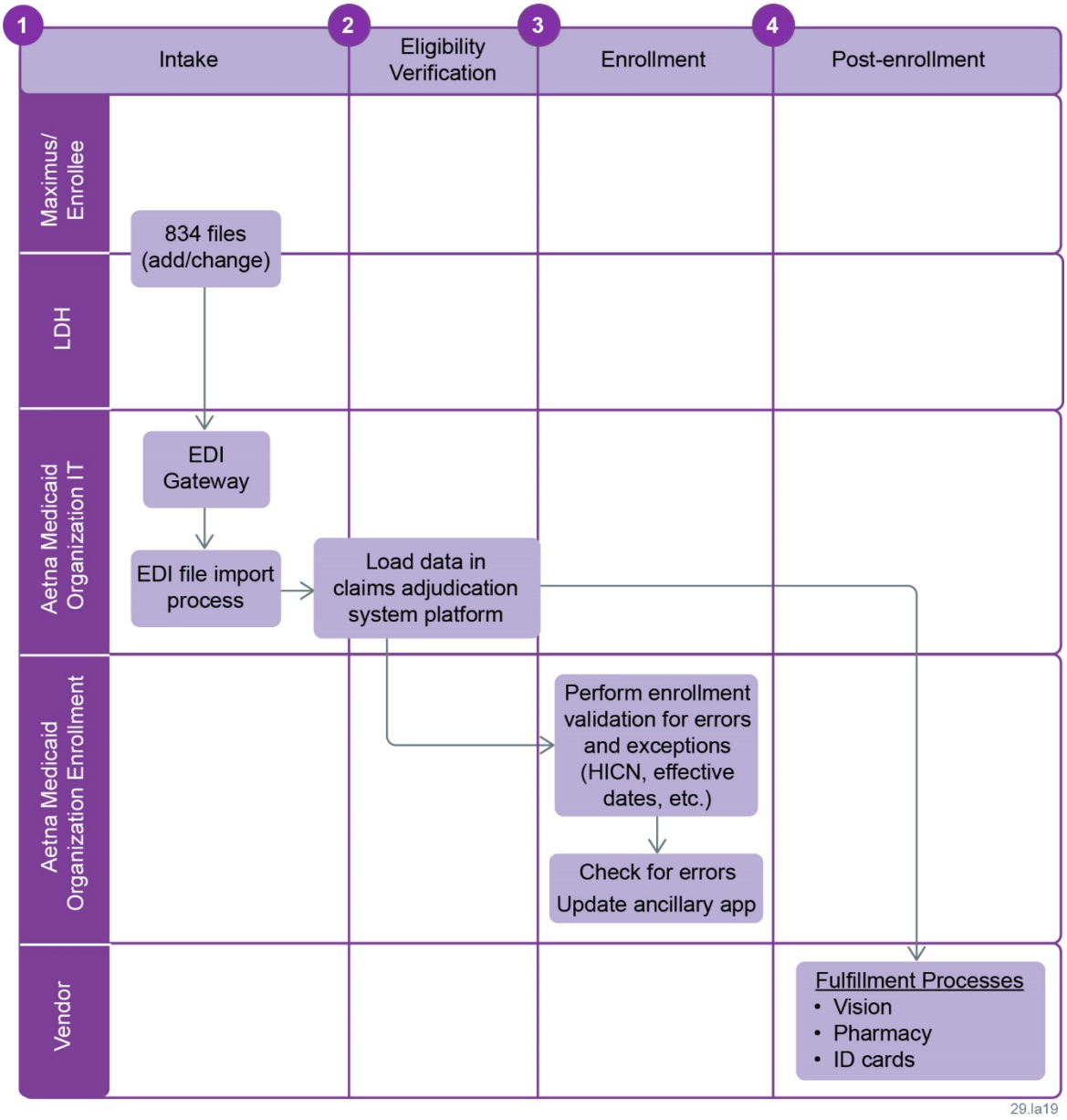

Figure 2.10.13-4: Enrollment Data and Process Flow

Aetna accurately loads and processes membership enrollment records.

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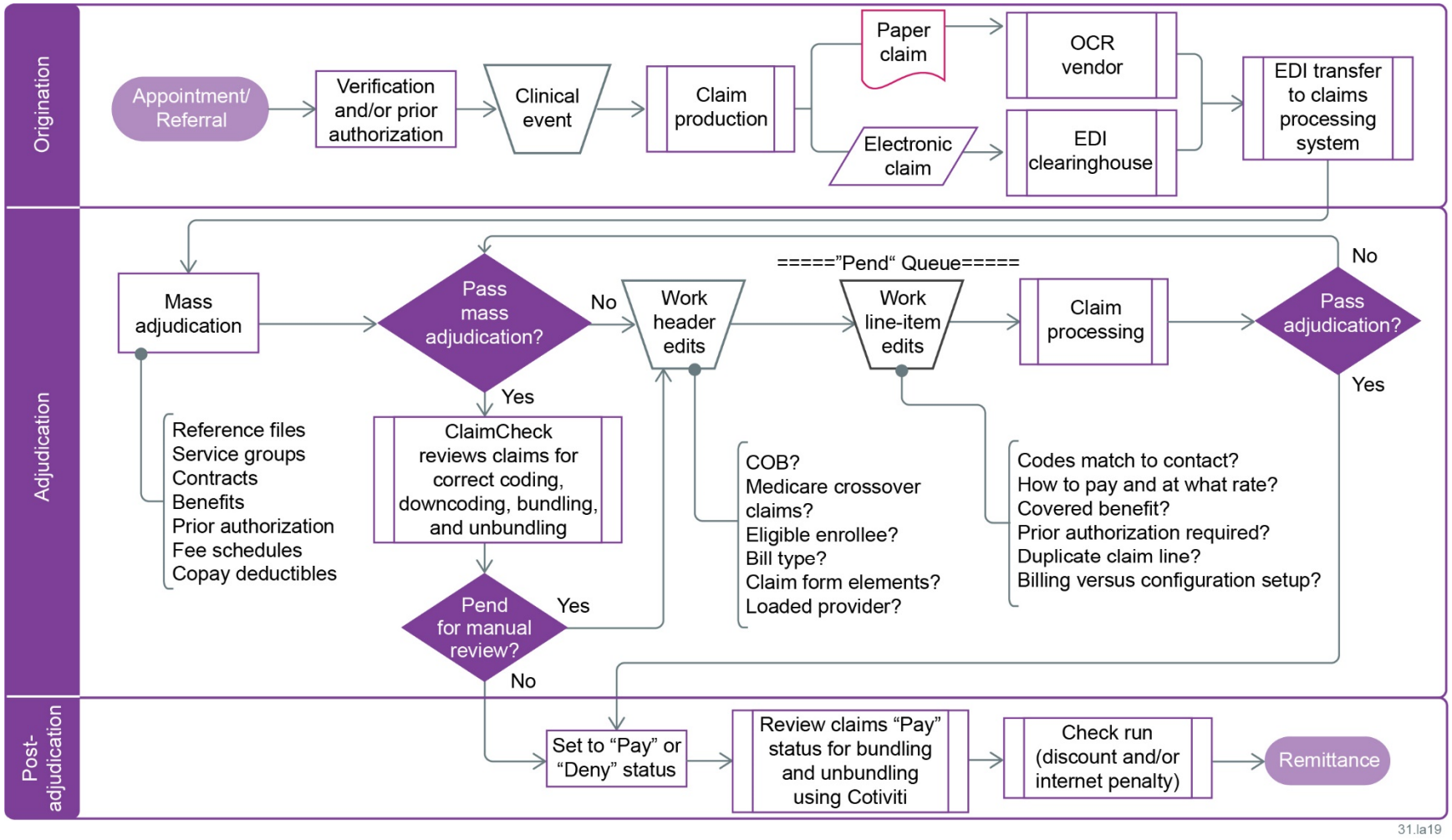

Figure 2.10.13-5: Claims Processing Data and Process Flow

Claims processing from origination to adjudication and post-adjudication.

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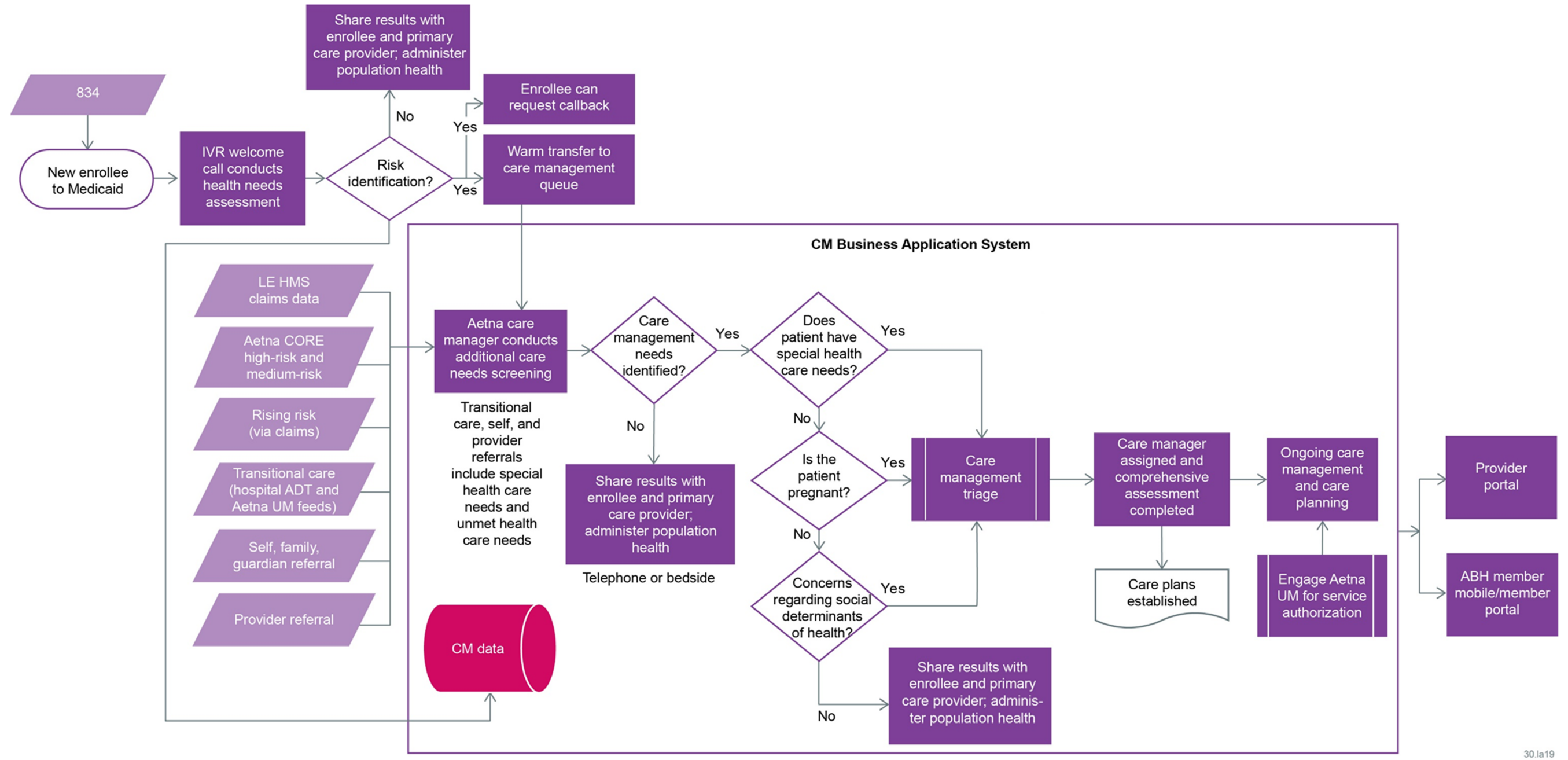

Figure 2.10.13-6: Care Management Data and Process Flow

Care management assessments and plans of care are documented, stored, and remain accessible to Care Management staff and permitted providers.

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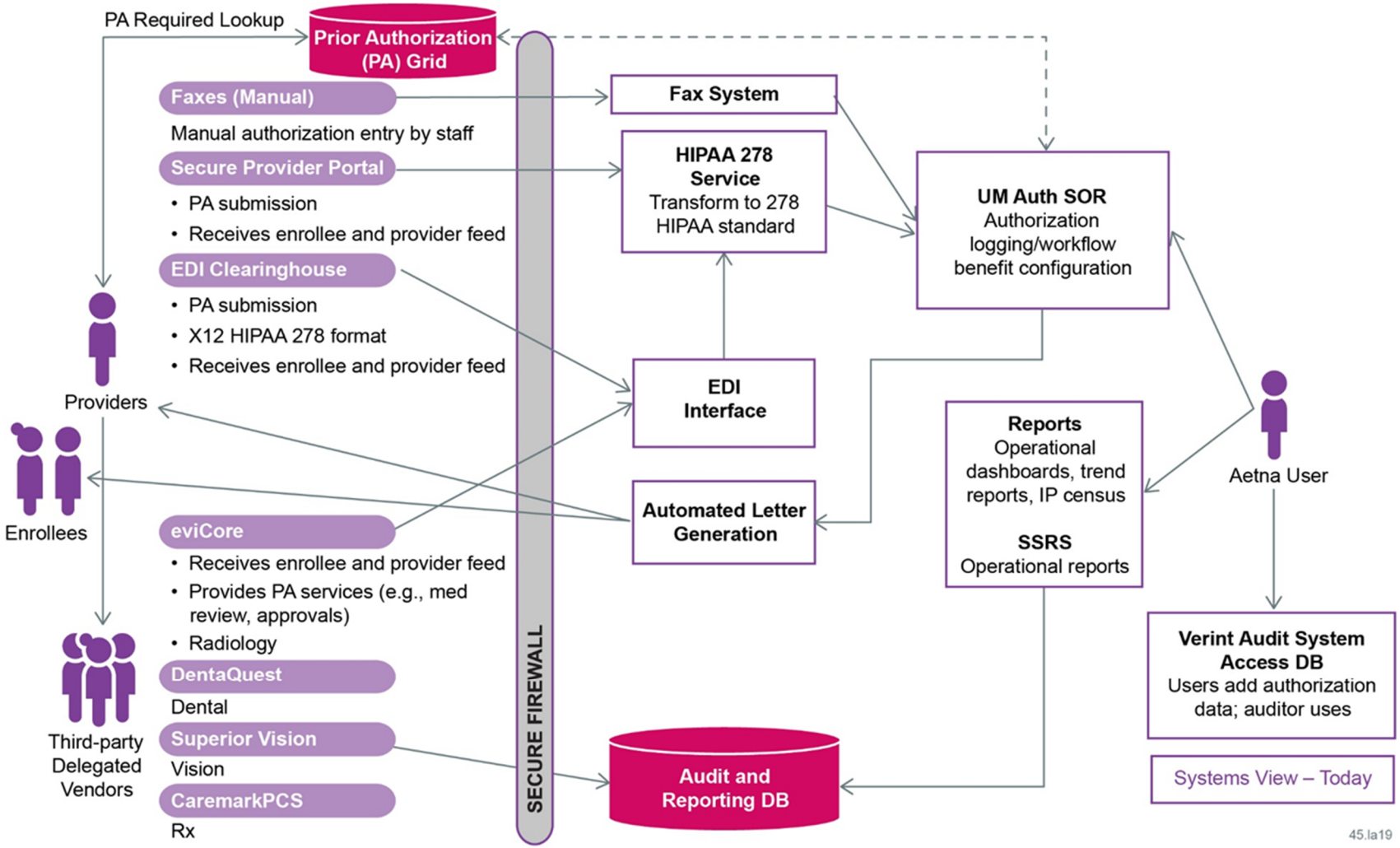

Figure 2.10.13-7: Utilization Management Data and Process Flow

The utilization management system captures data related to authorization requests and subsequent authorization decisions.

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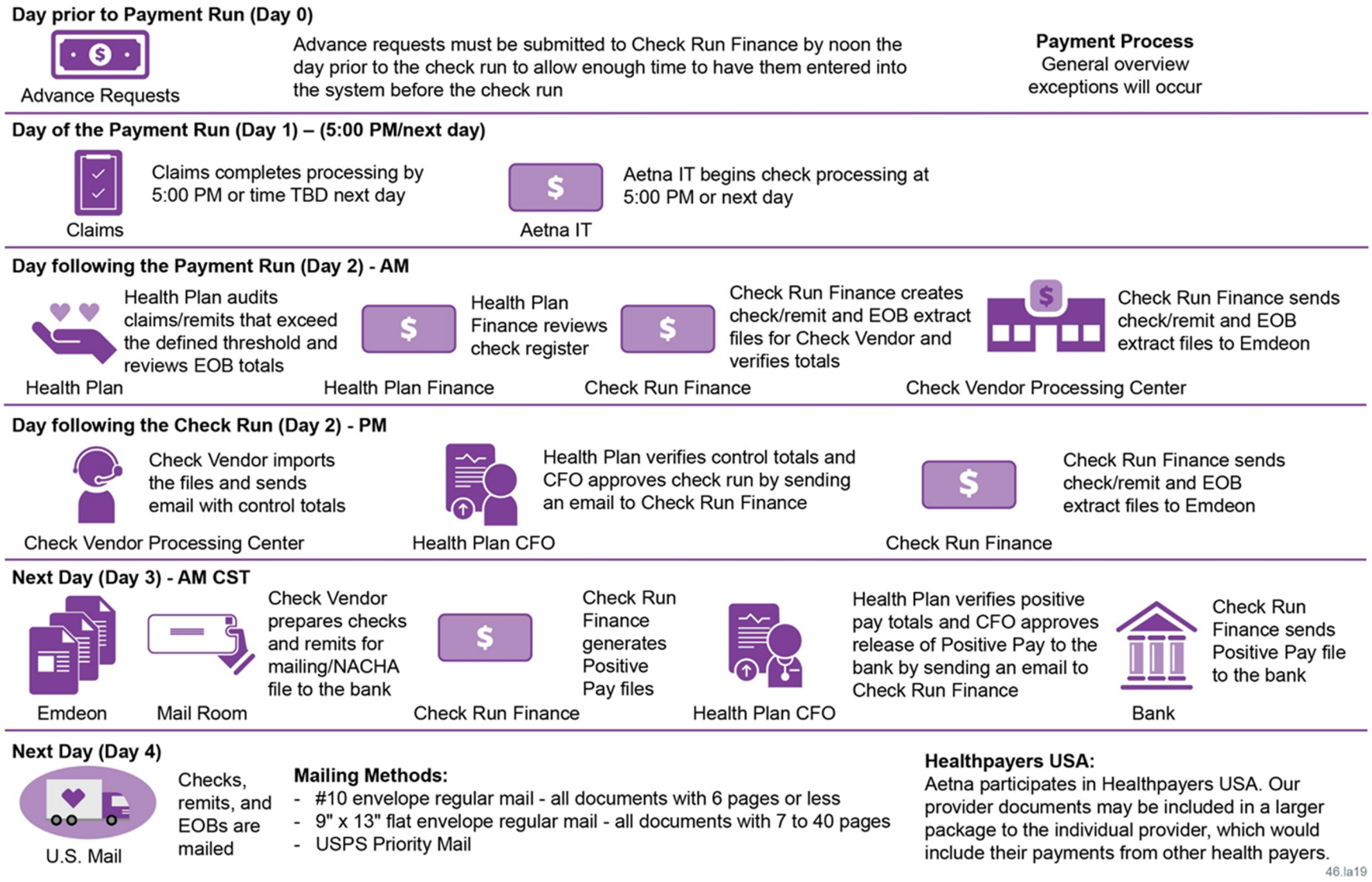

Figure 2.10.13-8: Financial Data and Process Flow

Financial processes are efficient and timely.

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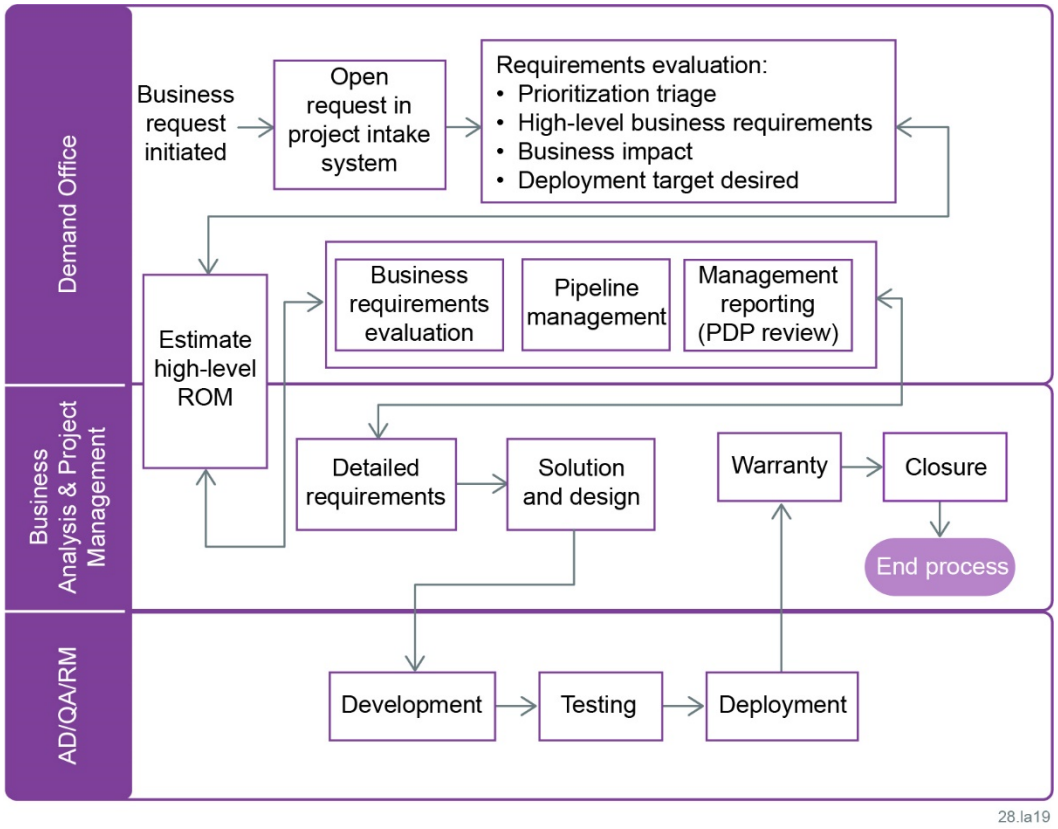

Figure 2.10.13-9: Standard MIS Change Control Process Flow Chart

Aetna utilizes a standardized process flow when implementing large-scale system changes.

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2.10.14 Program Integrity

To support Louisiana's efforts to build healthier communities, Aetna hosts regular Ted. E. Bear, M.D. festivals and fairs in all nine regions of the state. We invite several of our community partners to bring physical activities, such as yoga or Zumba, cooking and nutrition classes, and wellness screenings such as flu shots, immunizations, and body mass index checks. We also provide educational materials, safety instructions, and opportunities to connect our members to much-needed resources in their community.

2.10.14 Program Integrity

Aetna understands, acknowledges, and will comply with all program integrity (PI) and fraud, waste, and abuse requirements in the **RFP,** the **Model Contract,** and **the MCO Manual**.

Aetna's FWA Program and How We Address the Model Contract Requirements

Aetna's overall fraud, waste, and abuse (FWA) program complies with all State and federal laws and regulations relating to FWA in the Medicaid and Children's Health Insurance Program programs. Our approach consists of best practices—sound, proven policies and procedures that proactively prevent and reduce fraud, waste, and abuse. We enforce a zero-tolerance policy toward any form of FWA by staff, subcontractors, providers, enrollees, or others. Our compliance program contains robust PI processes designed to reduce or neutralize the deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification of services; prior authorization (PA) of services; or claiming payment for a service that was never delivered or received. Our major FWA activities include the following: **prevention**—prepayment claim review and routing to avoid fraudulent payments; **detection**—using proactive data analysis to identify providers of interest based on behaviors within their peer groups; **investigation**—thoroughly exploring historical/current provider billing/practice behavior; **recovery**—working with providers to understand, educate, and pursue recovery; and **reporting and compliance**—operational and financial results reporting and mandated State and federal fraud reporting. We focus on practices that are inconsistent with sound fiscal business or medical practices that result in unnecessary cost to the State's Medicaid program. Our PI program is supported by our unique local leadership and Aetna Medicaid organization that offers 30 years of national, robust experience in 16 states. This ultimately improves our enrollees' lives while reducing complexity and administrative burden for providers and enrollees and serving as responsible stewards of LDH's resources.

FWA Efforts Score High in 2018 Louisiana Compliance Audit

- Compliance rate of 100% for our FWA program
- Compliance rate of 100% for our reporting

Our PI process supports **Model Contract** requirements by being grounded in the U.S. Department of Health and Human Services and the Office of the Inspector General's (OIG) seven elements of an effective compliance program. Our approach includes information from the U.S. Government Accountability Office's July 2018 report, *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks,* and LDH's December 2018 report, *Medicaid Eligibility: Modified Adjusted Gross Income Determination Process.* We continually prevent FWA and neutralize challenges to PI by doing the following:

- Using Aetna's LDH-approved **policies and procedures**
- **Maintaining adequate staff and resources** to include a dedicated medical director and certified fraud examiners with a wide variety of backgrounds such as medical coding, Medicaid compliance, law enforcement, nursing, and social work to investigate incidents and develop corrective action plans
- Delivering provider, subcontractor, enrollee, and employee **training and education**
- **Maintaining effective communication** by collaborating with LDH to track and neutralize FWA, receiving support from our parent organizations (CVS Health Corporation [CVS] and Aetna Inc.), Compliance, and Special Investigation Units (SIUs), and following federal and State regulations and guidance to comply with **Model Contract Section 2.20**
- Publicizing disciplinary guidelines to all employees and providers
- **Using auditing and monitoring** tools such as sophisticated, market-savvy technology to measure compliance with program requirements
- **Initiating a prompt response** through investigating, referring, and reporting suspected and confirmed fraud and abuse to LDH and the Medicaid Fraud Control Unit (MFCU) and creating

corrective action plans—**we have 144 national full-time staff dedicated to FWA including the team dedicated specifically to Louisiana**

Our effective system for escalating/resolving issues and our oversight and monitoring programs verify adherence to our policies. We are committed to collaborating with State and federal agencies to combat Medicaid FWA and overpayment. We stay current on FWA and related issues by participating with the National Health Care Anti-Fraud Association (NHCAA), for which Aetna is a founding member, the National Association for Medicaid Program Integrity, the Centers for Medicare & Medicaid Services (CMS) Healthcare Fraud Prevention Partnership, and multiple health care anti-fraud task forces at state and federal levels.

Program Integrity Officer, Contract Compliance Officer, and Staff

Aetna takes full responsibility for all PI components, including compliance and our SIU—no aspects are subcontracted. As we do in our current model, we will meet the minimum staffing requirement of one PI officer, one contract compliance officer, and one FWA investigator for every 50,000 enrollees and fraction thereof for this new contract as stated in **Section 2.20.1.11**. We will also comply with requirements by locating these positions in Louisiana. **Figure 2.10.14-1** depicts Aetna's FWA reporting structure. Our FWA team, along with local executive support, supervises data collection. Program Integrity Officer Cody Cieutat is highly qualified and has the authority and corporate governance reporting relationships to oversee, implement, and maintain our PI program and FWA efforts. He reports to the chief executive officer (CEO) and board of directors and develops and implements policies, procedures, and practices designed to ensure compliance with contract requirements. Mr. Cieutat meets with our compliance officer and the LDH PI officer on a monthly call to discuss compliance-related issues and potential topics for review at the quarterly PI meetings. Our [redacted] meet with LDH and the State's Office of Attorney General MFCU quarterly, annually, and whenever requested by LDH, to discuss FWA, neglect, or overpayment issues as stated in **Section 2.18.18.2 of the Model Contract.** The compliance officer chairs the Compliance Committee, which meets quarterly or more often as appropriate to review trends, data mining, and specific allegations of FWA as well as risk and risk mitigation, training (compliance and FWA), quality compliance issues, and delegated oversight. The committee is comprised of senior executive leadership from Medical Management, Quality, Health Services, Provider Services, Enrollee Services, the Special Investigations Unit (FWA), Operations, Grievances and Appeals, Pharmacy, and Provider Network. The PI/FWA staff present information to the committee, facilitated by the compliance officer, as a way to create awareness to all other departments of potential risk and further identification of prevention opportunities, training, or trends pursuant to the contract in accordance with State and federal law.

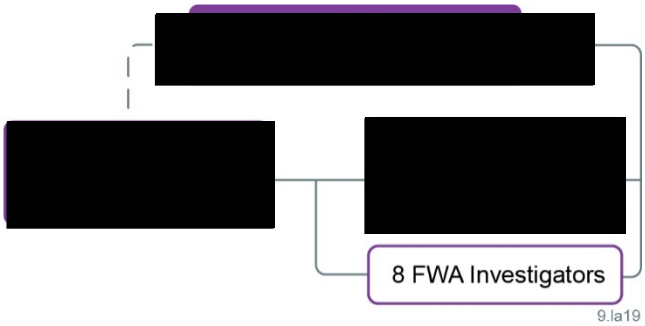


Figure 2.10.14-1: FWA Reporting Structure
Our FWA reporting structure ensures responsible oversight and executive input.

FWA Training for Employees, Subcontractors, and Providers (2.10.14.1.1)

Training is a key component to our prevention and detection. We deliver effective training programs and awareness initiatives to employees, subcontractors, and providers through a variety of forums.

Employee Training Programs and Awareness

We encourage collaboration, cross-training, and the exchange of best practices among all our staff. Our employee training supports our internal fraud prevention. Training begins on the first day of employment

and continues with Aetna's yearly education and training. This annual education includes all of our FWA and PI policies, our Code of Conduct, and ethics via a combination of in-person and online training modules. Trainings include the following: FWA mission and purpose; definitions and explanations of FWA; high-level overview of applicable federal and State regulations (such as the False Claims Act and anti-kickback regulations); how staff can report FWA to Compliance and FWA investigators; actions of an investigation (such as data mining, claims analysis, and medical record reviews); examples of successful FWA investigations; and overview of FWA partners (such as State MFCUs, the NHCAA, and CMS). Our core values of excellence and integrity align with LDH's goals and objectives to promote responsibility and accountability in the delivery of high-quality, cost-effective health care. Prevention, detection, and correction of instances of FWA and overpayment are vital to that commitment. These core values and commitment are consistently communicated to employees beginning at their onboarding/new-hire training through a variety of means, including in email communications, on our website, and during town hall and departmental meetings. Aetna's FWA policies are designed to help ensure that employees conduct business in a legal and ethical manner and to prevent, detect, and investigate embezzlement, internal theft, and other forms of employee fraud in addition to provider and enrollee FWA. New employees must complete this same training within 30 days of hire. Upon completion of initial and ongoing compliance training, our team members acknowledge that they participated and understood the information we provided and that they will adhere to compliance program requirements. **Our program integrity officer, FWA investigators, and other essential personnel receive specialized and mandatory trainings** on the investigative process; key State and federal regulations, processes, and procedures for addressing suspicious claims; and the procedure for facilitating communication among the health plan, appropriate authorities, and the FWA. Our in-person and web-based NHCAA- and industry-specific training includes coding clinics, fraud schemes in the behavioral health (BH) arena, medical record review strategies, prescription drug fraud schemes, and intensive outpatient therapy, among others. Our compliance and program integrity officers conduct ongoing FWA training at employee town halls, departmental meetings, monthly newsletters, and upon request. We also participate in all State trainings at the quarterly meetings.

Aetna publishes our **Code of Conduct training** on the intranet and on the Compliance and Regulatory Affairs home page. All employees are required to sign an attestation acknowledging that they understand and will comply with PI and compliance standards upon hire and annually as a component of their required compliance training. As set forth in our Code of Conduct, all business lines will be conducted based on the highest ethical standards and in strict compliance with applicable federal and State laws and regulations. Our Code of Conduct explains to all employees that disciplinary action will be taken, up to and including but not limited to termination, for the following:

- Failing to follow the Code of Conduct, other related policies, or breaking any laws or regulations
- Telling an employee to violate the code of conduct, an Aetna policy, a law, or a regulation
- Failing to share information, or providing false information in connection with an investigation, about a violation of the Code of Conduct, a law, or a regulation
- Retaliating against another employee who, in good faith, reports a suspected violation or who cooperates or helps with an investigation
- Neglecting to address or report a violation of the Code of Conduct, or a law or regulation, committed by someone an Aetna employee manages

We also reinforce that each employee is required to report any suspected violations of the Code of Conduct to their immediate supervisor, an Aetna compliance officer, or the CVS Health Ethics Line, which supports anonymous reporting via toll-free phone call, email, or written letter.

Provider and Subcontractor Training

Providers and subcontractors are educated on how to access our fraud and abuse form located on the main login page of our website. The link at the top right side of the page guides them to an easy-to-complete form and health plan and State toll-free numbers to call in case of suspected fraud.

Investigation Uncovers Enrollee Fraud

A local Enrollee Services representative notified FWA that an enrollee had misrepresented herself while making out-of-state transportation claims through Aetna. Once our FWA investigator contacted her primary insurer to confirm that the services had been received, we took steps to prevent further abuse. The investigator worked with our plan and the vendor to set up a prior authorization for future trips; travel would only be paid once the plan received a request with documentation from the provider. Once the PA was required, there were no more erroneous charges. This case is still pending with MFCU.

Provider Training

Initial provider training takes place during orientation, with ongoing/supplemental training occurring through online provider forums, our secure online provider portal (where content is available 24/7/365), the provider handbook, and through individual communications with the Provider Services team. Our providers are encouraged to request individual supplemental training via our Provider Services staff any time they need additional information. Providers are educated on the definitions of FWA, provider PI and compliance responsibilities, methods for preventing FWA, and how to report potential issues. Training also includes applicable laws such as the False Claims Act, Anti-Kick Back Statute, Stark Law, Office of Inspector General's List of Excluded Individuals/Entities, the General Services Administration System for Award Management, and the Health Insurance Portability and Accountability Act. Should providers have audit findings of potential FWA, we also provide FWA training to prevent further occurrences.

Subcontractor Training

All our subcontractors and their employees are required to participate in compliance and FWA training. We train our subcontractors in all areas of accountability and oversight for all functions and responsibilities that we delegate to them. In turn, we review their employee FWA program and verify that they provide FWA training to their employees. We monitor FWA activity, including whether the subcontractor is delivering the required reports and training, through subcontractor meetings.

FWA Prevention through Enrollee Engagement and Training (2.10.14.1.2)

Aetna's person-centered approach encourages enrollees to assume responsibility for their health, wellness, and care. We use the enrollee handbook, enrollee newsletters, website, and Enrollee Advisory Committee meetings as well as our verification of services process as ways to communicate with enrollees about their responsibilities in preventing and reporting instances of FWA. The enrollee handbook and website provide information on various types of fraud and abuse such as identification card fraud, inappropriate use of emergency department services, and prescription drug use and benefits. Each of these tools informs enrollees on the definition of fraud and abuse, their responsibilities, the responsibilities of others, and how and where to report suspected or known fraud and abuse. Enrollees are encouraged to report all suspected FWA by calling Aetna's fraud hotline, calling LDH's fraud and abuse hotline, or by submitting an online fraud and abuse form via our website.

Enrollee Training

Aetna is serious about tracking services and services billed to verify that the proper claims are being tracked to the enrollees receiving care and that no additional service claims are being billed for an enrollee who did not receive the service. We communicate information on FWA to our enrollees. Enrollees receive education on how to report FWA by calling the fraud hotline or using the online web form, as instructed in their enrollee materials and through explanation of benefits (EOB) letters mailed to a random sampling of enrollees every month. The following highlights our enrollee communications

vehicles concerning claims and FWA. All contacts display the amount billed, the enrollee rate, whether the claim is pending or not payable, deductible (if applicable), and copay, and include the following:

- **Enrollee mobile app:** Through a secure application, enrollees can view and verify their claims for primary care provider, pharmacy, specialist, transportation, BH, and other visits.
- **Enrollee secured portal:** Claims and pharmacy information is available for review.
- **EOB:** Enrollees can call our Enrollee Services staff and discuss the explanation of benefits and its significance; refer to their enrollee handbook, enrollee education materials, or the enrollee website; or discuss the EOB with their doctor. Enrollee EOB training includes how to track services received and confirmation that they will not have any balanced billing from us or their providers. Training also covers their responsibility to let us know if there are charges for services they did not receive.

Enrollee Helps Potential Medicaid Identity Theft

A Virginia enrollee's mother called our local fraud hotline to report potential Medicaid identity theft. Our PI department promptly reported the case to the state and provided our state partner and federal agencies with all requested information. We also issued a new identification number and card, and reviewed and identified claims resulting from the identity theft to confirm that no other members were involved. The state later announced the arrest of those involved and identified the theft as part of a scheme to obtain opioid drugs at six hospitals.

Using Data Analytic Algorithms to Detect and Prevent Fraud (2.10.14.1.3)

Aetna uses data analytics and auto-identification of potentially fraudulent claims to facilitate detection and mitigation of enrollee, provider, subcontractor, and vendor FWA throughout the claims lifecycle from prepayment to recovery. We use business intelligence software to identify providers whose billing, treatment, or patient profiles differ significantly from those of their peers. The FWA's Internal Analytics staff runs case- and scheme-specific reports that show our savings, recoveries, and prevented loss using Structured Query Language, Statistical Analysis System software, and Crystal Reports technology to support current investigations and identify new cases. The FWA team performs an annual review of the plan to identify high-dollar specialties, providers, and procedures codes. This can show the PI officer which specialties to review for outlier behavior. In addition, **on a quarterly basis, the FWA team runs a minimum of 25 tailored outlier reports of known fraudulent schemes** based on specialty and current procedural terminology codes to identify the top providers of certain services in LDH. Examples include services related to home- and community-based health care; claims from providers with historical overpayments, high resubmission/error rates, or high appeal rates; drugs/high-cost drugs; durable medical equipment (DME); services billed in a year without an associated physician visit such as outpatient or elective procedures; dramatic increase in individual provider billing year-over-year; rendering/performing providers who are prescribers/referrers of the same service; and services provided to enrollees with vulnerabilities such as extensive disabilities, multiple comorbidities, comorbid behavioral health, and frail elderly on expansive care plans. Examples that may trigger further investigation include the following:

- Discrepancy between the submitted diagnosis and the treatment
- Claims that are resubmitted with coding changes to gain benefits or alterations on claim submissions
- Questions about the medical necessity of services rendered
- High volume or high percentage of dollars paid in one or two procedures
- Providers using a post office box as their service address
- Pressure for quick claim payment

Additionally, we run quarterly outlier reports such as identifying the top providers billing 10 or more paid claims for adult day care services, the top paid providers of DME, and the top paid providers of physical therapy evaluations. The reports are referred to investigators for further review and appropriate action. At data mining meetings, FWA staff members, the medical director, clinicians, and certified coders discuss and prioritize data mining studies to analyze trends and schemes identified through various sources.

Our data mining is enhanced by **Healthcare Fraud Shield (HCFS), a platform that comes equipped with approximately 600 business rules and algorithms** that are maintained and updated quarterly. They are customizable at the health plan level to account for benefit variations, and can be applied pre- and post-payment. This platform identifies providers with potential FWA behaviors and assigns them a risk score. We use the HCFS application screens to visualize all leads and billing activity as well as download the past 12 months' worth of claims for each lead. This helps us further avoid inappropriate billing, identifies and mitigates provider confusion, and deters criminal activities, among others. It also enhances our success with our BH data mining and focuses our effort identifying significant BH issues. Our pharmacy benefits manager searches for outliers and potential fraud. For example, information from HCFS can supplement our pharmacy directors as they run high-cost claims reports. Current HCFS customers report returns from $3 to $10 for every dollar invested. Aetna completed a proof-of-concept analysis of the system in 2018, and based on the results, anticipates even greater increased FWA savings, recoveries, and prevented losses. We also receive and use leads provided by the Aetna Enterprise Analytics Fraud team. Our data analytics system provides efficient and proactive discovery of new fraudulent schemes, allowing for near real-time prepayment review capabilities to flag suspicious claims prior to adjudication. **The data analytics of all Aetna plans are shared among the plans to leverage the information on commonly used providers and provider types. This saves money by reducing the need for pay-and-chase methods of recovery**, fostering a comprehensive approach to addressing both enrollee and provider fraud by leveraging all available data sources to detect emerging fraudulent patterns. Our rules-based claims adjudication system maintains and processes health care administration data, providing increased efficiency. The provider module contains a unique provider identification number generated by the system, plus all billing and tax reporting information. The claims module shows the date of receipt, the history of actions taken on the claim, and the date of payment, including the check number. The system stores claims by specific benefit limits/lifetime benefit rules. It scrubs/edits this data for accuracy during claims processing and payment. Aetna's Medicaid Claim Quality Control department independently assesses the effectiveness of the Medicaid claims system configuration and claim procedures against the resulting adjudication process.

Defining and Identifying High-risk Claims (2.10.14.1.4)

We define high-risk claims as paid or denied claims from providers, or for enrollees whose individual profiles do not follow the expected and common pattern of their peers or have an element for patient safety/negligent. However, given the numerous FWA schemes, the definition is everchanging. Examples of high-risk claims are those paid as a percentage of billed charges, services related to home- and community-based health care, DME, and physical therapy, over-utilization and overprescribing of medications, billed for more than one unit of service, or claims that do not require PA. Currently, among the issues we review are providers who do not meet licensing requirements or those who do not have any 'barriers to entry' such as those in mental health rehabilitation; prescription claims without a corresponding medical service; use of non-emergent transportation without a medical claim; or enrollees who are inherently high-risk as referenced by the contract. We also flag claims for those enrollees with multiple chronic, physical illnesses, mental illness (with or without substance abuse), both physical and behavioral/cognitive problems, frail elderly with functional impairments, working-age people with disabilities, children with special needs, care/equipment from specialist providers such as DME, those with high emergency department use, and enrollees residing in nursing facilities.

Methods to Identifying High-risk Claims

We use a variety of technologies to prevent and detect questionable billing practices and to avoid fraudulent claims payments such as business intelligence software to identify providers whose billing, treatment, or patient demographic profiles differ significantly from their peers. We run a weekly report and manually review 100 percent of all claims submitted with dollar amounts of $70,000 or more and paid amounts of $30,000 or more. We also review the annual OIG work plan and follow CMS

recommendations on high-risk provider types. FWA investigators review the data mining report and take appropriate action. Additionally, we coordinate with our stakeholders, industry partners such as the Healthcare Fraud Prevention Partnership—a collaboration between the federal government, State agencies, law enforcement, private health insurance plans, and health care anti-fraud associations—and other managed care organizations (MCOs). Specific methods we use to identify high-risk claims include the following:

- **Internal applications** such as HCFS (previously mentioned) run enrollee analytics including: eligibility to determine if the home address is a P.O. Box; checking for multiple enrollees living at the same address/using the same phone number; verifying enrollee address and phone number during provider visits; pulling any enrollees with high emergency department use; and sorting through obituary files or investigatory news articles that may include enrollees or providers, among others.
- **Prior authorization** enables Aetna to monitor the use of defined outpatient services and procedures as well as non-emergency or elective hospitalizations before the enrollee receives the service. PAs confirm requested services are for eligible enrollees and are included in the defined benefits; provided at an appropriate level of care and place of service; appropriate, timely, and cost-effective; coordinated with medical management; communicated to applicable operations areas (e.g., finance, enrollee services, provider services) or per contractual requirement with external vendors; and documented accurately to facilitate timely reimbursement and reporting.
- **Drug utilization reviews** (DUR) are performed by Aetna's pharmacy benefit manager, CaremarkPCS, in addition to the State's required DUR reviews. We perform prospective, concurrent, and retrospective DURs as methods for identifying suspicious activity. DURs also enable enrollees to achieve improved health outcomes, help prevent negative outcomes, improve quality of care, and reduce costs by preventing inappropriate or unsafe drug use. The prospective and concurrent DUR processes are executed using computerized algorithms built into CaremarkPCS' claim history. The system prevents dispensing without further review and/or action by the dispensing pharmacists at the point of sale and creates alerts such as the following:
  - **Soft block alerts** so the pharmacist evaluates the enrollee's drug profile. The alerts offer considerations to the enrollee for discussion with their provider, counseling on appropriate drug use, and/or consultation with the provider concerning the appropriateness of the medication
  - **Hard block alerts** result in a rejection that would require the pharmacist to reach out to the prescribing provider to submit a request for PA and/or to contact the pharmacy help desk for an override prior to dispensing the requested medication
- **Retrospective DUR** adds a second layer of safety for situations that may have a negative clinical impact on an enrollee. Retail and mail prescriptions are reviewed daily for serious drug-to-drug interactions. The prescriber is notified with an actionable, enrollee-specific communication within 72 hours of the claim processing. This program provides near real-time review and intervention focused on increased enrollee safety and increased prescriber engagement. **In 2018, 3,422 drug interaction alerts were sent to prescribers within 72 hours of fill; 8 percent of the prescribers who responded noted that prescribers found intervention information useful 30 percent of the time, and not useful only 7 percent of the time**. A third layer of safety is applied through a program from CaremarkPCS to target high-risk drug classes, focusing on controlled substances and inappropriate use and misuse-related indicators such as poly-pharmacy, provider shopping, high-total controlled substance claims volume, and drugs at risk for FWA. On a quarterly basis, clinical pharmacists evaluate controlled substance claims and available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. Pharmacists also conduct follow-up activities using physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to our pharmacy director and case manager for further action. Target drugs include opiates, anti-anxiety and sedative hypnotic agents, muscle relaxants, and central nervous system stimulants.

- **Pharmacy Lock-In Program** allows Aetna to control the over-use of opioids by only allowing an enrollee to obtain their opioids prescription from the same physician and same pharmacy. Some of the enrollees referred to case management are participants in our lock-in program. Based on the various monitoring and trend analyses described previously, we implement or refine interventions to improve prescribing and utilization patterns and to control costs. These interventions may include but are not limited to the following:
  - Identifying prescribing patterns of specific practitioners that warrant outreach and/or education to review inconsistency with nationally recognized treatment protocols
  - Making referrals to the Lock-in Review Committee to evaluate identified enrollees' utilization to determine whether they are candidates for pharmacy or prescriber lock-in
  - Making referrals to FWA, the OIG, or law enforcement agencies for further investigation of enrollees, prescribing practitioners, and pharmacies
  - Identifying and making referrals of enrollees to service coordination for outreach and engagement with a focus on adherence to medication regimens
- **Targeted audits** (e.g., contract, benefit, provider, diagnosis, procedure, specific service, and place of service). Aetna audits 2 percent of manually adjudicated claims, 15 percent of auto-adjudicated claims, and claims with billed charges of $70,000 or greater are subject to 100 percent prepay high-dollar audit review on a daily basis. Each audit includes key departmental issues identified in addition to a summary of financial and procedural accuracy. Aetna finalizes, publishes, and distributes monthly and quarterly audit results to the business units. The reports include trends by error type, claim identification, and analyst identification, which enable the Claim Operations department to conduct continuous quality improvement discussions. Based on audit findings, management staff provide or track additional training as needed.
- **Post-payment reviews** are conducted in collaboration with Cotiviti to perform postpay reviews for all claims using data mining analytics, plus validation of diagnosis-related group accuracy. Cotiviti performs a clinical chart review if improper billing or potential FWA is identified and contacts the provider for adjustment or recoupment as needed. In addition to Cotiviti, we contract with Change Healthcare and Equian to provide multiple types of external claims audits daily to check for billing errors and inconsistencies, service appropriateness, and correct coding.
- **Non-emergency medical transportation fraud scheme detection** highlights red flags. In coordination with our transportation vendor, we use the following methods: analyzing trip logs; performing a random sample of calls/monthly EOB letters to enrollees to verify trips; and auditing transportation vendor claims and reviewing grievance and appeals data. The intention is to identify documentation of trips to a doctor's office when the patient does not have a scheduled appointment; billing for trips that did not take place; cancelled trips or trips for deceased members; transport by ambulance when the member could have been transported by car or other safe mode; falsification of trip reports; and non-licensed drivers or the use of excluded personnel. Additional prevention measures include license and exclusion checks.

Other Methods of Fraud Detection

FWA are detected through several other activities and sources, including the following:

- Universal Web Information Delivery, a reporting application that investigators use to pull data for their desktop audits; FWA investigators can run standard reports to supplement investigations by provider tax ID, national provider identifier, enrollee ID, and procedure codes, among others
- TIPS also reviewed during monthly FWA from other MCOs
- Referrals of suspected FWA by enrollees, providers, and Aetna departments outside the FWA area
- Referrals from law enforcement/State regulatory agencies such as LDH, MFCU, and OIG
- Monitoring of national trends and specific case referrals through Aetna affiliations with national industry groups, including the NHCAA

- Offering a toll-free, 24-hour telephone hotline for reports of actual or suspected FWA
- Maintaining an email address and web form for enrollees and providers to report FWA

Experience with Provider Recovery Collection (2.10.14.1.5)

Aetna uses verified, time-tested policies and procedures (P&Ps) to outline all the steps we take from fraud and abuse identification to pre- and post-recovery efforts. This safeguards us, our providers, and our subcontractors, and helps us proactively manage and analyze prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud to the State as required by **42 C.F.R. § 438.608(a)**. Aetna policies that protect our recovery efforts include the following:

2018 Louisiana FWA Savings

- Recoveries received: **$224,062**
- Recoveries pursuing: **$1,784,873**
- Flagged savings: **$826,542**
- Prevented loss: **$391,941**

Total program integrity savings: $26,237,246

- Procedures for notifying LDH of network providers' changed circumstance that may affect their eligibility to participate in the Medicaid managed care program
- Retention policies for the treatment of recoveries of overpayments from Aetna to providers, including recoveries of overpayments due to FWA
- Procedures for paying recoveries of overpayments to LDH when we are not permitted to retain the full recovered amount
- Procedures for reporting within 60 calendar days identified excess payments
- Procedures for routinely verifying whether services that have been represented to have been delivered by network providers were received by enrollees
- Procedures for providers to report and return overpayments within 60 days of identification

All overpayment recoveries are administered in accordance with LDH's requirements. We coordinate overpayment reimbursement with LDH to make certain payment recovery is accurately reflected in medical loss ratio calculations and capitation rate setting. Our specific encounters P&Ps help ensure compliance with LDH requirements and include data entry, claims manual adjudication, claims submission, non-contracted provider claims, claims inventory management, and micrographics. Our manual informs providers of their obligations to Aetna and LDH. Under the provider responsibilities section in the provider manual, we explain that providers must monitor and audit their activities to prevent/detect FWA; monitor/report on preventable conditions; retain patient records for the mandated period; ensure that all documentation provided is timely, accurate, and complete; ensure Aetna is the payer of last resort; and report/return any identified overpayments within 60 days. We will comply with all provider manual requirements, including submitting the manual to LDH for approval within 30 days of contract award before disseminating to our providers and submitting major updates within 15 days.

Experience Producing Reports and Proposed Innovations for Reporting Data

Once potential FWA is detected, our program integrity officer is responsible for the investigative process and reporting to LDH. After the investigation is complete, a final report including an executive summary, case notes, and recommendations, including any recovery figure, is presented to the compliance officer and the FWA Committee, when appropriate. This committee reviews the case and develops a corrective action plan. If Aetna finds a credible allegation of fraud at any point in the process, the case is reported to LDH and MFCU. When guided by LDH's workflow process, we pend the investigation and any other actions. For each complaint that warrants full investigation conducted in accordance with **42 C.F.R. §455.15 and §455.16**, Aetna provides LDH, at a minimum, with the provider name, ID number, source, and type; the nature and source of the complaint; the approximate amount of money, if applicable; and any legal or administrative disposition of the case needed to describe the activity regarding the complainant. Aetna sends a monthly report to LDH's Program Integrity Office on all audits performed and overpayments identified and recovered by Aetna or its subcontractors as well as a monthly report

stating all unsolicited provider refunds. We also report any overpayments made to us by LDH within 60 calendar days of identification. Examples of reports we use include the following:

- **The MCO enrollee fraud referral template** is used to evaluate an enrollee case to determine if a referral to LDH is warranted based on the findings. If the investigator has an allegation they cannot validate, yet details of the allegation are substantial, a referral will be made. Once the referral is complete, a workflow is set up; we have seven days to respond, approve, and email to LDH's program integrity and local law enforcement for further action.
- **Provider fraud notice** is used for validated allegations of fraud or abuse, and it includes information to determine if State sanctions are warranted. If so, a workflow is initiated, reviewed, and approved by our supervisor, an email is sent to LDH's PI Medicaid Fraud Control Unit's chief auditor, and then it is passed onto local law enforcement.
- **Provider fraud referral** is used to validate suspected fraud and determine if further action is required. If action is required, it is sent to LDH's PI for evaluation of sanctions and to MFCU to determine if a criminal investigation is warranted. Once workflows are established, reviewed, and approved, our supervisor will send the information to the provider fraud referral to LDH's PI and MFCU chief auditor and chief investigator for evaluation and local law enforcement review.
- **The SIU Medicaid Data Analytics reports** that track new, active, ongoing, and closed cases. The first one is a monthly TIPS report with data coming from the Case Tracker system (the SIU application that holds all referral/case detailed information and documentation). This report includes any active, open, or closed referrals/cases from the previous month, and is submitted to LDH by the SIU supervisor. The second report is the 2.17 Schedule AC Fraud and Abuse Activity report that lists all new, active, and closed fraud and abuse cases for the year and comes from our Case Tracker system and claims database system. The Data Analytics team submits this to internal employees in the Finance department. The third report is the PI 145 FWA quarterly report, created using our Case Tracker database, and is given to the FWA supervisor and investigators for review. Once completed, it is sent to compliance for LDH submission.

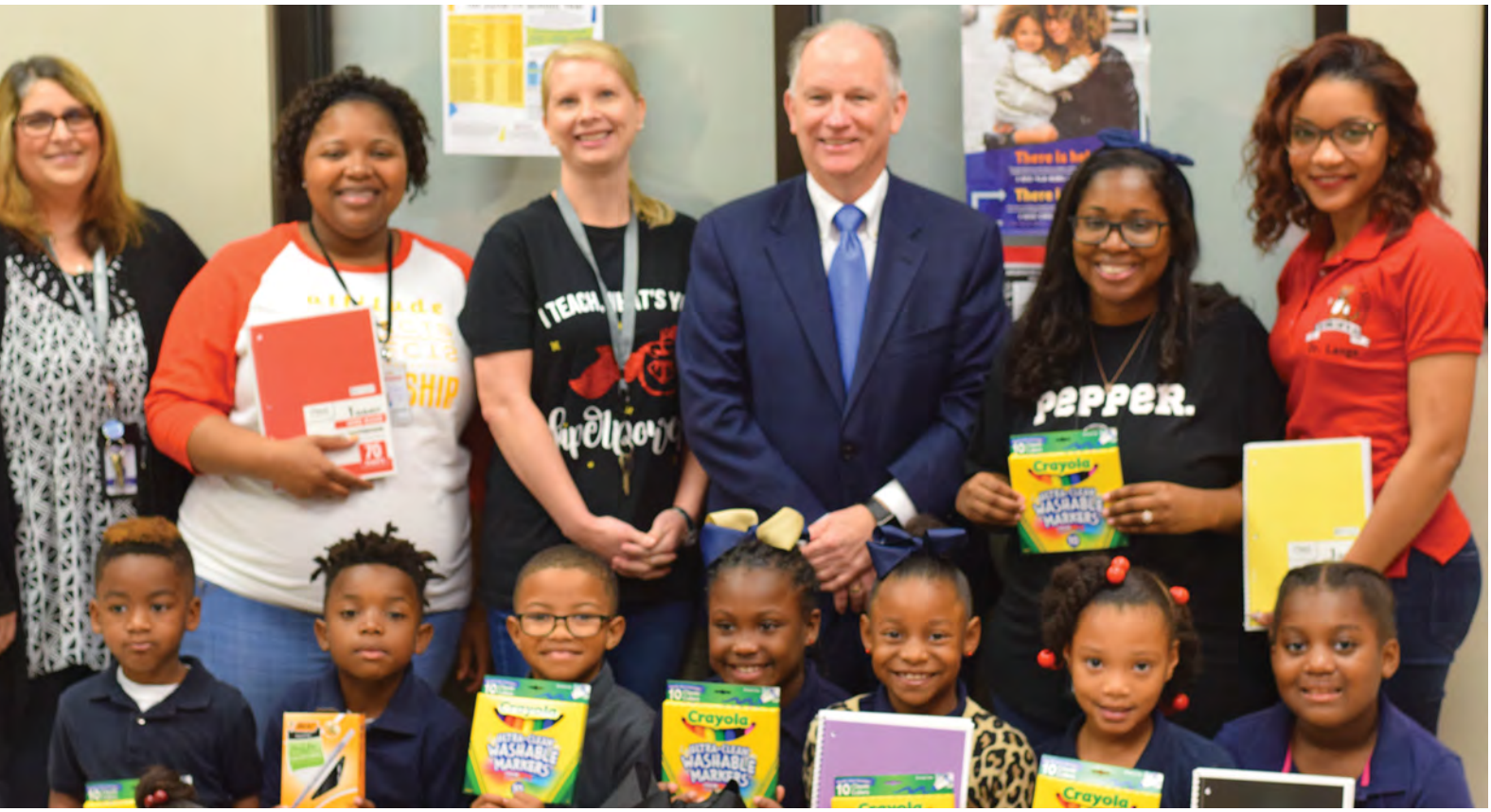
Coordination with Commercial and Medicare

As part of a national organization, our program integrity officer has open, immediate access to Aetna's corporate FWA leadership and tools to support our FWA prevention and detection efforts. This creates synergy with our corporate FWA investigators who monitor commercial and Medicare lines of business to leverage corporate-wide data. This economy of scale improves Aetna's ability to detect and remedy incidents of FWA. For example, if a provider improperly bills Medicare, FWA investigators check all lines of business for the same allegation, including Medicaid, which gives us additional leads through data mining we may not otherwise find. Similarly, Aetna's national Medical Economics department advises the local health plan regarding current trends and schemes occurring around the country.

Innovations for Reporting Data (2.10.14.2)

Enrollee-focused reporting innovation: We are in the process of creating our pending claims notification phone app. We will be providing claim notifications and other popup information in our enrollee mobile application to catch inappropriate claim billing after payment. This will allow the enrollee to either confirm or deny that the claim was theirs. We will provide easy-to-follow instructions when a member believes the claim was fraudulently submitted. **Internal-focused reporting innovation:** Healthcare Fraud Shield is our new lead generation tool, **a platform that comes equipped with approximately 600 business rules and algorithms** that are maintained and updated quarterly to prevent FWA. HCFS assigns a risk score for each provider or enrollee and uses application screens to show all leads/billing activity for follow-up. The tool can download the past 12 months' worth of claims for each lead. HCFS contains provider, enrollee, and alert dashboards that show the top potential FWA providers and enrollees, top scoring specialties, score analysis, and top changes in provider risk scores.

2.10.15 Veteran Initiative and Hudson Initiative Programs Participation



Each year, Aetna chooses schools in underserved communities to support throughout the school year. In the spring we help to restock the school supplies that many teachers are replacing with their own money for their classroom. We bring the basics such as crayons, markers, and pencils, as well as help to replace other much-needed supplies like copy paper, tissue, hand sanitizers, and cleaning supplies. In 2018, we served Donaldsonville Elementary School, providing essential items to over 300 students.

2.10.15 Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative)

Our commitment to veteran-owned and service-connected disabled veteran-owned small entrepreneurships (Veteran Initiative) and those participating in the Louisiana Initiative for Small Entrepreneurs (Hudson Initiative) helps us to better serve the communities in which we live and work. At Aetna, we believe that solutions for the people need to be of the people. This philosophy informs our approach not only to subcontracting, but also continues our tradition of Louisianans serving Louisianans.

Minority Business News (MBN USA) recognized Aetna among the 2017 Corporate 101: America's Most Admired Corporations for Supplier Diversity for demonstrated commitment to growing and developing minority-owned enterprises and "positively impacting the manner in which our world does business."

Aetna supports LDH's commitment to promoting full and equal business opportunities in State contracting and will comply with all federal and State laws and regulations, Healthy Louisiana policies, and rules regarding the use of Veteran and Hudson Initiative small entrepreneurships. Using local suppliers and subcontractors is valuable to Aetna—giving back to the community and gaining local insights improves our ability to serve our members. In our view, this is fundamental to success and innovation in a multicultural world. During our current contract, we maximized our use of Veteran and Hudson Initiative small entrepreneurships, and going forward, we will continue that commitment.

Aetna has made a good faith effort to identify services of certified small entrepreneurships to maximize and fulfill our subcontracting needs. In **Table 2.10.15-1,** we identify Louisiana Veteran and Hudson Initiative small entrepreneurships Aetna subcontracts for the Healthy Louisiana program.

Table 2.10.15-1: Veteran and Hudson Initiatives Subcontractors

Subcontractor Name	Hudson, Veteran, or Service-Connected Disabled Veteran/ Certification Number	Description of Work to be Performed	Anticipated Dollar Value of the Subcontract (3-Year Total)
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

Subcontractor Name	Hudson, Veteran, or Service-Connected Disabled Veteran/ Certification Number	Description of Work to be Performed	Anticipated Dollar Value of the Subcontract (3-Year Total)
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]	[redacted]

Subcontractor Name	Hudson, Veteran, or Service-Connected Disabled Veteran/ Certification Number	Description of Work to be Performed	Anticipated Dollar Value of the Subcontract (3-Year Total)
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]			[redacted]

Commitment to Supplier and Subcontractor Diversity

To support the local market, Aetna looks for ways to use businesses and suppliers that are certified as Veteran and Hudson Initiative small entrepreneurships. Supplier, subcontractor, and employee diversity can help us better understand and serve our multicultural markets, improve our products and services, and create a stronger, more vital company. By evaluating a diverse slate of subcontractors, we can lower costs and increase innovation. We also gain valuable insights into multicultural markets to better serve the communities where we live and work.

Leroy's LipSmack'n Lemonade

Aetna Better Health of Louisiana is especially proud to include Leroy's LipSmack'n Lemonade as one of our valued Hudson Initiative small entrepreneurs. We met owner Leroy Hayward III at a March of Dimes event we sponsored in 2018, when he was 11 years old. Leroy has growth hormone deficiency and hearing loss in both ears. His passion for lemonade and entrepreneurship prompted him to enter the Louisiana Lemonade Day contest, an annual event for young lemonade entrepreneurs[1]. Leroy's LipSmack'n Lemonade is the only Lemonade Day Entrepreneur of the Year award-winner with whom we subcontract. Leroy's lemonade stand will provide natural refreshment at Aetna Better Health of Louisiana community and employee engagement events.

We strive to be inclusive in our sourcing activities. We have established proactive efforts to reach Veteran and Hudson Initiative small entrepreneurships. Other Aetna Medicaid organization health plans have achieved a level of success in purchasing through historically underutilized subcontractors in support of our national portfolio. We continue to look for new opportunities to integrate them into the way we do business. As in the past, Aetna will report to the State our expenditures for certified Veteran and Hudson Initiative small entrepreneurships in Louisiana.

Supplier Diversity Program Objectives

Aetna's supplier diversity program has two major objectives. The first objective is to increase first-tier dollars procured directly through historically underutilized subcontractors such as Veteran and Hudson Initiative small entrepreneurships. Each year, Aetna establishes both enterprise and business-area subcontractor and supplier diversity targets that are directly tied to our management scorecard. We track and communicate performance to key business area leaders each month and to our Executive Committee each quarter. As an

DiversityInc named Aetna once again to its Top 50 Companies for Diversity in 2018. Aetna placed #30 on the Top 50 list and #12 on the Top Companies for Employee Resource Groups Specialty List.

[1] Randall, Kayla, "Summer Sippin': Leroy's LipSmack'n Lemonade," 225 Magazine (June 1, 2016): accessed April 12, 2019; https://www.225batonrouge.com/food-drink/summer-sippin-leroys-lipsmackn-lemonade.

enterprise, we strive to demonstrate year-over-year growth in our supplier diversity expense. The second objective of our program is to develop second-tier purchasing partnership relationships. Aetna requests our prime suppliers to meet second-tier targets in support of both our diversity strategy and business needs. We believe that to be successful, not only do we have to support historically underutilized subcontractors, but so must the other companies with whom we do business.

Aetna's Community Involvement

In addition to maximizing our investment in Veteran and Hudson Initiative small entrepreneurships, Aetna holds a national corporate membership with the following diversity organizations, through which we gain insights that inform our strategy and approach to diversity with our suppliers:

- National Minority Supplier Development Council
- Women's Business Enterprise National Council
- National LGBT Chamber of Commerce

Aetna also participates on the following boards and councils:

- Board of Directors for the Greater New England Minority Supplier Development Council
- Procurement Council through the National LGBT Chamber of Commerce

We remain committed to maximizing supplier diversity and contracting with Louisiana-certified Veteran and Hudson Initiative small entrepreneurships to better serve the Louisiana communities where we live and work. By working with local small entrepreneurships, we uphold our commitment to quality, ready access, and innovation to maximize enrollee health, advance health equity, and address social determinants of health within a flexible, value-based approach.

Attachment A

Louisiana | Transforming Health Care | **Aetna**

ATTACHMENT A: Certificate of Authority

State of Louisiana

UNION JUSTICE AND CONFIDENCE

JAMES J. DONELON

COMMISSIONER OF INSURANCE

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

DO HEREBY CERTIFY THAT

Aetna Better Health Inc.

has complied with all requirements and is hereby licensed to act as a

HEALTH MAINTENACE ORGANIZATION

in the State of Louisiana
This license shall remain in effect until canceled, suspended, revoked.

License is restricted to participation in Coordinated Care Program
and Medicare Advantage Program

Amended License. Original issued June 1st, 2011

Given Under my signature, authenticated with the impress of my

Seal of office, at the City of Baton Rouge, this, 9th day of

April A.D. 2018

James J. Donelon
Commissioner of Insurance

Attachment B

Louisiana | Transforming Health Care | **Aetna**

Attachment B: Audited Financial Statements and Tax Authority Certificate

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Aetna Better Health® of Louisiana Audited Financial Statements 2015

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Financial Statements - Statutory Basis

Aetna Better Health, Inc.
(a Louisiana corporation)

Year Ended December 31, 2015
with Independent Auditors' Report

KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Aetna Better Health, Inc. (a Louisiana corporation):

Report on the Financial Statements

We have audited the accompanying financial statements of Aetna Better Health, Inc. (a Louisiana corporation) (the "Company"), which comprises the statutory statements of admitted assets, liabilities, capital and surplus as of December 31, 2015, and the related statutory statements of revenue and expenses, changes in capital and surplus, and cash flows for the year then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Louisiana Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by Aetna Better Health, Inc. (a Louisiana corporation) using statutory accounting practices prescribed or permitted by the Louisiana Department of Insurance, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

The effects on the financial statements of the variances between the statutory accounting practices and U.S. generally accepted accounting principles as described in Note 2, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting practices and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Aetna Better Health, Inc. (a Louisiana corporation) as of December 31, 2015, or the results of its operations or its cash flows for the year then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the assets, liabilities, and capital and surplus of Aetna Better Health, Inc. (a Louisiana corporation) as of December 31, 2015, and the results of its operation and its cash flows for the year then ended, in accordance with statutory accounting practices prescribed or permitted by the Louisiana Department of Insurance described in Note 2.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the Supplemental Investment Risks Interrogatories and Summary Investment Schedule is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Louisiana Department of Insurance. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

KPMG LLP

KPMG LLP
Hartford, Connecticut
May 27, 2016

Aetna Better Health, Inc.
(a Louisiana corporation)
As of December 31, 2015

Statutory Statements of Assets

	Current Year		
	Assets	Nonadmitted Assets	Net Admitted Assets
1 Bonds	$26,090,197	$0	$26,090,197
2 Stocks:			
2.1 Preferred stocks	0	0	0
2.2 Common stocks	0	0	0
3 Mortgage loans on real estate:			
3.1 First liens	0	0	0
3.2 Other than first liens	0	0	0
4 Real estate:			
4.1 Properties occupied by the company	0	0	0
4.2 Properties held for the production of income	0	0	0
4.3 Properties held for sale	0	0	0
5 Cash ($4,048,867 in 2015), cash equivalents ($28,422,216 in 2015) and short-term investments ($1,002,791 in 2015)	33,473,874	0	33,473,874
6 Contract loans	0	0	0
7 Derivatives	0	0	0
8 Other invested assets	0	0	0
9 Receivables for securities	0	0	0
10 Securities lending reinvested collateral assets	0	0	0
11 Aggregate write-ins for invested assets	0	0	0
12 Subtotals, cash and invested assets (Lines 1 to 11)	59,564,071	0	59,564,071
13 Title plants (for Title insurers only)	0	0	0
14 Investment income due and accrued	69,039	0	69,039
15 Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection	27,763,134	0	27,763,134
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due	0	0	0
15.3 Accrued retrospective premiums and contracts subject to redetermination	0	0	0
16 Reinsurance:			
16.1 Amounts recoverable from reinsurers	0	0	0
16.2 Funds held by or deposited with reinsured companies	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0
17 Amounts receivable relating to uninsured plans	0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	1,038,833	0	1,038,833
18.2 Net deferred tax asset	0	0	0
19 Guaranty funds receivable or on deposit	0	0	0
20 Electronic data processing equipment and software	0	0	0
21 Furniture and equipment, including health care delivery assets	0	0	0
22 Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0
23 Receivables from parent, subsidiaries and affiliates	0	0	0
24 Health care and other amounts receivable	641,113	641,113	0
25 Aggregate write-ins for other than invested assets	0	0	0
26 Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	89,076,190	641,113	88,435,077
27 From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0
28 TOTALS (Lines 26 and 27)	$89,076,190	$641,113	$88,435,077

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
As of December 31, 2015

Statutory Statements of Liabilities, Capital and Surplus

		Current Year
		Total
1	Claims unpaid	$45,984,685
2	Accrued medical incentive pool and bonus amounts	0
3	Unpaid claims adjustment expenses	452,486
4	Aggregate health policy reserves, including the liability of $0 in 2015 for medical loss ratio rebate per the Public Health Service Act	475,465
5	Aggregate life policy reserves	0
6	Property/casualty unearned premium reserve	0
7	Aggregate health claim reserves	0
8	Premiums received in advance	0
9	General expenses due or accrued	3,809,226
10.1	Current federal and foreign income tax payable and interest thereon	0
10.2	Net deferred tax liability	0
11	Ceded reinsurance premiums payable	0
12	Amounts withheld or retained for the account of others	0
13	Remittances and items not allocated	0
14	Borrowed money and interest thereon	0
15	Amounts due to parent, subsidiaries and affiliates	14,218,553
16	Derivatives	0
17	Payable for securities	0
18	Payable for securities lending	0
19	Funds held under reinsurance treaties	0
20	Reinsurance in unauthorized companies	0
21	Net adjustments in assets and liabilities due to foreign exchange rates	0
22	Liability for amounts held under uninsured plans	0
23	Aggregate write-ins for other liabilities	0
24	Total liabilities (Lines 1 to 23)	64,940,415
25	Aggregate write-ins for special surplus funds	3,290,000
26	Common capital stock	0
27	Preferred capital stock	0
28	Gross paid in and contributed surplus	37,000,000
29	Surplus notes	0
30	Aggregate write-ins for other than special surplus funds	0
31	Unassigned surplus	(16,795,338)
32	Less treasury stock at cost:	
	32.1 0.000 shares common	0
	32.2 0.000 shares preferred	0
33	Total capital and surplus (Lines 25 to 31 minus Line 32)	23,494,662
34	Total liabilities, capital and surplus (Lines 24 and 33)	$88,435,077

Details of Write-Ins		
2501	Estimated Health Insurer Fee accrual	$3,290,000
2502		0
2503		0
2599	Totals (Lines 2501 thru 2503) (Line 25 above)	$3,290,000

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
For the Year Ended December 31, 2015

Statutory Statements of Revenue and Expenses

		Current Year Total
1	Line not used	
2	Net premium income	$180,663,358
3	Change in unearned premium reserves and reserve for rate credits	0
4	Fee-for-service	0
5	Risk revenue	0
6	Aggregate write-ins for other health care related revenues	0
7	Aggregate write-ins for other non-health revenues	0
8	Total revenues (Lines 2 to 7)	180,663,358
Hospital and Medical:		
9	Hospital/medical benefits	135,316,665
10	Other professional services	568,368
11	Outside referrals	6,282,972
12	Emergency room and out-of-area	8,499,034
13	Prescription drugs	19,554,305
14	Aggregate write-ins for other hospital and medical	0
15	Incentive pool, withhold adjustments and bonus amounts	0
16	Subtotal (Lines 9 to 15)	170,221,344
Less:		
17	Net reinsurance recoveries	0
18	Total hospital and medical (Lines 16 minus 17)	170,221,344
19	Non-health claims (net)	0
20	Claims adjustment expenses	9,093,459
21	General administrative expenses	19,707,734
22	Increase in reserves for life and accident and health contracts	475,465
23	Total underwriting deductions (Lines 18 through 22)	199,498,002
24	Net underwriting loss (Lines 8 minus 23)	(18,834,644)
25	Net investment income earned	65,155
26	Net realized capital losses less capital gains tax of $8,591 in 2015	(231,506)
27	Net investment losses (Lines 25 plus 26)	(166,351)
28	Net gain or (loss) from agents' or premium balances charged off	0
29	Aggregate write-ins for other income or expenses	0
30	Net loss after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	(19,000,995)
31	Federal and foreign income tax benefits incurred	(6,118,234)
32	Net loss (Lines 30 minus 31)	$(12,882,761)

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
For the Year Ended December 31, 2015

Statutory Statements of Changes in Capital and Surplus

	Current Year
CAPITAL AND SURPLUS ACCOUNT	
33 Capital and surplus prior reporting period	$3,018,536
34 Net loss from Line 32	(12,882,761)
35 Change in valuation basis of aggregate policy and claim reserves	0
36 Change in net unrealized capital gains and (losses) less capital gains tax	0
37 Change in net unrealized foreign exchange capital gain or (loss)	0
38 Change in net deferred income tax	0
39 Change in nonadmitted assets	(641,113)
40 Change in unauthorized and certified reinsurance	0
41 Change in treasury stock	0
42 Change in surplus notes	0
43 Cumulative effect of changes in accounting principles	0
44 Capital changes:	
44.1 Paid in	0
44.2 Transferred from surplus (Stock Dividend)	0
44.3 Transferred to surplus	0
45 Surplus adjustments:	
45.1 Paid in	34,000,000
45.2 Transferred to capital (Stock Dividend)	0
45.3 Transferred from capital	0
46 Dividends to stockholders	0
47 Aggregate write-ins for gains or (losses) in surplus	0
48 Net change in capital and surplus (Lines 34 to 47)	20,476,126
49 Capital and surplus end of reporting period (Line 33 plus 48)	$23,494,662

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
For the Year Ended December 31, 2015

Statutory Statements of Cash Flows

	Current Year
CASH FROM OPERATIONS	
1 Premiums collected net of reinsurance	$152,900,224
2 Net investment income	15,687
3 Miscellaneous income	(641,113)
4 Total (Lines 1 through 3)	152,274,798
5 Benefit and loss related payments	124,236,659
6 Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0
7 Commissions, expenses paid and aggregate write-ins for deductions	24,539,481
8 Dividends paid to policyholders	0
9 Federal and foreign income taxes recovered net of $0 tax on capital gains (losses)	(5,071,077)
10 Total (Lines 5 through 9)	143,705,063
11 Net cash from operations (Line 4 minus Line 10)	8,569,735
CASH FROM INVESTMENTS	
12 Proceeds from investments sold, matured or repaid:	
12.1 Bonds	13,161,300
12.2 Stocks	0
12.3 Mortgage loans	0
12.4 Real estate	0
12.5 Other invested assets	0
12.6 Net losses on cash, cash equivalents and short-term investments	(140)
12.7 Miscellaneous proceeds	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	13,161,160
13 Cost of investments acquired (long-term only):	
13.1 Bonds	39,492,046
13.2 Stocks	0
13.3 Mortgage loans	0
13.4 Real estate	0
13.5 Other invested assets	0
13.6 Miscellaneous applications	0
13.7 Total investments acquired (Lines 13.1 to 13.6)	39,492,046
14 Net increase (decrease) in contract loans and premium notes	0
15 Net cash from investments (Line 12.8 minus Lines 13.7 and 14)	(26,330,886)
CASH FROM FINANCING AND MISCELLANEOUS SOURCES	
16 Cash provided (applied):	
16.1 Surplus notes, capital notes	0
16.2 Capital and paid in surplus, less treasury stock	34,000,000
16.3 Borrowed funds	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0
16.5 Dividends to stockholders	0
16.6 Other cash provided	14,218,362
17 Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	48,218,362
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS	
18 Net change in cash, cash equivalents and short-term investments (Line 11 plus Line 15 plus Line 17)	30,457,211
19 Cash, cash equivalents and short-term investments:	
19.1 Beginning of year	3,016,663
19.2 End of year (Line 18 plus Line 19.1)	$33,473,874

See accompanying notes to statutory financial statements.

AETNA BETTER HEALTH, INC.
(a Louisiana corporation)

NOTES TO STATUTORY FINANCIAL STATEMENTS
December 31, 2015

1. Organization and operation

Aetna Better Health, Inc. (a Louisiana corporation) (the "Company") is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is Aetna Inc. ("Aetna").

The Company was incorporated in the State of Louisiana on July 27, 2010. Effective February 1, 2015, the Company began administering a health plan for individuals who qualify for Medicaid coverage in the State of Louisiana. The contract with the Louisiana Department of Health and Hospitals is for a term through January 31, 2018. In the event the contract is not renewed, the Company has received a guarantee of financial support by its parent through December 31, 2017. The conditions of such support stipulate that the parent has the ability to provide the necessary financial support to the Company and that there are no restrictions on the parent to provide such support.

2. Summary of significant accounting policies

Accounting practices

The accompanying statutory financial statements of the Company have been prepared in conformity with accounting practices prescribed or permitted by the Louisiana Department of Insurance ("Louisiana Department") ("Louisiana Accounting Practices"). The Louisiana Department recognizes only statutory accounting practices prescribed or permitted by the State of Louisiana for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP"). The Company's net loss and capital and surplus as stated on a NAIC SAP basis and on the basis of practices prescribed or permitted by the State of Louisiana were the same as of and for the year ended December 31, 2015.

The Louisiana Accounting Practices vary from U.S. generally accepted accounting principles ("GAAP"). The primary differences include the following:

- Certain assets, designated as nonadmitted assets (other receivables, which are nonadmitted in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 4 - *Assets and Nonadmitted Assets*) are not recorded as assets, but are charged to surplus. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet, and are, therefore, considered nonadmitted;
- Bonds are recorded at amortized cost except for those with an NAIC designation of 3 through 6, which are reported at the lower of amortized cost or fair value. Therefore, changes in unrealized gains and losses for those securities held at amortized cost are not reflected in the financial statements. Under GAAP, bonds classified as available for sale are recorded at fair value, and related changes in unrealized gains and losses are recorded as a component of equity, net of deferred federal income taxes; and
- Deferred tax assets and liabilities are determined and admitted in accordance with SSAP No. 101 - *Income Taxes* ("SSAP No. 101"). Changes in net deferred tax assets and liabilities are reflected as changes in surplus, whereas under U.S. GAAP, changes in such assets and liabilities are reflected in net income. In addition, statutory accounting requires consideration of a statutory allowance adjustment in the calculation of adjusted gross deferred tax assets and an admissibility test for deferred tax assets.

There were no permitted practices by the State of Louisiana for the year ended December 31, 2015.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Louisiana Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenues and expenses. Actual results could differ from those estimates.

Significant accounting policies

The Company applies the following significant accounting policies:

Cash, cash equivalents and short-term investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value.

Bonds

Bonds, which include special deposits as discussed more fully in Note 4, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections at December 31, 2015. Bonds include all investments whose maturity is greater than one year when purchased.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities, an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For loan-backed and structured securities, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

Investment income due and accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2015, the Company did not have any nonadmitted investment income due and accrued.

Premiums and amounts due and unpaid

Premium revenue for prepaid health care products is recognized as income in the month in which enrollees are entitled to health care services.

Nonadmitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances.

The Company did not have any premiums or amounts due and unpaid at December 31, 2015.

Hospital and medical costs and claims adjustment expenses and related reserves

Hospital and medical costs consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health claim reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Statutory Statements of Assets and Liabilities, Capital and Surplus date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, contract requirement changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in hospital and medical costs in the Statutory Statements of Revenue and Expenses in the period they are determined. Capitation costs, which are recorded in hospital and medical expenses in the Statutory Statements of Revenue and Expenses, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

Claims adjustment expenses, which include cost containment expenses, represent the costs incurred related to the claim settlement process such as costs to record, process and adjust claims. These expenses are included in the Company's management agreement with an affiliate described in Note 7.

Aggregate health policy reserves and related expenses

Premium deficiency reserves ("PDR") are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Where allowed, anticipated investment income is considered in the calculation of any PDR. For purposes of calculating a PDR, contracts are grouped in manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts. The PDR balance of $475,465 was included in aggregate health policy reserves in the Statutory Statements of Liabilities, Capital and Surplus at December 31, 2015.

Fees Paid to the Federal Government by Health Insurers

Beginning January 1, 2014, SSAP No. 106 – *Affordable Care Act Assessments* ("SSAP No. 106") required (1) that the health insurer fee be recognized in full on January 1 of the fee year (the calendar year in which the assessment must be paid to the federal government), in the operating expense category of insurance taxes, licenses and fees, excluding federal income taxes and (2) that in each data year preceding a fee year a reporting entity pro-ratably accrue by reclassifying from unassigned funds (surplus) to aggregate write-ins for special surplus funds an amount equal to its estimated subsequent fee year assessment. This reclassification has no impact on total capital and surplus and is reversed in full on January 1 of the fee year beginning with fee years starting on January 1, 2015 and after.

Reinsurance

In the normal course of business, the Company seeks to reduce the loss that may arise from catastrophes or other events that cause unfavorable underwriting results and to help balance its risks and capital by reinsuring certain levels of risk with other insurance enterprises. The reinsurance coverage does not relieve the Company of its primary obligations. Reinsurance premiums and reserves related to reinsured business are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts. Premiums ceded for medical losses and the related unpaid reserves have been reported as reductions of these items. The reinsurance agreements are more fully discussed in Note 9.

Federal income taxes

The Company is included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries pursuant to the terms of a tax sharing agreement. In accordance with a written tax sharing agreement with an affiliate, the Company's current federal income tax provisions are generally computed as if the Company were filing a separate federal income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent realized in the consolidated return. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets ("DTAs") and liabilities ("DTLs") represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized ("adjusted gross DTAs"). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a. b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Service ("IRS") tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the statutory balance sheet adjusted to exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

   The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains (losses)", also a separate component of gains and losses in surplus.

Going concern

Effective December 31, 2016, the Company will adopt amended accounting guidance related to management's evaluation of whether there is a substantial doubt about the entity's ability to continue as a going concern and the related disclosures and will make disclosures at that time and thereafter pursuant to the guidance.

3. Accounting changes and corrections of errors

During 2016, the Company recorded a correction to current federal and foreign income tax recoverable and interest thereon in the amount of $1,009,750. This adjustment is further discussed in Note 16.

The Company did not have any accounting changes in the year ended December 31, 2015.

4. Special deposits

Special deposits, included in bonds, consist of U.S. Treasury Notes, at amortized cost, which approximates fair value, of $1,000,000 at December 31, 2015. These assets are restricted in accordance with certain state requirements relating to HMOs.

5. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments, which include special deposits, cash equivalents, and short-term investments, at December 31, 2015:

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$54,515,204	$54,515,204	$20,352	-	$54,535,556
Industrial and miscellaneous (unaffiliated)	1,000,000	1,000,000	-	-	1,000,000
Total	$55,515,204	$55,515,204	$20,352	-	$55,535,556

At December 31, 2015, the Company did not have any bonds and other financial instruments, which include special deposits, with unrealized losses.

The contractual or expected maturities of bonds, cash equivalents and short-term investments at December 31, 2015 were as follows:

	Carrying value	Fair value
Due one year or less	$29,425,007	$29,425,007
Due after one year through five years	26,090,197	26,110,549
	$55,515,204	$55,535,556

The maturity for a mortgage pass-through security, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association ("FNMA") and Government National Mortgage Association ("GNMA") pools.

Proceeds from the sales of bonds and other financial instruments were approximately $13,161,000 in 2015. There were no proceeds from the maturities of bonds in 2015. Gross realized gains on sales of bonds were approximately $46,000 in 2015. Gross realized losses on sales of bonds was approximately $21,000 in 2015. Included in net realized capital losses for 2015 were approximately $248,000 of OTTI charges on debt securities that were in an unrealized loss position. The Company conducts regular reviews of its bond investments to assess whether a decline in fair value below carrying value is an OTTI. The Company will also recognize an OTTI on debt securities when we intend to sell a security that is in an unrealized loss position. Declines deemed to be OTTI are recognized as realized capital losses.

There was no investment income due and accrued excluded from surplus at December 31, 2015.

Restricted assets (including pledged)

The Company had $1,000,000 on deposit with other regulatory bodies, which represented 1.13% of total admitted assets at December 31, 2015.

The Company did not have any assets pledged as collateral not captured in other categories at December 31, 2015.

The Company did not have any other restricted assets at December 31, 2015.

6. Financial instruments

Financial instruments measured at fair value in the financial statements

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The statutory carrying values and estimated fair values of the Company's financial instruments at December 31, 2015 were as follows:

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3	Not practicable (carrying value)
Bonds, short-term investments and cash equivalents	$55,535,556	$55,515,204	$54,532,765	$1,002,791	-	-
Total	$55,535,556	$55,515,204	$54,532,765	$1,002,791	-	-

The valuation methods and assumptions used by the Company in estimating the fair value of debt securities are discussed in Note 2.

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets during 2015. There were no transfers between the Company's Level 1 or 2 financial assets during 2015.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

7. Information concerning Parent, subsidiaries, and affiliates

As of and for the year ended December 31, 2015, the Company had the following significant transactions with affiliates:

The Company and Aetna Medicaid Administrators LLC ("AMA"), indirectly a wholly-owned subsidiary of Aetna, are parties to an administrative services agreement, under which AMA provides certain administrative services, including accounting and processing of premiums and claims. Under this agreement, the Company will remit a percentage of its earned premium revenue, as applicable, to AMA as a fee. For these services, the Company was charged $14,218,553 in 2015. The agreement also provides for interest on all intercompany balances. There was no interest earned (incurred) on amounts due from (to) affiliates in 2015.

The Company has coverage for certain litigation exposures ($10,000,000 per claim and in the aggregate including defense costs) through an affiliated captive insurance company.

As explained in Note 2, the Company participates in a tax sharing agreement with Aetna and Aetna's other subsidiaries. All federal income tax receivables/payables were due from/due to Aetna.

Amounts due to and due from affiliates shown in the accompanying Statutory Statements of Assets, Liabilities, Capital and Surplus include the Company's net receipts and disbursements processed by affiliates and transactions related to its administrative services agreement with AMA.

At December 31, 2015, the Company had the following amounts due to affiliates:

	December 31, 2015
Amounts due to affiliates	
Aetna Inc.	$10,237,657
Aetna Medicaid Administrators LLC	3,980,896
	$14,218,553

The Company had no amounts due from affiliates at December 31, 2015.

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

8. Income taxes

The components of the net DTAs recognized in the Company's Statutory Statements of Assets and Liabilities, Capital and Surplus are as follows:

	December 31, 2015		
	Ordinary	Capital	Total
Gross DTAs	$1,535,388	$86,806	$1,622,194
Statutory valuation allowance adjustment	(1,533,871)	(86,806)	(1,620,677)
Adjusted gross DTAs	1,517	-	1,517
DTAs nonadmitted	-	-	-
Subtotal net admitted DTAs	1,517	-	1,517
DTLs	-	(1,517)	(1,517)
Net admitted DTAs	$1,517	$(1,517)	-

The amount of admitted gross DTAs admitted under each component of SSAP No. 101 is as follows:

	December 31, 2015		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$1,365	-	$1,365
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	-	-	-
1. Adjusted gross DTAs expected to be realized following the balance sheet date	-	-	-
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	$2,450,441
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	152	-	152
(d) DTAs admitted as the result of application of SSAP No. 101	$1,517	-	$1,517

	2015
(a) Ratio percentage used to determine recovery period and threshold limitation amount	292%
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in (b)2 above	$23,494,662

There was no impact of tax planning strategies on the Company's adjusted gross DTAs or net admitted adjusted gross DTAs at December 31, 2015. The Company's tax-planning strategies did not include the use of reinsurance.

There are no DTLs that were not recognized at December 31, 2015.

The benefit for income taxes for the year ended December 31, 2015 were as follows:

	December 31, 2015
Federal income tax benefit on operations	$(6,118,234)
Federal income tax on net capital gains	8,591
Federal income tax benefit incurred	$(6,109,643)

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2015 were as follows:

	December 31, 2015
DTAs:	
Ordinary	
Claims unpaid	$1,144,585
Premium deficiency reserve	166,413
Provider advances – nonadmitted	224,390
Total ordinary DTAs	1,535,388
Statutory valuation allowance adjustment	(1,533,871)
Nonadmitted ordinary DTAs	-
Admitted ordinary DTAs	1,517
Capital	
Investments - impairment	86,806
Total admitted capital DTAs	86,806
Statutory valuation allowance adjustment	(86,806)
Nonadmitted capital DTAs	-
Admitted capital DTAs	-
Admitted DTAs	1,517
DTLs:	
Ordinary	
Ordinary DTLs	-
Capital	
Investments	1,517
Capital DTLs	1,517
Total DTLs	1,517
Net admitted DTAs	-

The change in net deferred income taxes is comprised of the following:

	December 31		
	2015	2014	Change
Total DTAs	$1,517	-	$1,517
Total DTLs	(1,517)	-	(1,517)
Net DTAs/(DTLs)	-	-	-
Tax effect of unrealized gains (losses)			-
Change in net deferred income tax			-

The valuation allowance adjustment to gross DTAs was $1,620,677 for December 31, 2015.

The benefit for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference are as follows:

	December 31, 2015	Effective tax rate
Benefit computed at statutory rate	$(6,647,340)	35.0%
Other permanent items	(5,673)	0.0%
Transfer pricing adjustment	(852,917)	4.5%
Change in nonadmitted assets	(224,390)	1.2%
Change in statutory valuation allowance adjustment	1,620,677	(8.5)%
Total	$(6,109,643)	32.2%
Federal and foreign income tax benefit	$(6,109,643)	32.2%
Change in net deferred income taxes	-	0.0%
Total statutory income taxes	$(6,109,643)	32.2%

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm's length prices as compared to what would be charged to an unrelated entity, which results in a permanent deduction for tax reporting purposes.

At December 31, 2015, the Company had no net capital loss or net operating loss carryforwards for tax purposes.

There are no federal income taxes incurred that are available for recoupment in the event of future net losses for the year ended December 31, 2015.

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2015.

At December 31, 2015, the Company's Federal Income Tax Return was consolidated with the following entities:

Aetna Inc. - Parent Company
@ Credentials Inc.
Active Health Management Inc.
Adminco, Inc.
Administrative Enterprises, Inc.
AE Fourteen Incorporated
Aetna ACO Holdings, Inc.
Aetna Better Health Inc. (Connecticut)
Aetna Better Health Inc. (Florida)
Aetna Better Health Inc. (Georgia)
Aetna Better Health Inc. (Illinois)
Aetna Better Health Inc. (New Jersey)
Aetna Better Health Inc. (New York)
Aetna Better Health Inc. (Ohio)
Aetna Better Health Inc. (Pennsylvania)
Aetna Better Health Inc. (Tennessee)
Aetna Better Health of California Inc.
Aetna Better Health of Iowa Inc.
Aetna Better Health of Kentucky Insurance Company
Aetna Better Health of Michigan Inc.
Aetna Better Health of Missouri LLC
Aetna Better Health of Texas Inc.
Aetna Better Health, Inc. (Louisiana)
Aetna Dental Inc. (New Jersey)
Aetna Dental Inc. (Texas)
Aetna Dental of California Inc.
Aetna Health and Life Insurance Company
Aetna Health Finance, Inc.
Aetna Health Inc. (Connecticut)
Aetna Health Inc. (Florida)
Aetna Health Inc. (Georgia)
Aetna Health Inc. (Iowa)
Aetna Health Inc. (Louisiana)
Aetna Health Inc. (Maine)
Aetna Health Inc. (Michigan)
Aetna Health Inc. (New Jersey)
Aetna Health Inc. (New York)
Aetna Health Inc. (Pennsylvania)
Aetna Health Inc. (Texas)
Aetna Health Insurance Company
Aetna Health Insurance Company of New York
Aetna Health of California Inc.
Aetna Health of Utah Inc.
Aetna HealthAssurance Pennsylvania Inc.
Aetna Insurance Company of Connecticut
Aetna Integrated Informatics, Inc.
Cofinity, Inc.
Corporate Benefit Strategies, Inc.
Coventry Consumer Advantage, Inc.
Coventry Financial Management Services, Inc.
Coventry Health and Life Insurance Company
Coventry Health Care National Accounts, Inc.
Coventry Health Care National Network, Inc.
Coventry Health Care of Delaware, Inc.
Coventry Health Care of Florida, Inc.
Coventry Health Care of Georgia, Inc.
Coventry Health Care of Illinois, Inc.
Coventry Health Care of Kansas, Inc.
Coventry Health Care of Missouri, Inc.
Coventry Health Care of Nebraska, Inc.
Coventry Health Care of Pennsylvania, Inc.
Coventry Health Care of Texas, Inc.
Coventry Health Care of the Carolinas, Inc.
Coventry Health Care of Virginia, Inc.
Coventry Health Care of West Virginia, Inc.
Coventry Health Care Workers Compensation, Inc.
Coventry Health Plan of Florida, Inc.
Coventry HealthCare Management Corporation
Coventry Prescription Management Services, Inc.
Coventry Rehabilitation Services, Inc.
Coventry Transplant Network, Inc.
Delaware Physicians Care, Incorporated
Echo Merger Sub, Inc.
First Health Group Corp.
First Health Life and Health Insurance Company
First Script Network Services, Inc.
Florida Health Plan Administrators, LLC
FOCUS Healthcare Management, Inc.
Group Dental Service of Maryland, Inc.
Group Dental Service, Inc.
Health and Human Resource Center, Inc.
Health Data & Management Solutions, Inc.
Health Re, Incorporated
HealthAmerica Pennsylvania, Inc.
HealthAssurance Financial Services, Inc.
HealthAssurance Pennsylvania, Inc.
Managed Care Coordinators, Inc.
Medicity Inc.
Mental Health Associates, Inc.
Mental Health Network of New York IPA, Inc.
Meritain Health, Inc.
MetraComp, Inc.

Aetna International Inc.
Aetna Ireland Inc.
Aetna Life & Casualty (Bermuda) Ltd.
Aetna Life Assignment Company
Aetna Life Insurance Company
Aetna Risk Assurance Company of Connecticut, Inc.
Aetna Risk Indemnity Company Limited
Aetna Student Health Agency Inc.
AHP Holdings, Inc.
Allviant Corporation
American Health Holding, Inc.
AUSHC Holdings, Inc.
Broadspire National Services, Inc.
bSwift, LLC
Cambridge Life Insurance Company
Carefree Insurance Services, Inc.
Chickering Claims Administrators, Inc.
Claims Administration Corp.
MHNet Life and Health Insurance Co.
MHNet of Florida, Inc.
Niagara Re, Inc.
PayFlex Holdings, Inc.
PayFlex Systems USA, Inc.
Performax, Inc.
Precision Benefit Services, Inc.
Prime Net, Inc.
Prodigy Health Group, Inc.
Professional Risk Management, Inc.
Resources for Living, LLC
Schaller Anderson Medical Administrators, Incorporated
Strategic Resource Company
The Vasquez Group Inc.
U.S. Health Care Properties, Inc.
Work and Family Benefits, Inc.

As explained in Note 2, the Company participates in a tax sharing agreement with its parent and affiliates.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

The Company is subject to Louisiana premium taxes. Premium tax expenses were recorded in general administrative expenses in the Statutory Statements of Revenue and Expenses. Premium tax expenses were $3,813,410 for the year ended December 31, 2015. The Company had premium taxes payable of $3,813,410 at December 31, 2015 which was recorded as general expenses due or accrued in the Statutory Statements of Liabilities.

9. Reinsurance

Effective February 1, 2015, the Company and Berkley Life and Health Insurance Company ("Berkley") entered into an excess loss reinsurance agreement for Medicaid only dual eligible members. Under this agreement, Berkley is liable for 90% of covered expenses in excess of the specific deductible of $350,000 per covered member, with a maximum reimbursement of $5,000,000 per member per agreement year. The Company paid reinsurance premiums of $282,984 in 2015.

10. Change in claims unpaid, unpaid claims adjustment expense, and aggregate health claim reserves

The following table shows the components of the change in claims unpaid, unpaid claims adjustment expense and aggregate health claim reserves for the year ended December 31, 2015:

	2015
Balance, January 1	-
Health care receivable	-
Balance, January 1, net of health care receivable	-
Incurred related to:	
Current year	$183,167,045
Prior years	-
Total incurred	183,167,045
Paid related to:	
Current year	136,729,874
Prior years	-
Total paid	136,729,874
Balance, December 31, net of health care receivable	46,437,171
Health care receivable	-
Balance, December 31	$46,437,171

Net coordination of benefits is implicit in the claims incurred but not reported calculation and could not be specifically identified.

11. Capital and surplus, shareholder's dividend restrictions and quasi-reorganizations

The Company had 10,000 shares of common stock with no par value authorized, with 1,000 shares issued and outstanding at December 31, 2015.

The Company did not have any preferred stock outstanding at December 31, 2015.

Dividend restrictions

No domestic stock insurer shall declare and pay any dividends to its stockholders unless its capital is fully paid in cash and is unimpaired and it has a surplus beyond its capital stock and the initial minimum surplus required and all other liabilities equal to fifteen percent of its capital stock, provided that this restriction shall not apply to an insurer when its paid-in capital and surplus exceed the minimum required by the Louisiana Department Code by one hundred percent or more.

At December 31, 2015, there was no portion of the Company's profits that may be paid as ordinary dividends to stockholders.

The Company did not pay any dividends in 2015. The Company received capital contributions in the amounts of $24,000,000 and $10,000,000 from its parent on December 28 and March 31, 2015, respectively. The Louisiana Department approved these transactions on December 28 and March 30, 2015, respectively.

There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2015, except as noted in Note 13.

The Company did not hold any stock for any special purposes at December 31, 2015.

Changes in the balances of special surplus funds from the prior year are due to the accrual of estimated ACA health insurer fees reclassified from unassigned funds or surplus to aggregate write-ins for special surplus funds as discussed more fully in Notes 2 and 17.

At December 31, 2015, there was no portion of unassigned funds or surplus that was represented or reduced by unrealized gains and losses.

The Company did not have any special surplus funds or surplus notes at December 31, 2015.

12. Contingencies

Litigation and Regulatory Proceedings

The following description of litigation and regulatory proceedings covers Aetna Inc. and certain of its subsidiaries, including the Company (collectively, "we", "our" or "us"). Certain of the proceedings described below may not impact the Company directly but may have an indirect impact on the Company as the Company is a member of the Aetna holding company group.

Out-of-Network Benefit Proceedings

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption In re: Aetna UCR Litigation, MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the

physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after tax charge to net income attributable to Aetna of approximately $78.0 million in the fourth quarter of 2012. There was no after-tax charge to net income for the Company associated to the proposed settlement.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. We intend to vigorously defend ourselves against the claims brought by the plaintiffs. As a result of the termination of settlement, we released the reserve established, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses of Aetna by $67.0 million ($103.0 million pretax).

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to vigorously defend ourselves against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, patent infringement and other intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly in our Medicaid business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, The Centers for Medicare & Medicaid Services ("CMS"), the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "*Out-of-Network Benefit Proceedings*."

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in a change in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "*Other Litigation and Regulatory Proceedings*," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, "Health Care Reform" or "ACA"), enacted in March 2010, has changed and will continue to make broad-based changes to the U.S. health care system. The Company expects Health Care Reform and changes to Health Care Reform to continue to significantly impact the Company's business operations and financial results, including the Company's pricing, medical benefit ratios and the geographies in which the Company's products are available. Health Care Reform presents the Company with business opportunities, but also with financial and regulatory challenges. Most of the key components of Health Care Reform were phased in during or prior to 2014, including health insurance exchanges ("Public Exchanges), required MLRs in commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's CMS quality performance ratings or "star ratings." The effects of these changes are reflected in the Company's financial results. Certain components of Health Care Reform will continue to be phased in until 2020.

The Company is dedicating and will continue to be required to dedicate significant resources and incur significant expenses during 2016 to implement and comply with Health Care Reform and changes in Health Care Reform as well as state level health care reform. While most of the significant aspects of Health Care Reform became effective during or prior to 2014, significant parts of Health Care Reform, including aspects of Public Exchanges, nondiscrimination requirements, reinsurance, risk corridor and risk adjustment, continue to evolve through the promulgation of regulations and guidance at the federal level. It is likely that further changes will be made to Health Care Reform at the federal and/or state level as issues arise and its practical effects become clearer. Growing state and federal budgetary pressures make it more likely that any changes will be adverse to us. As a result, many of the specific aspects and impacts of Health Care Reform will not be known for several years, and given the inherent difficulty of foreseeing how individuals and businesses will respond to the choices afforded them by Health Care Reform, the Company cannot predict the full effect Health Care Reform will have on the Company or the impact of future changes to Health Care Reform. It is reasonably possible that Health Care Reform or changes to Health Care Reform, in the aggregate, could have a significant adverse effect on the Company's business operations and financial results.

Ongoing legislative and regulatory changes to Health Care Reform, other pending efforts in the U.S. Congress to amend or restrict funding for various aspects of Health Care Reform (including risk corridors), the 2016 presidential election, pending litigation challenging aspects of the law and federal budget negotiations continue to create uncertainty about the ultimate impact of Health Care Reform. Examples of these legislative and regulatory changes include: the December 2015 suspension of the health insurer fee for 2017 and two year delay of the "Cadillac" tax on high-cost employer-sponsored health coverage; the October 2015 Protecting Affordable Coverage for Employees Act, which leaves groups with 51 to 100 employees within the large group category for each state unless the state exercises its option to include these groups within the small group category; and the October 2015 HHS announcement that Health Care Reform risk corridor receivables for the 2014 program year would only be funded at 12.6%. The pending litigation includes the House of Representatives' challenge to HHS's ability to make payments under ACA's Cost Sharing Subsidiary program without an explicit appropriation.

As described above, the availability of funding for the ACA's temporary risk corridor program is an example of this uncertainty. In May 2014, CMS published a final rule on Public Exchanges. The final rule provides that payments to health plans under the ACA's risk corridor program will no longer be limited to the aggregate amount of the risk corridor collections received by HHS over the duration of the risk corridor program. However, it is possible that payments to health plans under the risk corridor program will require additional appropriation legislation to be passed by the U.S. Congress. In each of December 2014 and December 2015, legislation was enacted that prohibits HHS's use of certain funds to pay HHS's potential obligation under the ACA's risk corridor program. In October 2015, HHS announced that 2014 Health Care

Reform risk corridor receivables would be funded at 12.6% to the extent HHS fully collects risk corridor payables. In addition, these limited risk corridor payments may create instability in the marketplace for individual commercial products in 2016 and going forward by, among other things, causing health plans to change or stop offering their Public Exchange products. 2016 is the last program year for the ACA's risk corridor program.

The federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system. The Company cannot predict whether pending or future federal or state legislation or court proceedings, including future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or Health Care Reform or the impact those changes will have on the Company's business operations or financial results, but the effects could be materially adverse.

13. Minimum capital and surplus

Pursuant to the laws of Louisiana, each health maintenance organization shall establish prior to the issuance of any certificate of authority, and shall maintain as long as it does business in Louisiana as a health maintenance organization, capital and surplus in the amount of three million dollars. At December 31, 2015, the Company's capital and surplus exceeded all such requirements.

The NAIC and the State of Louisiana adopted risk-based capital ("RBC") standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company's adjusted capital and surplus to its required capital and surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of the company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2015, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

14. Medicaid

Medicaid and dual eligible products also are regulated by CMS and state Medicaid agencies, which have the right to audit our performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products, dual eligible products and Children's Health Insurance Program ("CHIP") contracts also are subject to federal and state regulations and oversight by state Medicaid agencies regarding the services we provide to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and the Company's Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or renew existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to auto assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions against the Company if it fails to comply with CMS or state regulations or our contractual requirements. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact of those changes.

15. Accounting for the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (collectively, "Health Care Reform") Reinsurance, Risk Adjustment and Risk Corridor (the "3Rs") pursuant to SSAP No. 107 and INT 15-01: ACA Risk Corridors Collectibility ("INT 15-01")

Reinsurance

Health Care Reform established a temporary reinsurance program that expires at the end of 2016. Under this program, all issuers of major medical commercial insurance products and self-insured plan sponsors are required to contribute funding in amounts set by the U.S. Department of Health and Human Services ("HHS"). A portion of the funds collected will be utilized to reimburse issuers' high claims costs incurred for qualified individual members. The expense related to this required funding is reflected in insurance, taxes, licenses and fees for all of the Company's insurance products with the exception of products associated with qualified individual members; this expense for qualified individual members is reflected as a reduction of premium revenue. When annual claim costs incurred by the Company's qualified individual members exceed a specified attachment point, the Company is entitled to certain reimbursements from this program. The Company records amounts recoverable for claims paid and unpaid and ceded claim benefit recoveries to reflect its estimate of these recoveries. At December 31, 2015, the Company did not record a payable or a receivable under the temporary three-year reinsurance program.

Risk Adjustment

Health Care Reform established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable or payable for the current calendar year and reflects the impact as an adjustment to its premium revenue. At December 31, 2015, the Company did not record a payable or a receivable under the risk adjustment program.

Risk Corridor

Health Care Reform established a temporary risk sharing program, which expires at the end of 2016, for qualified individual and small group insurance plans. Under this program the Company makes (or receives) a payment to (or from) HHS based on the ratio of allowable costs to target costs (as defined by Health Care Reform). The Company records a risk corridor receivable or payable as an adjustment to premium revenue based on the Company's estimate of the ultimate risk sharing amount for the current calendar year.

The Company expects to perform an annual final reconciliation and settlement with HHS of the 3Rs in each subsequent year.

16. Reconciliation to statutory financial statements as filed with the Louisiana Department

The Company's federal and foreign income tax benefits incurred were understated on the statutory financial statements for December 31, 2015.

The following is a reconciliation of December 31, 2015 total assets as reflected in the accompanying Statutory Statements of Assets to amounts reported to the Louisiana Department (statutory reports) in the Company's 2015 annual statement:

Total assets as reflected in the accompanying Statutory Statements of Assets	$88,435,077
Increase in current federal and foreign income tax recoverable and interest thereon	1,009,750
Total assets as reported in the annual statement	$89,444,827

The following is a reconciliation of December 31, 2015 capital and surplus as reflected in the accompanying Statutory Statements of Liabilities, Capital and Surplus to amounts reported to the Louisiana Department (statutory reports) in the Company's 2015 annual statement:

Capital and surplus as reflected in the accompanying Statutory Statements of Liabilities, Capital and Surplus	$23,494,662
Increase in current federal and foreign tax recoverable and interest thereon	1,009,750
Statutory capital and surplus as reported in the annual statement	$24,504,412

The following is a reconciliation of December 31, 2015 net loss as reflected in the accompanying Statutory Statements of Revenue and Expenses to amounts reported to the Louisiana Department (statutory reports) in the Company's 2015 annual statement:

Net loss as reflected in the accompanying Statutory Statements of Revenue and Expenses	$(12,882,761)
Increase in federal and foreign income tax benefits incurred	1,009,750
Statutory net loss as reported in the annual statement	$(11,873,011)

17. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through May 27, 2016.

The Company had no known reportable recognized subsequent events.

Type II - Nonrecognized subsequent events

Subsequent events have been considered through May 27, 2016.

On January 1, 2016, the Company will be subject to an annual fee under section 9010 of the Federal ACA. This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2015, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2016, and estimates their portion of the annual health insurance industry fee to be payable on September 30, 2016 to be $3,290,000. This amount is reflected in special surplus. This assessment is expected to impact RBC by 14%. Reporting the ACA assessment as of December 31, 2015, would not have triggered an RBC action level.

	2015
ACA fee assessment payable for upcoming year	$3,290,000
ACA fee assessment paid	-
Premium written subject to ACA 9010 assessment	$180,946,342
Total Adjusted Capital before surplus adjustment	$23,494,662
Total Adjusted Capital after surplus adjustment	$20,204,622
Authorized Control Level after surplus adjustment	$8,385,950

SUPPLEMENTAL INFORMATION

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SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For the year ended December 31, 2015

(To be filed by April 1)

Of Aetna Better Health, Inc. (a Louisiana corporation)

Address (City, State, Zip Code): Kenner LA 70062

NAIC Group Code.....0001 NAIC Company Code.....15616 Employer's ID Number.....80-0629718

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $.....88,435,077

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	WHITNEY NATL CD	ST BOND	$.....250,000	.....0.283 %
2.02	LIBERTY BANK CD	ST BOND	$.....250,000	.....0.283 %
2.03	CAPITAL ONE CAPITAL VI CD	ST BOND	$.....250,000	.....0.283 %
2.04	CITIZENS BANK & TRUST CD	ST BOND	$.....250,000	.....0.283 %
2.05			$.....0	.....0.000 %
2.06			$.....0	.....0.000 %
2.07			$.....0	.....0.000 %
2.08			$.....0	.....0.000 %
2.09			$.....0	.....0.000 %
2.10			$.....0	.....0.000 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2
3.01	NAIC-1	$.....55,515,204	.....62.775 %
3.02	NAIC-2	$.....0	.....0.000 %
3.03	NAIC-3	$.....0	.....0.000 %
3.04	NAIC-4	$.....0	.....0.000 %
3.05	NAIC-5	$.....0	.....0.000 %
3.06	NAIC-6	$.....0	.....0.000 %
	Preferred Stocks	**3**	**4**
3.07	P/RP-1	$.....0	.....0.000 %
3.08	P/RP-2	$.....0	.....0.000 %
3.09	P/RP-3	$.....0	.....0.000 %
3.10	P/RP-4	$.....0	.....0.000 %
3.11	P/RP-5	$.....0	.....0.000 %
3.12	P/RP-6	$.....0	.....0.000 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 4.01 above is yes, responses are not required for interrogatories 5-10.

4.02	Total admitted assets held in foreign investments	$.....0	.....0.000 %
4.03	Foreign-currency-denominated investments	$.....0	.....0.000 %
4.04	Insurance liabilities denominated in that same foreign currency	$.....0	.....0.000 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$.....0	.....0.000 %
5.02	Countries designated NAIC-2	$.....0	.....0.000 %
5.03	Countries designated NAIC-3 or below	$.....0	.....0.000 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC-1:		
6.01	Country 1:	$.....0	.....0.000 %
6.02	Country 2:	$.....0	.....0.000 %
	Countries designated NAIC-2:		
6.03	Country 1:	$.....0	.....0.000 %
6.04	Country 2:	$.....0	.....0.000 %
	Countries designated NAIC-3 or below:		
6.05	Country 1:	$.....0	.....0.000 %
6.06	Country 2:	$.....0	.....0.000 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$.....0	.....0.000 %

See accompanying independent auditors' report.

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.000 %
8.02	Countries designated NAIC-2	$ 0	0.000 %
8.03	Countries designated NAIC-3 or below	$ 0	0.000 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC-1:		
9.01	Country 1:	$ 0	0.000 %
9.02	Country 2:	$ 0	0.000 %
	Countries designated NAIC-2:		
9.03	Country 1:	$ 0	0.000 %
9.04	Country 2:	$ 0	0.000 %
	Countries designated NAIC-3 or below:		
9.05	Country 1:	$ 0	0.000 %
9.06	Country 2:	$ 0	0.000 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01			$ 0	0.000 %
10.02			$ 0	0.000 %
10.03			$ 0	0.000 %
10.04			$ 0	0.000 %
10.05			$ 0	0.000 %
10.06			$ 0	0.000 %
10.07			$ 0	0.000 %
10.08			$ 0	0.000 %
10.09			$ 0	0.000 %
10.10			$ 0	0.000 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of Interrogatory 11.

11.02	Total admitted assets held in Canadian Investments	$ 0	0.000 %
11.03	Canadian currency-denominated investments	$ 0	0.000 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.000 %
11.05	Unhedged Canadian currency exposure	$ 0	0.000 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.000 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.000 %
12.04		$ 0	0.000 %
12.05		$ 0	0.000 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interest less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Name of Issuer	2	3
13.02		$ 0	0.000 %
13.03		$ 0	0.000 %
13.04		$ 0	0.000 %
13.05		$ 0	0.000 %
13.06		$ 0	0.000 %
13.07		$ 0	0.000 %
13.08		$ 0	0.000 %
13.09		$ 0	0.000 %
13.10		$ 0	0.000 %
13.11		$ 0	0.000 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.000 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.000 %
14.04		$ 0	0.000 %
14.05		$ 0	0.000 %

See accompanying independent auditors' report.

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.000 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.000 %
15.04		$ 0	0.000 %
15.05		$ 0	0.000 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.000 %
16.03		$ 0	0.000 %
16.04		$ 0	0.000 %
16.05		$ 0	0.000 %
16.06		$ 0	0.000 %
16.07		$ 0	0.000 %
16.08		$ 0	0.000 %
16.09		$ 0	0.000 %
16.10		$ 0	0.000 %
16.11		$ 0	0.000 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.000 %
16.13	Mortgage loans over 90 days past due	$ 0	0.000 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.000 %
16.15	Mortgage loans foreclosed	$ 0	0.000 %
16.16	Restructured mortgage loans	$ 0	0.000 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

Loan-to-Value	Residential		Commercial		Agricultural	
	1	2	3	4	5	6
17.01 above 95%	$ 0	0.000 %	$ 0	0.000 %	$ 0	0.000 %
17.02 91% to 95%	$ 0	0.000 %	$ 0	0.000 %	$ 0	0.000 %
17.03 81% to 90%	$ 0	0.000 %	$ 0	0.000 %	$ 0	0.000 %
17.04 71% to 80%	$ 0	0.000 %	$ 0	0.000 %	$ 0	0.000 %
17.05 below 70%	$ 0	0.000 %	$ 0	0.000 %	$ 0	0.000 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate:

	Description	2	3
18.02		$ 0	0.000 %
18.03		$ 0	0.000 %
18.04		$ 0	0.000 %
18.05		$ 0	0.000 %
18.06		$ 0	0.000 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans.

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans	$ 0	0.000 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.000 %
19.04		$ 0	0.000 %
19.05		$ 0	0.000 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

	At Year-End		At End of Each Quarter		
			1st Qtr	2nd Qtr	3rd Qtr
	1	2	3	4	5
20.01 Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.000 %	$ 0	$ 0	$ 0
20.02 Repurchase agreements	$ 0	0.000 %	$ 0	$ 0	$ 0
20.03 Reverse repurchase agreements	$ 0	0.000 %	$ 0	$ 0	$ 0
20.04 Dollar repurchase agreements	$ 0	0.000 %	$ 0	$ 0	$ 0
20.05 Dollar reverse repurchase agreements	$ 0	0.000 %	$ 0	$ 0	$ 0

See accompanying independent auditors' report.

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps and floors:

	Owned		Written	
	1	2	3	4
21.01 Hedging	$0	0.000 %	$0	0.000 %
21.02 Income generation	$0	0.000 %	$0	0.000 %
21.03 Other	$0	0.000 %	$0	0.000 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

	At Year-End		At End of Each Quarter		
			1st Qtr	2nd Qtr	3rd Qtr
	1	2	3	4	5
22.01 Hedging	$0	0.000 %	$0	$0	$0
22.02 Income generation	$0	0.000 %	$0	$0	$0
22.03 Replications	$0	0.000 %	$0	$0	$0
22.04 Other	$0	0.000 %	$0	$0	$0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

	At Year-End		At End of Each Quarter		
			1st Qtr	2nd Qtr	3rd Qtr
	1	2	3	4	5
23.01 Hedging	$0	0.000 %	$0	$0	$0
23.02 Income generation	$0	0.000 %	$0	$0	$0
23.03 Replications	$0	0.000 %	$0	$0	$0
23.04 Other	$0	0.000 %	$0	$0	$0

See accompanying independent auditors' report.

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings 1 Amount	Gross Investment Holdings 2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities	26,090,197	43.8	26,090,197	0	26,090,197	43.8
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies	0	0.0	0	0	0	0.0
1.22 Issued by U.S. government sponsored agencies	0	0.0	0	0	0	0.0
1.3 Non-U.S. government (including Canada, excluding mortgage-backed securities)	0	0.0	0	0	0	0.0
1.4 Securities issued by states, territories and possessions and political subdivisions in the U.S.:						
1.41 States, territories and possessions general obligations	0	0.0	0	0	0	0.0
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	0	0.0	0	0	0	0.0
1.43 Revenue and assessment obligations	0	0.0	0	0	0	0.0
1.44 Industrial development and similar obligations	0	0.0	0	0	0	0.0
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	0	0.0	0	0	0	0.0
1.512 Issued or guaranteed by FNMA and FHLMC	0	0.0	0	0	0	0.0
1.513 All other	0	0.0	0	0	0	0.0
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	0	0.0	0	0	0	0.0
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-based securities issued or guaranteed by agencies shown in Line 1.521	0	0.0	0	0	0	0.0
1.523 All other	0	0.0	0	0	0	0.0
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	0	0.0	0	0	0	0.0
2.2 Unaffiliated non-U.S. securities (including Canada)	0	0.0	0	0	0	0.0
2.3 Affiliated securities	0	0.0	0	0	0	0.0
3. Equity interests:						
3.1 Investments in mutual funds	0	0.0	0	0	0	0.0
3.2 Preferred stocks:						
3.21 Affiliated	0	0.0	0	0	0	0.0
3.22 Unaffiliated	0	0.0	0	0	0	0.0
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated	0	0.0	0	0	0	0.0
3.32 Unaffiliated	0	0.0	0	0	0	0.0
3.4 Other equity securities:						
3.41 Affiliated	0	0.0	0	0	0	0.0
3.42 Unaffiliated	0	0.0	0	0	0	0.0
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated	0	0.0	0	0	0	0.0
3.52 Unaffiliated	0	0.0	0	0	0	0.0
4. Mortgage loans:						
4.1 Construction and land development	0	0.0	0	0	0	0.0
4.2 Agricultural	0	0.0	0	0	0	0.0
4.3 Single family residential properties	0	0.0	0	0	0	0.0
4.4 Multifamily residential properties	0	0.0	0	0	0	0.0
4.5 Commercial loans	0	0.0	0	0	0	0.0
4.6 Mezzanine real estate loans	0	0.0	0	0	0	0.0
5. Real estate investments:						
5.1 Property occupied by company	0	0.0	0	0	0	0.0
5.2 Property held for production of income (including $.....0 of property acquired in satisfaction of debt)	0	0.0	0	0	0	0.0
5.3 Property held for sale (including $.....0 property acquired in satisfaction of debt)	0	0.0	0	0	0	0.0
6. Contract loans	0	0.0	0	0	0	0.0
7. Derivatives	0	0.0	0	0	0	0.0
8. Receivables for securities	0	0.0	0	0	0	0.0
9. Securities lending (Line 10, Asset Page reinvested collateral)	0	0.0	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	33,473,874	56.2	33,473,874	0	33,473,874	56.2
11. Other invested assets	0	0.0	0	0	0	0.0
12. Total invested assets	59,564,071	100.0	59,564,071	0	59,564,071	100.0

See accompanying independent auditors' report.

Aetna Better Health® of Louisiana Audited Financial Statements 2016

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Financial Statements - Statutory Basis

Aetna Better Health, Inc.
(a Louisiana corporation)

Years Ended December 31, 2016 and 2015
with Independent Auditors' Report

KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Aetna Better Health, Inc. (a Louisiana corporation)

Report on the Financial Statements

We have audited the accompanying financial statements of Aetna Better Health, Inc. (a Louisiana corporation), which comprise the statutory statements of assets, liabilities, and capital and surplus as of December 31, 2016 and 2015, and the related statutory statements of revenue and expense, changes in capital and surplus, and cash flow for the years then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Louisiana Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by Aetna Better Health, Inc. (a Louisiana corporation) using statutory accounting practices prescribed or permitted by the Louisiana Department of Insurance, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

The effects on the financial statements of the variances between the statutory accounting practices described in Note 2 and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting practices and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Aetna Better Health, Inc. (a Louisiana corporation) as of December 31, 2016 and 2015, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the assets, liabilities, and surplus of Aetna Better Health, Inc. (a Louisiana corporation) as of December 31, 2016 and 2015, and the results of its operations and its cash flow for the years then ended, in accordance with statutory accounting practices prescribed or permitted by the Louisiana Department of Insurance described in Note 2.

Other Matters

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the Supplemental Investment Risks Interrogatories and Summary Investment Schedule is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Louisiana Department of Insurance. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

KPMG LLP

June 1, 2017

Aetna Better Health, Inc.
(a Louisiana corporation)
As of December 31, 2016 and 2015

Statutory Statements of Assets

	Current Year			Prior Year
	Assets	Nonadmitted Assets	Net Admitted Assets	Net Admitted Assets
01 Bonds (Schedule D)	$130,822,565	$0	$130,822,565	$26,090,197
02.1 Preferred stocks (Schedule D)	0	0	0	0
02.2 Common stocks (Schedule D)	0	0	0	0
03.1 Mortgage loans on real estate: First liens	0	0	0	0
03.2 Mortgage loans on real estate: Other than first liens	0	0	0	0
04.1 Properties occupied by the company	0	0	0	0
04.2 Properties held for the production of income	0	0	0	0
04.3 Properties held for sale	0	0	0	0
05 Cash ($4,287,013 in 2016 and $4,048,867 in 2015), cash equivalents ($27,398,733 in 2016 and $28,422,216 in 2015) and short-term investments ($251,425 in 2016 and $1,002,791 in 2015)	31,937,171	0	31,937,171	33,473,874
06 Contract loans	0	0	0	0
07 Derivatives (Schedule DB)	0	0	0	0
08 Other invested assets (Schedule BA)	0	0	0	0
09 Receivables for securities	84,375	0	84,375	0
10 Securities lending reinvested collateral assets (Schedule DL)	0	0	0	0
11 Aggregate write-ins for invested assets	0	0	0	0
12 Subtotals, cash and invested assets (Lines 1 to 11)	162,844,111	0	162,844,111	59,564,071
13 Title plants (for Title insurers only)	0	0	0	0
14 Investment income due and accrued	501,774	0	501,774	69,039
15.1 Uncollected premiums and agents' balances in the course of collection	47,348,249	0	47,348,249	27,763,134
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due	0	0	0	0
15.3 Accrued retrospective premiums and contracts subject to redetermination	0	0	0	0
16.1 Amounts recoverable from reinsurers	45,536	0	45,536	0
16.2 Funds held by or deposited with reinsured companies	0	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0	0
17 Amounts receivable relating to uninsured plans	0	0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	0	0	0	1,038,833
18.2 Net deferred tax asset	27,617	0	27,617	0
19 Guaranty funds receivable or on deposit	0	0	0	0
20 Electronic data processing equipment and software	0	0	0	0
21 Furniture and equipment, including health care delivery assets	0	0	0	0
22 Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23 Receivables from parent, subsidiaries and affiliates	0	0	0	0
24 Health care ($1,009,300 in 2016 and $0 in 2015) and other amounts receivable	4,350,549	3,341,249	1,009,300	0
25 Aggregate write-ins for other than invested assets	0	0	0	0
26 Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	215,117,836	3,341,249	211,776,587	88,435,077
27 From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28 Total (Lines 26 and 27)	$215,117,836	$3,341,249	$211,776,587	$88,435,077

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
As of December 31, 2016 and 2015

Statutory Statements of Liabilities, Capital and Surplus

		Current Year	Prior Year
		Total	Total
01	Claims unpaid	$109,181,413	$45,954,741
02	Accrued medical incentive pool and bonus amounts	0	0
03	Unpaid claim adjustment expenses	1,524,381	452,486
04	Aggregate health policy reserves, including the liability of $0 in 2016 and 2015 for medical loss ratio rebate per the Public Health Service Act	0	475,465
05	Aggregate life policy reserves	0	0
06	Property/casualty unearned premium reserves	0	0
07	Aggregate health claim reserves	0	0
08	Premiums received in advance	0	0
09	General expenses due or accrued	19,990,878	3,809,226
10.1	Current federal and foreign income tax payable and interest thereon	469,280	0
10.2	Net deferred tax liability	0	0
11	Ceded reinsurance premiums payable	0	0
12	Amounts withheld or retained for the account of others	0	0
13	Remittances and items not allocated	259,133	29,944
14	Borrowed money and interest thereon	0	0
15	Amounts due to parent, subsidiaries and affiliates	17,313,429	14,218,553
16	Derivatives	0	0
17	Payable for securities	0	0
18	Payable for securities lending	0	0
19	Funds held under reinsurance treaties	0	0
20	Reinsurance in unauthorized and certified	0	0
21	Net adjustments in assets and liabilities due to foreign exchange rates	0	0
22	Liability for amounts held under uninsured plans	0	0
23	Aggregate write-ins for other liabilities	69,620	0
24	Total liabilities (Lines 1 to 23)	148,808,134	64,940,415
25	Aggregate write-ins for special surplus funds	0	3,290,000
26	Common capital stock	0	0
27	Preferred capital stock	0	0
28	Gross paid in and contributed surplus	87,000,000	37,000,000
29	Surplus notes	0	0
30	Aggregate write-ins for other than special surplus funds	0	0
31	Unassigned surplus	(24,031,547)	(16,795,338)
32.1	Less treasury stock, at cost: 0 shares common	0	0
32.2	Less treasury stock, at cost: 0 shares preferred	0	0
33	Total capital and surplus (Lines 25 to 31 minus Line 32)	62,968,453	23,494,662
34	Total liabilities, capital and surplus (Lines 24 and 33)	$211,776,587	$88,435,077

Details of Write-Ins			
2301	Escheat payable	$69,620	$0
2302		0	0
2303		0	0
2398	Summary of remaining write-ins for Line 23 from overflow page	0	0
2399	Totals (Lines 2301 thru 2303) (Line 23 above)	$69,620	$0
2501	Estimated Health Insurer Fee accrual	$0	$3,290,000
2502		0	0
2503		0	0
2598	Summary of remaining write-ins for Line 25 from overflow page	0	0
2599	Totals (Lines 2501 thru 2503) (Line 25 above)	$0	$3,290,000

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
For the Years Ended December 31, 2016 and 2015

Statutory Statements of Revenue and Expenses

	Current Year Total	Prior Year Total
01 Line not used		
02 Net premium income	$421,937,923	$180,663,358
03 Change in unearned premium reserves and reserve for rate credits	0	0
04 Fee-for-service	0	0
05 Risk revenue	0	0
06 Aggregate write-ins for other health care related revenues	625	0
07 Aggregate write-ins for other non-health revenues	0	0
08 Total revenues (Lines 2 to 7)	421,938,548	180,663,358
09 Hospital/medical benefits	271,724,278	135,316,665
10 Other professional services	4,987,775	568,368
11 Outside referrals	17,231,867	6,282,972
12 Emergency room and out-of-area	22,227,103	8,499,034
13 Prescription drugs	54,590,753	19,554,305
14 Aggregate write-ins for other hospital and medical	0	0
15 Incentive pool, withhold adjustments and bonus amounts	0	0
16 Subtotal (Lines 9 to 15)	370,761,776	170,221,344
17 Net reinsurance recoveries	467,279	0
18 Total hospital and medical (Lines 16 minus 17)	370,294,497	170,221,344
19 Non-health claims (net)	0	0
20 Claims adjustment expenses	12,902,017	9,093,459
21 General administrative expenses	46,132,830	19,707,734
22 Increase in reserves for life and accident and health contracts	(475,465)	475,465
23 Total underwriting deductions (Lines 18 through 22)	428,853,879	199,498,002
24 Net underwriting loss (Lines 8 minus 23)	(6,915,331)	(18,834,644)
25 Net investment income earned	604,219	65,155
26 Net realized capital gains less capital gains tax of $16,823 in 2016 and $8,591 in 2015	(1,775,264)	(231,506)
27 Net investment losses (Lines 25 plus 26)	(1,171,045)	(166,351)
28 Net gain or (loss) from agents' or premium balances charged off	0	0
29 Aggregate write-ins for other income or expenses	(1,320,000)	0
30 Net loss after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	(9,406,376)	(19,000,995)
31 Federal and foreign income tax benefits incurred	(1,552,686)	(6,118,234)
32 Net loss	$(7,853,690)	$(12,882,761)

Details of Write-Ins		
601 Other income	$625	$0
602	0	0
603	0	0
698 Summary of remaining write-ins for Line 6 from overflow page	0	0
699 Totals (Lines 0601 thru 0603) (Line 6 above)	$625	$0
2901 Regulatory fines and penalties	$(1,320,000)	$0
2902	0	0
2903	0	0
2998 Summary of remaining write-ins for Line 29 from overflow page	0	0
2999 Totals (Lines 2901 thru 2903) (Line 29 above)	$(1,320,000)	$0

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
For the Years Ended December 31, 2016 and 2015

Statutory Statements of Changes in Capital and Surplus

		Current Year	Prior Year
33	Capital and surplus prior reporting year	$23,494,662	$3,018,536
34	Net loss from Line 32	(7,853,690)	(12,882,761)
35	Change in valuation basis of aggregate policy and claim reserves	0	0
36	Change in net unrealized capital gains or (losses) less capital gains tax	0	0
37	Change in net unrealized foreign exchange capital gain or (loss)	0	0
38	Change in net deferred income tax	27,617	0
39	Change in nonadmitted assets	(2,700,136)	(641,113)
40	Change in unauthorized and certified reinsurance	0	0
41	Change in treasury stock	0	0
42	Change in surplus notes	0	0
43	Cumulative effect of changes in accounting principles	0	0
44.1	Capital Changes: Paid in	0	0
44.2	Transferred from surplus (Stock Dividend)	0	0
44.3	Transferred to surplus	0	0
45.1	Surplus adjustments: Paid in	50,000,000	34,000,000
45.2	Transferred to capital (Stock Dividend)	0	0
45.3	Transferred from capital	0	0
46	Dividends to stockholders	0	0
47	Aggregate write-ins for gains or (losses) in surplus	0	0
48	Net change in capital and surplus (Lines 34 to 47)	39,473,791	20,476,126
49	Capital and surplus end of reporting period (Line 33 plus 48)	$62,968,453	$23,494,662

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
For the Years Ended December 31, 2016 and 2015

Statutory Statements of Cash Flows

	Current Year	Prior Year
01 Premiums collected net of reinsurance	$402,352,808	$152,900,224
02 Net investment income	76,321	15,687
03 Miscellaneous income	(2,707,169)	(641,113)
04 Total (Lines 1 to 3)	399,721,960	152,274,798
05 Benefit and loss related payments	308,115,003	124,236,659
06 Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0
07 Commissions, expenses paid and aggregate write-ins for deductions	43,101,300	24,539,481
08 Dividends paid to policyholders	0	0
09 Federal and foreign income taxes recovered net of $0 tax on capital gains (losses)	(3,043,976)	(5,071,077)
10 Total (Lines 5 through 9)	348,172,327	143,705,063
11 Net cash from operations (Line 4 minus Line 10)	51,549,633	8,569,735
12.1 Proceeds - Bonds	11,473,125	13,161,300
12.2 Stocks	0	0
12.3 Mortgage loans	0	0
12.4 Real estate	0	0
12.5 Other invested assets	0	0
12.6 Net losses on cash, cash equivalents and short-term investments	(1,148)	(140)
12.7 Miscellaneous proceeds	0	0
12.8 Total investment (Lines 12.1 to 12.7)	11,471,977	13,161,160
13.1 Cost of investments - Bonds	117,867,623	39,492,046
13.2 Stocks	0	0
13.3 Mortgage loans	0	0
13.4 Real estate	0	0
13.5 Other invested assets	0	0
13.6 Miscellaneous applications	84,375	0
13.7 Total investments acquired (Lines 13.1 to 13.6)	117,951,998	39,492,046
14 Net increase or (decrease) in contract loans and premium notes	0	0
15 Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	(106,480,021)	(26,330,886)
16.1 Surplus notes, capital notes	0	0
16.2 Capital and paid in surplus, less treasury stock	50,000,000	34,000,000
16.3 Borrowed funds	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5 Dividends to stockholders	0	0
16.6 Other cash provided	3,393,685	14,218,362
17 Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	53,393,685	48,218,362
18 Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	(1,536,703)	30,457,211
19.1 Cash, cash equivalents and short term investments - Beginning of year	33,473,874	3,016,663
19.2 Cash, cash equivalents and short term investments - End of period (Line 18 plus Line 19.1)	$31,937,171	$33,473,874

See accompanying notes to statutory financial statements.

AETNA BETTER HEALTH, INC.
(a Louisiana corporation)

NOTES TO STATUTORY FINANCIAL STATEMENTS
December 31, 2016 and 2015

1. Organization and operation

Aetna Better Health, Inc. (a Louisiana corporation) (the "Company") is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is Aetna Inc. ("Aetna").

The Company was incorporated in the State of Louisiana on July 27, 2010. Effective February 1, 2015, the Company began administering a health plan for individuals who qualify for Medicaid coverage in the State of Louisiana. The contract with the Louisiana Department of Health and Hospitals is for a term through January 31, 2018. In the event the contract is not renewed, the Company has received a guarantee of financial support by its parent through December 31, 2018. The conditions of such support stipulate that the parent has the ability to provide the necessary financial support to the Company and that there are no restrictions on the parent to provide such support.

2. Summary of significant accounting policies

Accounting practices

The accompanying statutory financial statements of the Company have been prepared in conformity with accounting practices prescribed or permitted by the Louisiana Department of Insurance ("Louisiana Department") ("Louisiana Accounting Practices"). The Louisiana Department recognizes only statutory accounting practices prescribed or permitted by the State of Louisiana for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP"). The Company's net loss and capital and surplus as stated on a NAIC SAP basis and on the basis of practices prescribed or permitted by the State of Louisiana were the same as of and for the years ended December 31, 2016 and 2015.

The Louisiana Accounting Practices vary from U.S. generally accepted accounting principles ("GAAP"). The primary differences include the following:

- Certain assets, designated as nonadmitted assets (other receivables, which are nonadmitted in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 4 - *Assets and Nonadmitted Assets*) are not recorded as assets, but are charged to surplus. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the Statutory Statements of Assets, and are, therefore, considered nonadmitted;
- Bonds are recorded at amortized cost except for those with an NAIC designation of 3 through 6, which are reported at the lower of amortized cost or fair value. Therefore, changes in unrealized gains and losses for those securities held at amortized cost are not reflected in the financial statements. Under GAAP, bonds classified as available for sale are recorded at fair value, and related changes in unrealized gains and losses are recorded as a component of equity, net of deferred federal income taxes; and
- Deferred tax assets and liabilities are determined and admitted in accordance with SSAP No. 101 - *Income Taxes* ("SSAP No. 101"). Changes in net deferred tax assets and liabilities are reflected as changes in surplus, whereas under U.S. GAAP, changes in such assets and liabilities are reflected in net income. In addition, statutory accounting requires consideration of a statutory allowance adjustment in the calculation of adjusted gross deferred tax assets and an admissibility test for deferred tax assets.

There were no permitted practices by the State of Louisiana for the years ended December 31, 2016 and 2015.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Louisiana Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenues and expenses. Actual results could differ from those estimates.

Significant accounting policies

The Company applies the following significant accounting policies:

Cash, cash equivalents and short-term investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value.

Bonds

Bonds, which include special deposits as discussed more fully in Note 4, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections at December 31, 2016 and 2015. Bonds include all investments whose maturity is greater than one year when purchased.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities, an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For loan-backed and structured securities, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

Investment income due and accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2016 and 2015, the Company did not have any nonadmitted investment income due and accrued.

Premiums and amounts due and unpaid

Premium revenue for prepaid health care products is recognized as income in the month in which enrollees are entitled to health care services.

Nonadmitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances.

The Company did not have any premiums or amounts due and unpaid at December 31, 2016 and 2015.

Hospital and medical costs and claims adjustment expenses and related reserves

Hospital and medical costs consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health claim reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Statutory Statements of Assets and Liabilities, Capital and Surplus date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, contract requirement changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in hospital and medical costs in the Statutory Statements of Revenue and Expenses in the period they are determined. Capitation costs, which are recorded in hospital and medical expenses in the Statutory Statements of Revenue and Expenses, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

Claims adjustment expenses, which include cost containment expenses, represent the costs incurred related to the claim settlement process such as costs to record, process and adjust claims. These expenses are included in the Company's management agreement with an affiliate described in Note 7.

Aggregate health policy reserves and related expenses

Premium deficiency reserves ("PDR") are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Where allowed, anticipated investment income is considered in the calculation of any PDR. For purposes of calculating a PDR, contracts are grouped in manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts. The Company had no PDR at December 31, 2016. The PDR balance of $475,465 was included in aggregate health policy reserves in the Statutory Statements of Liabilities, Capital and Surplus at December 31, 2015.

Fees Paid to the Federal Government by Health Insurers

SSAP No. 106 – *Affordable Care Act Section 9010 Assessment* ("SSAP No. 106") required (1) that the health insurer fee be recognized in full on January 1 of the fee year (the calendar year in which the assessment must be paid to the federal government), in the operating expense category of insurance taxes, licenses and fees, excluding federal income taxes and (2) that in each data year preceding a fee year a reporting entity pro-ratably accrue by reclassifying from unassigned funds (surplus) to aggregate write-ins for special surplus funds an amount equal to its estimated subsequent fee year assessment. This reclassification has no impact on total capital and surplus and is reversed in full on January 1 of the fee year beginning with fee years starting on January 1, 2015 and after. In December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the health insurer fee. As interpreted in INT 16-01: ACA Section 9010 Assessment 2017 Moratorium, because there is not an ACA Section 9010 fee due in September 2017, there is not an accrual of a liability on January 1, 2017 based on 2016 data year net written premiums. Accrual of a liability on January 1, 2018 for the ACA Section 9010 assessment based on 2017 data year net written premiums and the reclassification from unassigned funds (surplus) to aggregate write-ins for special surplus funds equal to the estimated 2018 fee year assessment accrued in data year 2017 will both continue as prescribed under SSAP No. 106. See Note 18 for disclosure of all amounts related to the health insurer fee for the Company.

Federal income taxes

The Company is included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries pursuant to the terms of a tax sharing agreement. In accordance with a written tax sharing agreement with an affiliate, the Company's current federal income tax provisions are generally computed as if the Company were filing a separate federal income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent realized in the consolidated return. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets ("DTAs") and liabilities ("DTLs") represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized ("adjusted gross DTAs"). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a. b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Service ("IRS") tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the statutory balance sheet adjusted to exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

   The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains (losses)", also a separate component of gains and losses in surplus.

Reinsurance

In the normal course of business, the Company seeks to reduce the loss that may arise from catastrophes or other events that cause unfavorable underwriting results and to help balance its risks and capital by reinsuring certain levels of risk with other insurance enterprises. The reinsurance coverage does not relieve the Company of its primary obligations. Reinsurance premiums and reserves related to reinsured business are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts. Premiums ceded for medical losses and the related unpaid reserves have been reported as reductions of these items. The reinsurance agreements are more fully discussed in Note 10.

Going concern

As of June 1, 2017, management has evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

3. Accounting changes and corrections of errors

The Company did not have any accounting changes in the years ended December 31, 2016 and 2015.

4. Special deposits

Special deposits, included in bonds, consist of U.S. Treasury Notes, at amortized cost, which approximates fair value, of $1,000,000 at December 31, 2016 and 2015. These assets are restricted in accordance with certain state requirements relating to HMOs.

5. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments, which include special deposits, cash equivalents, and short-term investments, at December 31, 2016 and 2015:

December 31, 2016

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$128,840,975	$128,840,975	$375,202	-	$129,216,177
U.S. states, territories and possessions (direct and guaranteed)	8,097,059	8,097,059	44,630	$(51,279)	8,090,410
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	11,757,953	11,757,953	64,383	(2,384)	11,819,952
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	8,776,736	8,776,736	144,639	-	8,921,375
Industrial and miscellaneous (unaffiliated)	1,000,000	1,000,000	-	-	1,000,000
Total	$158,472,723	$158,472,723	$628,854	$(53,663)	$159,047,914

December 31, 2015

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$54,515,204	$54,515,204	$20,352	-	$54,535,556
Industrial and miscellaneous (unaffiliated)	1,000,000	1,000,000	-	-	1,000,000
Total	$55,515,204	$55,515,204	$20,352	-	$55,535,556

Summarized below are the Company's bonds and other financial instruments, which include special deposits, with unrealized losses at December 31, 2016, along with the related fair values, aggregated by the length of time the investments have been in an unrealized loss position:

December 31, 2016

	Less than 12 months			Greater than 12 months		
	Number of Securities	Fair value	Unrealized losses	Number of Securities	Fair value	Unrealized losses
U.S. states, territories and possessions (direct and guaranteed)	1	$5,844,750	$(51,279)	-	-	-
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	1	2,685,517	(2,384)	-	-	-
Total	2	$8,530,267	$(53,663)	-	-	-

	Total		
	Number of Securities	Fair value	Unrealized losses
U.S. states, territories and possessions (direct and guaranteed)	1	$5,844,750	$(51,279)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	1	2,685,517	(2,384)
Total	2	$8,530,267	$(53,663)

At December 31, 2015, the Company did not have any bonds and other financial instruments, which include special deposits, with unrealized losses.

The Company has reviewed the investments in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. In performing this review, we considered factors such as the quality of the investment security based on research performed by external rating agencies and internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Furthermore, the Company has no intention to sell the investments in the table above at December 31, 2016 before their cost can be recovered and for loan-backed and structured securities the Company has the ability and intent to hold these securities for a period of time sufficient to recover the amortized cost; therefore, no OTTI was determined to have occurred on these

investments. In determining if the Company needs to sell before full recovery of value, the Company considers the forecasted recovery period, expected investment returns relative to other funding sources, projected cash flow and capital requirements, regulatory obligations, and other factors. Unrealized losses at December 31, 2016 associated with the Company's bond portfolio were primarily driven by higher Treasury yields in 2016 over 2015.

The contractual or expected maturities of bonds, cash equivalents and short-term investments at December 31, 2016 were as follows:

	Carrying value	Fair value
Due one year or less	$28,400,158	$28,400,158
Due after one year through five years	84,913,000	85,243,596
Due after five years through ten years	40,782,829	40,882,785
Due after ten years	4,376,736	4,521,375
	$158,472,723	$159,047,914

The maturity for a mortgage pass-through security, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association ("FNMA") and Government National Mortgage Association ("GNMA") pools.

Proceeds from the sales of bonds and other financial instruments were $11,473,125 and $13,161,300 in 2016 and 2015, respectively. There were no proceeds from the maturities of bonds in 2016 and 2015. Gross realized gains on sales of bonds were $51,866 and $45,838 in 2016 and 2015, respectively. There were no gross realized losses on sales of bonds in 2016. Gross realized losses on sales of bonds was $21,264 in 2015. Included in net realized capital losses for 2016 and 2015 were $1,810,687 and $248,017, respectively, of OTTI charges on debt securities that were in an unrealized loss position. The Company conducts regular reviews of its bond investments to assess whether a decline in fair value below carrying value is an OTTI. The Company will also recognize an OTTI on debt securities when the Company intends to sell a security that is in an unrealized loss position. Declines deemed to be OTTI are recognized as realized capital losses. The Company had no individually material realized capital losses on debt or equity securities that impacted its results of operations in 2016 or 2015.

There was no investment income due and accrued excluded from surplus at December 31,2016 and 2015.

Restricted assets (including pledged)

The Company had $1,000,000 on deposit with other regulatory bodies, which represented 0.47% and 1.13% of total admitted assets at December 31, 2016 and 2015, respectively.

The Company did not have any assets pledged as collateral not captured in other categories at December 31, 2016 and 2015.

The Company did not have any other restricted assets at December 31, 2016 and 2015.

6. Financial instruments

Financial instruments measured at fair value in the financial statements

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The statutory carrying values and estimated fair values of the Company's financial instruments at December 31, 2016 and 2015 were as follows:

December 31, 2016

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3	Not practicable (carrying value)
Bonds, short-term investments and cash equivalents	$159,047,914	$158,472,723	$129,214,752	$29,833,162	-	-
Total	$159,047,914	$158,472,723	$129,214,752	$29,833,162	-	-

December 31, 2015

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3	Not practicable (carrying value)
Bonds, short-term investments and cash equivalents	$55,535,556	$55,515,204	$54,532,765	$1,002,791	-	-
Total	$55,535,556	$55,515,204	$54,532,765	$1,002,791	-	-

The valuation methods and assumptions used by the Company in estimating the fair value of debt securities are discussed in Note 2.

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets during 2016 or 2015. There were no transfers between the Company's Level 1 or 2 financial assets during 2016 or 2015.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

7. Information concerning Parent, subsidiaries, and affiliates

As of and for the years ended December 31, 2016 and 2015, the Company had the following significant transactions with affiliates:

The Company and AMA are parties to an administrative services agreement, under which AMA provides certain administrative services, including accounting and processing of premiums and claims. Under this agreement, the Company will remit a percentage of its earned premium revenue, as applicable, to AMA as a fee. For these services, the Company was charged $31,302,565 in 2016 and $24,581,615 in 2015. The agreement also provides for interest on all intercompany balances. There was no interest earned (incurred) on amounts due from (to) affiliates in 2016 or 2015.

Prior to March 1, 2016, the Company had coverage for certain litigation exposures ($10,000,000 per claim and in the aggregate including defense costs) through an affiliated captive insurance company.

As explained in Note 2, the Company participates in a tax sharing agreement with Aetna and Aetna's other subsidiaries. All federal income tax receivables/payables were due from/due to Aetna.

Amounts due to and due from affiliates shown in the accompanying Statutory Statements of Assets, Liabilities, Capital and Surplus include the Company's net receipts and disbursements processed by affiliates and transactions related to its administrative services agreement with AMA.

At December 31, 2016 and 2015, the Company reported $3,230,743 and $3,980,896, respectively, due to AMA related to this agreement. The Company also reported $13,582,380 and $10,237,657 due to Aetna at December 31, 2016 and 2015, respectively.

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

8. Health care receivables

Pharmaceutical rebates

The Company receives pharmaceutical rebates through an arrangement with Aetna Health Management, LLC ("AHM"), indirectly a wholly-owned subsidiary of Aetna. AHM has contractual agreements with pharmaceutical companies for rebates, which cover the Company's membership as well as the membership of other Aetna affiliates. The Company receives those rebates from AHM (either directly or through intercompany arrangements with other Aetna affiliates) that relate to the Company's membership. The Company estimates pharmaceutical rebate receivables based upon the historical payment trends, actual utilization and other variables. Actual rebates collected are applied to the collection periods below, using a first in, first out methodology. The Company had admitted pharmaceutical rebate receivables of $453,001 at December 31, 2016. The Company had no admitted pharmaceutical rebate receivables at December 31, 2015. (Refer to the Company's accounting practices related to pharmaceutical rebate receivables in Note 2).

The following table discloses the quarterly revenue and subsequent cash collections relating to the pharmaceutical rebates:

Quarter	Estimated pharmacy rebates as reported on financial statements	Pharmacy rebates as invoiced/ confirmed	Actual rebates collected within 90 days of invoicing/ confirmation	Actual rebates collected within 91 to 180 days of invoicing/ confirmation	Actual rebates collected more than 180 days after invoicing/ confirmation
12/31/2016	$453,001	-	-	-	-
9/30/2016	$364,342	$364,342	-	-	-
6/30/2016	$167,062	$167,061	$44,026	-	-
3/31/2016	$142,155	$142,089	$83,063	$40,304	-
12/31/2015	$138,640	$140,287	$61,099	$49,907	$12,020
9/30/2015	$126,685	$126,659	$36,348	$68,449	$8,552
6/30/2015	$92,635	$91,697	$21,139	$55,620	$6,264
3/31/2015	$49,466	$49,238	$22,742	$18,368	$4,832

9. Income taxes

The components of the net DTAs recognized in the Company's Statutory Statements of Assets and Liabilities, Capital and Surplus are as follows:

	December 31, 2016		
	Ordinary	Capital	Total
Gross DTAs	$4,085,476	$720,547	$4,806,023
Statutory valuation allowance adjustment	(4,085,476)	(654,122)	(4,739,598)
Adjusted gross DTAs	-	66,425	66,425
DTAs nonadmitted	-	-	-
Subtotal net admitted DTAs	-	66,425	66,425
DTLs	-	(38,808)	(38,808)
Net admitted DTAs	-	$27,617	$27,617

	December 31, 2015		
	Ordinary	Capital	Total
Gross DTAs	$1,535,388	$86,806	$1,622,194
Statutory valuation allowance adjustment	(1,533,871)	(86,806)	(1,620,677)
Adjusted gross DTAs	1,517	-	1,517
DTAs nonadmitted	-	-	-
Subtotal net admitted DTAs	1,517	-	1,517
DTLs	-	(1,517)	(1,517)
Net admitted DTAs	$1,517	$(1,517)	-

	Change		
	Ordinary	Capital	Total
Gross DTAs	$2,550,088	$633,741	$3,183,829
Statutory valuation allowance adjustment	(2,551,605)	(567,316)	(3,118,921)
Adjusted gross DTAs	(1,517)	66,425	64,908
DTAs nonadmitted	-	-	-
Subtotal net admitted DTAs	(1,517)	66,425	64,908
DTLs		(37,291)	(37,291)
Net admitted DTAs	$(1,517)	$29,134	$27,617

The amount of admitted gross DTAs admitted under each component of SSAP No. 101 is as follows:

	December 31, 2016		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	-	$27,617	$27,617
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	-	-	-
1. Adjusted gross DTAs expected to be realized following the balance sheet date	-	-	-
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	9,759,096
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	-	38,808	38,808
(d) DTAs admitted as the result of application of SSAP No. 101	-	$66,425	$66,425

	December 31, 2015		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$1,365	-	$1,365
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	-	-	-
1. Adjusted gross DTAs expected to be realized following the balance sheet date	-	-	-
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	$2,450,441
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	152	-	152
(d) DTAs admitted as the result of application of SSAP No. 101	$1,517	-	$1,517

	Change		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$(1,365)	$27,617	$26,252
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	-	-	-
1. Adjusted gross DTAs expected to be realized following the balance sheet date	-	-	-
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	$7,308,655
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	(152)	38,808	38,656
(d) DTAs admitted as the result of application of SSAP No. 101	$(1,517)	$66,425	$64,908

	2016	2015
(a) Ratio percentage used to determine recovery period and threshold limitation amount	433%	292%
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in (b)2 above	$64,894,225	$23,494,662

The impact of tax planning strategies is as follows:

	December 31, 2016		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	-	$66,425	$66,425
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	0%	0%
3. Net admitted adjusted gross DTAs	-	$66,425	$66,425
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	0%	0%

	December 31, 2015		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$1,517	-	$1,517
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	0%	0%
3. Net admitted adjusted gross DTAs	$1,517	-	$1,517
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	0%	0%

	Change		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$(1,517)	$66,425	$64,908
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	0%	0%
3. Net admitted adjusted gross DTAs	$(1,517)	$66,425	$64,908
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	0%	0%

The Company's tax-planning strategies did not include the use of reinsurance.

There are no DTLs that were not recognized at December 31, 2016 or 2015.

The (benefit) provision for income taxes for the years ended December 31, 2016 and 2015 were as follows:

	December 31		
	2016	2015	Change
Federal income tax benefit on operations	$(1,552,686)	$(6,118,234)	$4,565,548
Federal income tax expense on net capital gains	16,823	8,591	8,232
Federal income tax benefit incurred	$(1,535,863)	$(6,109,643)	$4,573,780

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2016 and 2015 were as follows:

	December 31		
	2016	2015	Change
DTAs:			
Ordinary			
Claims unpaid	$2,916,040	$1,144,585	$1,771,455
Premium deficiency reserve	-	166,413	(166,413)
Provider advances – nonadmitted	1,169,436	224,390	945,046
Total ordinary DTAs	4,085,476	1,535,388	2,550,088
Statutory valuation allowance adjustment	(4,085,476)	(1,533,871)	(2,551,605)
Nonadmitted ordinary DTAs	-	-	-
Admitted ordinary DTAs	-	1,517	(1,517)
Capital			
Investments	720,547	86,806	633,741
Total admitted capital DTAs	720,547	86,806	633,741
Statutory valuation allowance adjustment	(654,122)	(86,806)	(567,316)
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	66,425	-	66,425
Admitted DTAs	66,425	1,517	64,908
DTLs:			
Ordinary			
Ordinary DTLs	-	-	-
Capital			
Investments	38,808	1,517	37,291
Capital DTLs	38,808	1,517	37,291
Total DTLs	38,808	1,517	37,291
Net admitted DTAs	$27,617	-	$27,617

The change in net deferred income taxes is comprised of the following:

	December 31		
	2016	2015	Change
Total DTAs	$66,425	$1,517	$64,908
Total DTLs	(38,808)	(1,517)	(37,291)
Net DTAs/(DTLs)	27,617	-	27,617
Tax effect of unrealized gains (losses)			-
Change in net deferred income tax			27,617

The valuation allowance adjustment to gross DTAs was $4,739,598 and $1,620,677 at December 31, 2016 and 2015, respectively

The benefit for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference are as follows:

	December 31, 2016	Effective tax rate	December 31, 2015	Effective tax rate
Benefit computed at statutory rate	$(3,286,344)	35.0%	$(6,647,340)	35.0%
Health Insurer Fee	1,130,668	(12.0)%	-	
Transfer pricing adjustment	(1,982,297)	21.1%	(852,917)	4.5%
Tax exempt interest	(16,407)	0.2%	-	0.0%
Change in nonadmitted assets	(945,046)	10.1%	(224,390)	1.2%
Prior year true-up	(44,975)	0.5%	-	0.0%
Change in statutory valuation allowance adjustment	3,118,921	(33.2)%	1,620,677	(8.5)%
Non-deductible penalties	462,000	(5.0)%	-	0.0%
Other	-	0.0%	(5,673)	0.0%
Total	$(1,563,480)	16.7%	$(6,109,643)	32.2%
Federal and foreign income tax (benefit) expense	$(1,535,863)	16.4%	$(6,109,643)	32.2%
Change in net deferred income taxes	(27,617)	0.3%	-	0.0%
Total statutory income taxes	$(1,563,480)	16.7%	$(6,109,643)	32.2%

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm's length prices as compared to what would be charged to an unrelated entity, which results in a permanent deduction for tax reporting purposes.

At December 31, 2016 and 2015, the Company had no net capital loss or net operating loss carryforwards for tax purposes.

The amount of federal income taxes incurred that are available for recoupment in the event of future net losses are:

Year	Ordinary	Capital	Total
2016	-	$16,822	$16,822
2015	-	8,950	8,950
2014	-	1,845	1,845
Total	-	$27,617	$27,617

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2016 and 2015.

At December 31, 2016, the Company's Federal Income Tax Return was consolidated with the following entities:

Aetna Inc.
@ Credentials Inc.
Active Health Management Inc.
Adminco, Inc.
Administrative Enterprises, Inc.
AE Fourteen Incorporated
Aetna ACO Holdings, Inc.
Aetna Better Health Inc. (Connecticut)
Aetna Better Health Inc. (Georgia)
Aetna Better Health Inc. (Illinois)
Aetna Better Health Inc. (New Jersey)
Aetna Better Health Inc. (New York)
Aetna Better Health Inc. (Ohio)
Aetna Better Health Inc. (Pennsylvania)
Aetna Better Health Inc. (Tennessee)
Aetna Better Health of California Inc.
Aetna Better Health of Iowa Inc.
Aetna Better Health of Kansas Inc.
Aetna Better Health of Kentucky Insurance Company
Aetna Better Health of Michigan Inc.
Aetna Better Health of Missouri LLC
Aetna Better Health of Nevada Inc.
Aetna Better Health of Oklahoma Inc.
Aetna Better Health of Texas Inc.
Aetna Better Health, Inc. (Louisiana)
Aetna Dental Inc. (New Jersey)
Aetna Dental Inc. (Texas)
Aetna Dental of California Inc.
Aetna Florida Inc. (fka Aetna Better Health Inc. (Florida))
Aetna Health and Life Insurance Company
Aetna Health Inc. (Connecticut)
Aetna Health Inc. (Florida)
Aetna Health Inc. (Georgia)
Aetna Health Inc. (Louisiana)
Aetna Health Inc. (Maine)
Aetna Health Inc. (Michigan)
Aetna Health Inc. (New Jersey)
Aetna Health Inc. (New York)
Aetna Health Inc. (Pennsylvania)
Aetna Health Inc. (Texas)
Aetna Health Insurance Company
Aetna Health Insurance Company of New York
Aetna Health of California Inc.
Aetna Health of Iowa Inc. (fka Aetna Health Inc. (Iowa))
Aetna Health of Utah Inc.
Aetna HealthAssurance Pennsylvania, Inc.
bswift, LLC
Carefree Insurance Services, Inc.
Claims Administration Corporation
Cofinity, Inc.
Corporate Benefit Strategies, Inc.
Coventry Consumer Advantage, Inc.
Coventry Health and Life Insurance Company
Coventry Health Care National Accounts, Inc.
Coventry Health Care National Network, Inc.
Coventry Health Care of Delaware, Inc.
Coventry Health Care of Florida, Inc.
Coventry Health Care of Illinois, Inc.
Coventry Health Care of Kansas, Inc.
Coventry Health Care of Missouri, Inc.
Coventry Health Care of Nebraska, Inc.
Coventry Health Care of the Carolinas, Inc.
Coventry Health Care of Virginia, Inc.
Coventry Health Care of West Virginia, Inc.
Coventry Health Care Workers' Compensation, Inc.
Coventry Health Plan of Florida, Inc.
Coventry HealthCare Management Corporation
Coventry Prescription Management Services, Inc.
Coventry Rehabilitation Services, Inc.
Coventry Transplant Network, Inc.
Delaware Physicians Care, Incorporated
Echo Merger Sub, Inc.
First Health Group Corp.
First Health Life and Health Insurance Company
First Script Network Services, Inc.
Florida Health Plan Administrators, LLC
FOCUS Healthcare Management, Inc.
Futrix Inc.
Group Dental Service of Maryland, Inc.
Group Dental Service, Inc.
Health and Human Resource Center, Inc.
Health Data & Management Solutions, Inc.
Health Re, Incorporated
HealthAmerica Pennsylvania, Inc.
HealthAssurance Pennsylvania, Inc.
Managed Care Coordinators, Inc.
Medicity Inc.
Mental Health Associates, Inc.
Mental Health Network of New York IPA, Inc.
Meritain Health, Inc.
MetraComp, Inc.
MHNet Life and Health Insurance Company
MHNet of Florida, Inc.

Aetna Insurance Company of Connecticut	Niagara Re, Inc.
Aetna Integrated Informatics, Inc.	PayFlex Holdings, Inc.
Aetna International Inc.	PayFlex Systems USA, Inc.
Aetna Ireland Inc.	Performax, Inc.
Aetna Life & Casualty (Bermuda) Ltd.	Precision Benefit Services, Inc.
Aetna Life Assignment Company	Prime Net, Inc.
Aetna Life Insurance Company	Prodigy Health Group, Inc.
Aetna Risk Assurance Company of Connecticut, Inc.	Professional Risk Management, Inc.
Aetna Student Health Agency Inc.	Resources for Living, LLC
AHP Holdings, Inc.	Schaller Anderson Medical Administrators, Incorporated
Allviant Corporation	Strategic Resource Company
American Health Holding, Inc.	The Vasquez Group Inc.
AUSHC Holdings, Inc.	U.S. Health Care Properties, Inc.
Broadspire National Services, Inc.	Work and Family Benefits, Inc.

As explained in Note 2, the Company participates in a tax sharing agreement with its parent and affiliates.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

The Company is subject to Louisiana premium taxes. Premium tax expenses were recorded in general administrative expenses in the Statutory Statements of Revenue and Expenses. Premium tax expenses were $23,560,150 and $3,813,410 for the years ended December 31, 2016 and 2015, respectively. The Company had premium taxes payable of $19,234,270 and $3,813,410 at December 31, 2016 and 2015, respectively, which was recorded as general expenses due or accrued in the Statutory Statements of Liabilities.

10. Reinsurance

Effective February 1, 2016, the Company and Berkley Life and Health Insurance Company ("Berkley") entered into an excess loss reinsurance agreement for Medicaid only dual eligible members. Under this agreement, Berkley is liable for 90% of covered expenses in excess of the specific deductible of $350,000 per covered member, with a maximum reimbursement of $5,000,000 per member per agreement year. The Company paid reinsurance premiums of $574,667 in 2016 and $282,984 in 2015. In 2016, the Company realized reinsurance recoveries of $467,279. The Company had no reinsurance recoveries in 2015.

11. Change in claims unpaid, unpaid claims adjustment expense, and aggregate health claim reserves

The following table shows the components of the change in claims unpaid, unpaid claims adjustment expense and aggregate health claim reserves for the years ended December 31, 2016 and 2015:

	2016	2015
Balance, January 1	$46,407,227	-
Health care receivable	-	-
Balance, January 1, net of health care receivable	46,407,227	-
Incurred related to:		
Current year	394,571,509	$179,314,803
Prior years	(11,374,995)	-
Total incurred	383,196,514	179,314,803
Paid related to:		
Current year	286,666,821	132,907,576
Prior years	33,232,768	-
Total paid	319,899,589	132,907,576
Balance, December 31, net of health care receivable	109,704,152	46,407,227
Health care receivable	1,001,642	-
Balance, December 31	$110,705,794	$46,407,227

In 2016, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased by $11,374,995 from $46,407,227 in 2015 to $35,032,232 in 2016. The lower than anticipated health care cost trend rates observed in 2016 for claims incurred in 2015 were generally due to the result of ongoing analysis of recent loss development trends. Health care cost trend rates observed in 2016 for claims incurred in 2015 were generally consistent with expectations. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends.

Net coordination of benefits is implicit in the claims incurred but not reported calculation and could not be specifically identified.

12. Capital and surplus, shareholder's dividend restrictions and quasi-reorganizations

The Company had 10,000 shares of common stock with no par value authorized, with 1,000 shares issued and outstanding at December 31, 2016 and 2015.

The Company did not have any preferred stock outstanding at December 31, 2016 and 2015.

Dividend restrictions

No domestic stock insurer shall declare and pay any dividends to its stockholders unless its capital is fully paid in cash and is unimpaired and it has a surplus beyond its capital stock and the initial minimum surplus required and all other liabilities equal to fifteen percent of its capital stock, provided that this restriction shall not apply to an insurer when its paid-in capital and surplus exceed the minimum required by the Louisiana Department Code by one hundred percent or more.

At December 31, 2016 and 2015, there was no portion of the Company's profits that may be paid as ordinary dividends to stockholders.

The Company did not pay any dividends in 2016 or 2015. The Company received capital contributions in the amounts of $10,000,000, $20,000,000 and $20,000,000 from its parent on March 30, June 29 and September 28, 2016, respectively. The Louisiana Department approved these transactions on March 30, June 29 and September 28, 2016, respectively. The Company received capital contributions in the amounts of $24,000,000 and $10,000,000 from its parent on December 28 and March 31, 2015, respectively. The Louisiana Department approved these transactions on December 28 and March 30, 2015, respectively.

There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2016 or 2015, except as noted in Note 14.

The Company did not hold any stock for any special purposes at December 31, 2016 or 2015.

Changes in the balances of special surplus funds from the prior year are due to the accrual of estimated ACA health insurer fees reclassified from unassigned funds or surplus to aggregate write-ins for special surplus funds as discussed more fully in Notes 2 and 18.

At December 31, 2016 and 2015, there was no portion of unassigned funds or surplus that was represented or reduced by unrealized gains and losses.

The Company did not have any special surplus funds or surplus notes at December 31, 2016 or 2015.

13. Contingencies

Litigation and Regulatory Proceedings

The following description of litigation and regulatory proceedings covers Aetna Inc. and certain of its subsidiaries, including the Company (collectively, "we", "our" or "us"). Certain of the proceedings described below may not impact the Company directly but may have an indirect impact on the Company as the Company is a member of the Aetna holding company group.

Out-of-Network Benefit Proceedings

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation*, MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, Aetna recorded an after tax charge to net income of approximately $78.0 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses of Aetna Inc. by $67.0 million ($103.0 million pretax). There was no after-tax charge to net income for the Company associated to the proposed settlement.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to defend ourselves vigorously against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, patent infringement and other intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, the Centers for Medicare and Medicaid Services ("CMS"), the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our withdrawal from certain states' health insurance exchanges ("Public Exchanges") for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "*Out-of-Network Benefit Proceedings*."

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "*Other Litigation and Regulatory Proceedings*," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Litigation exposure coverage

Effective March 1, 2016, the Company has coverage for certain litigation exposures ($10,000,000 per claim and in the aggregate including defense costs) through an unaffiliated insurance company.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, "Health Care Reform" or "ACA"), has made broad-based changes to the U.S. health care system. On January 20, 2017, the President signed an executive order that gives the regulatory agencies that enforce the ACA the authority to interpret regulations issued under the ACA in a way that limits fiscal burdens on states and financial or regulatory burdens on individuals, providers, health insurers and others. The practical implications of that order are unclear, and the future of the ACA is uncertain. While we anticipate efforts in 2017 and beyond to substantially modify, repeal or replace the ACA, the Company expects aspects of the ACA to continue to significantly impact the Company's business operations and operating results, including the Company's pricing, medical benefit ratios and the geographies in which the Company's products are available. Health Care Reform has presented the Company with business opportunities, but also with financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, including Public Exchanges, required minimum MLRs in commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's CMS quality performance ratings or "star ratings." The effects of these changes are reflected in the Company's operating results. If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2020.

The Company has dedicated and expects to continue to be required to dedicate significant resources and incur significant expenses during 2017 to implement and comply with Health Care Reform and changes in Health Care Reform as well as state level health care reform. While most of the significant aspects of Health Care Reform became effective during or prior to 2014, significant parts of Health Care Reform, including aspects of nondiscrimination requirements, continue to evolve through the promulgation of executive orders, regulations and guidance. Additional changes to Health Care Reform and

those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing state and federal budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or repeal or replacement of, Health Care Reform and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. Given the inherent difficulty of foreseeing the nature and scope of future changes to Health Care Reform and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact to the Company of future changes to Health Care Reform. It is reasonably possible that repeal or replacement of or other changes to Health Care Reform and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's business operations and financial results.

Potential repeal of Health Care Reform, ongoing legislative and regulatory changes to Health Care Reform, other pending efforts in the U.S. Congress to amend or restrict funding for various aspects of Health Care Reform (including risk corridors and Health Care Reform's Cost Sharing Subsidy program), the results of the 2016 presidential, congressional and state level elections, pending litigation challenging aspects of the law and federal budget negotiations continue to create uncertainty about the ultimate impact of Health Care Reform. Examples of recent legislative and regulatory changes include: the January 20, 2017 executive order relating to Health Care Reform; the November 2016 HHS announcement that risk corridor collections for the 2015 program year will be applied first to amounts owed to plans for the 2014 program year; the May 2016 final regulations relating to Health Care Reform's non-discrimination requirements; the December 2015 suspension of the health insurer fee for 2017 and two year delay of the "Cadillac" tax on high-cost employer-sponsored health coverage; the October 2015 PACE, which leaves groups with 51 to 100 employees within the large group category for each state unless the state exercises its option to include these groups within the small group category; and the October 2015 HHS announcement that Health Care Reform's risk corridor receivables for the 2014 program year would only be funded at 12.6%. With respect to pending litigation, in May 2016, the U.S. District Court for the District of Columbia ruled that the U.S. Department of Health and Human Services does not have the authority to make payments under Health Care Reform's Cost Sharing Subsidy program. Implementation of this decision has been stayed pending appeal. A final ruling that adversely impacts the Cost Sharing Subsidy program could cause significant adverse selection in individual Public Exchange products and instability in the individual Public Exchange marketplace and could have a material adverse effect on the Company's business, cash flows, financial condition and operating results as well as hinder the Company's ability to offer Public Exchange products.

As described above, the availability of funding for the ACA's temporary risk corridor program is an example of this uncertainty. The Company continues to believe that receipt of any risk corridor payment from HHS for the 2016 or 2015 program year and receipt of such payments in excess of the announced prorated amount for the 2014 program year are uncertain. At December 31, 2016, the Company had no receivable for the remaining 2014 program year prorated amount that had not been collected from HHS and had no receivable for either of the 2015 or 2016 program years. In addition, these limited risk corridor payments created additional instability in the marketplace for individual commercial products in 2016 and going forward by contributing to decisions by health plans to change or stop offering their Public Exchange products. 2016 was the last program year for Health Care Reform's risk corridor program. On-going uncertainty regarding the funding of Health Care Reform-related programs and subsidies can be expected to create additional instability in the marketplace.

In addition to efforts to amend, repeal or replace Health Care Reform and the related regulations, the federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's business. The Company cannot predict whether pending or future federal or state legislation or court proceedings, including future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or Health Care Reform or the impact those changes will have on the Company's business operations or operating results, but the effects could be materially adverse.

In addition, Health Care Reform ties a portion of each Medicare Advantage plans' reimbursement to the achievement of favorable CMS quality performance measures ("star ratings"). Since 2015, only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' operating results in 2017 and going forward will be significantly affected by their star ratings.

14. Minimum capital and surplus

Pursuant to the laws of Louisiana, each health maintenance organization shall establish prior to the issuance of any certificate of authority, and shall maintain as long as it does business in Louisiana as a health maintenance organization, capital and surplus in the amount of three million dollars. At December 31, 2016 and 2015, the Company's capital and surplus exceeded all such requirements.

The NAIC and the State of Louisiana adopted risk-based capital ("RBC") standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company's adjusted capital and surplus to its required capital and surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of the company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2016 and 2015, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

15. Medicaid

The Company's Medicaid and dual eligible products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products, dual eligible products and Children's Health Insurance Program ("CHIP") contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services the Company provides to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and the Company's Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or renew existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions against the Company if it fails to comply with CMS or state regulations or the Company's contractual requirements. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or financial results, but the effects could be materially adverse.

16. Accounting for the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (collectively, "Health Care Reform") Reinsurance, Risk Adjustment and Risk Corridor (the "3Rs") pursuant to SSAP No. 107 and INT 15-01: ACA Risk Corridors Collectibility ("INT 15-01")

Reinsurance

Health Care Reform established a temporary reinsurance program that expired at the end of 2016. Under this program, all issuers of major medical commercial insurance products and self-insured plan sponsors are required to contribute funding in amounts set by the U.S. Department of Health and Human Services ("HHS"). A portion of the funds collected will be utilized to reimburse issuers' high claims costs incurred for qualified individual members. The expense related to this required funding is reflected in insurance, taxes, licenses and fees for all of the Company's insurance products with the exception of products associated with qualified individual members; this expense for qualified individual members is reflected as a reduction of premium revenue. When annual claim costs incurred by the Company's qualified individual members exceed a specified attachment point, the Company is entitled to certain reimbursements from this program. The Company records amounts recoverable for claims paid and unpaid and ceded claim benefit recoveries to reflect its estimate of these recoveries. At December 31, 2016 and 2015, the Company did not record a payable or a receivable under the temporary three-year reinsurance program.

Risk Adjustment

Health Care Reform established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable or payable for the current calendar year and reflects the impact as an adjustment to its premium revenue. At December 31, 2016 and 2015, the Company did not record a payable or a receivable under the risk adjustment program.

Risk Corridor

Health Care Reform established a temporary risk sharing program, which expires at the end of 2016, for qualified individual and small group insurance plans. Under this program the Company makes (or receives) a payment to (or from) HHS based on the ratio of allowable costs to target costs (as defined by Health Care Reform). The Company records a risk corridor receivable or payable as an adjustment to premium revenue based on the Company's estimate of the ultimate risk sharing amount for the current calendar year. In October 2015, HHS announced that 2014 Health Care Reform risk corridor receivables would be funded at 12.6% to the extent HHS fully collects risk corridor payables. In November 2015, INT 15-01 was issued as guidance to address the accounting for risk corridor receivables. In conjunction with this guidance, the Company recorded a risk corridor receivable at December 31, 2015 that coincided with the portion of the 2014 Health Care Reform risk corridor receivables that were considered collectible. The Company currently has not recorded any risk corridor receivables for the 2016 and 2015 program years or any amount in excess of HHS's announced pro-rated funding amount for the 2014 program year because payments from HHS are uncertain. The Company currently has not recorded any risk corridor receivables for the 2016 and 2015 program years.

The Company expects to perform an annual final reconciliation and settlement with HHS of the 3Rs in each subsequent year.

17. Reconciliation to statutory financial statements as filed with the Louisiana Department

The Company's nonadmitted health care receivables were understated on the statutory financial statements for December 31, 2016.

The following is a reconciliation of December 31, 2016 total assets as reflected in the accompanying Statutory Statements of Assets to amounts reported to the Louisiana Department (statutory reports) in the Company's 2016 annual statement:

Total assets as reflected in the accompanying Statutory Statements of Assets	$211,776,587
Decrease in health care receivables	2,119,801
Total assets as reported in the annual statement	$213,896,388

The following is a reconciliation of December 31, 2016 capital and surplus as reflected in the accompanying Statutory Statements of Liabilities, Capital and Surplus to amounts reported to the Louisiana Department (statutory reports) in the Company's 2016 annual statement:

Capital and surplus as reflected in the accompanying Statutory Statements of Liabilities, Capital and Surplus	$62,968,453
Increase in nonadmitted health care receivables	2,119,801
Statutory capital and surplus as reported in the annual statement	$65,088,254

The Company's federal and foreign income tax benefits incurred were understated on the statutory financial statements for December 31, 2015.

The following is a reconciliation of December 31, 2015 total assets as reflected in the accompanying Statutory Statements of Assets to amounts reported to the Louisiana Department (statutory reports) in the Company's 2015 annual statement:

Total assets as reflected in the accompanying Statutory Statements of Assets	$88,435,077
Increase in current federal and foreign income tax recoverable and interest thereon	1,009,750
Total assets as reported in the annual statement	$89,444,827

The following is a reconciliation of December 31, 2015 capital and surplus as reflected in the accompanying Statutory Statements of Liabilities, Capital and Surplus to amounts reported to the Louisiana Department (statutory reports) in the Company's 2015 annual statement:

Capital and surplus as reflected in the accompanying Statutory Statements of Liabilities, Capital and Surplus	$23,494,662
Increase in current federal and foreign tax recoverable and interest thereon	1,009,750
Statutory capital and surplus as reported in the annual statement	$24,504,412

The following is a reconciliation of December 31, 2015 net loss as reflected in the accompanying Statutory Statements of Revenue and Expenses to amounts reported to the Louisiana Department (statutory reports) in the Company's 2015 annual statement:

Net loss as reflected in the accompanying Statutory Statements of Revenue and Expenses	$(12,882,761)
Increase in federal and foreign income tax benefits incurred	1,009,750
Statutory net loss as reported in the annual statement	$(11,873,011)

18. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through June 1, 2017.

The Company had no known reportable recognized subsequent events.

Type II - Nonrecognized subsequent events

Subsequent events have been considered through June 1, 2017.

As discussed in Note 2, in December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the health insurer fee. As a result, there is no annual health insurance industry fee payable on September 30, 2017 and there are no amounts reflected in the Company's aggregate write-ins for special surplus funds related to this payable at December 31, 2016 as a result. There is also no resulting impact to the Company's RBC to assess as of December 31, 2016 as a result of this suspension. As of December 31, 2015, the Company estimated its portion of the annual health industry fee that was payable on September 30, 2016 to be $3,290,000. This was estimated based on premiums written subject to the ACA assessment of $180,946,342. During 2016, the Company paid $3,230,480 to the federal government for its portion of the health insurer fee due on September 30, 2016.

SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2016
(To Be Filed by April 1)

Of The Aetna Better Health, Inc. (a Louisiana corporation)

ADDRESS (City, State and Zip Code) Kenner , LA 70062

NAIC Group Code 0001 NAIC Company Code 15616 Federal Employer's Identification Number (FEIN) 80-0629718

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 211,776,587

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	LOUISIANA STATE REF-SER B	Bond	$ 8,097,059	3.8 %
2.02	DOUGLAS CNTY NE SCH DIST 1	Bond	$ 4,620,819	2.2 %
2.03	COLUMBIA DIST OF SER D	Bond	$ 4,449,232	2.1 %
2.04	LOUISIANA PUB FACS AUTH REV VAR COCA COLA BOTTLING CO	Bond	$ 4,400,000	2.1 %
2.05	ALABAMA ECON SETTLEMENT AUTH BP SETTLEMENT REV-SER A	Bond	$ 4,376,736	2.1 %
2.06	NEW YORK ST DORM AUTH ST SER A	Bond	$ 2,687,902	1.3 %
2.07	WHITNEY BANK	Bond	$ 250,000	0.1 %
2.08	CAPITAL ONE	Bond	$ 250,000	0.1 %
2.09	LIBERTY BANK AND TRUST	Bond	$ 250,000	0.1 %
2.10	CITIZENS BANK	Short Term	$ 250,000	0.1 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 158,472,723	74.8 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 0	0.0 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 0	0.0 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 0	0.0 %
5.02	Countries designated NAIC-2	$ 0	0.0 %
5.03	Countries designated NAIC-3 or below	$ 0	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1:	$ 0	0.0 %
6.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
6.03	Country 1:	$ 0	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01			$ 0	0.0 %
10.02			$ 0	0.0 %
10.03			$ 0	0.0 %
10.04			$ 0	0.0 %
10.05			$ 0	0.0 %
10.06			$ 0	0.0 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings 1 Amount	Gross Investment Holdings 2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1.	Bonds:						
	1.1 U.S. treasury securities	101,440,817	62.293	101,440,817	0	101,440,817	62.293
	1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
	1.21 Issued by U.S. government agencies	0	0.000	0	0	0	0.000
	1.22 Issued by U.S. government sponsored agencies	0	0.000	0	0	0	0.000
	1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	0	0.000	0	0	0	0.000
	1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
	1.41 States, territories and possessions general obligations	8,097,059	4.972	8,097,059	0	8,097,059	4.972
	1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	11,757,953	7.220	11,757,953	0	11,757,953	7.220
	1.43 Revenue and assessment obligations	8,776,736	5.390	8,776,736	0	8,776,736	5.390
	1.44 Industrial development and similar obligations	0	0.000	0	0	0	0.000
	1.5 Mortgage-backed securities (includes residential and commercial MBS):						
	1.51 Pass-through securities:						
	1.511 Issued or guaranteed by GNMA	0	0.000	0	0	0	0.000
	1.512 Issued or guaranteed by FNMA and FHLMC	0	0.000	0	0	0	0.000
	1.513 All other	0	0.000	0	0	0	0.000
	1.52 CMOs and REMICs:						
	1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	0	0.000	0	0	0	0.000
	1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	0	0.000	0	0	0	0.000
	1.523 All other	0	0.000	0	0	0	0.000
2.	Other debt and other fixed income securities (excluding short-term):						
	2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	750,000	0.461	750,000	0	750,000	0.461
	2.2 Unaffiliated non-U.S. securities (including Canada)	0	0.000	0	0	0	0.000
	2.3 Affiliated securities	0	0.000	0	0	0	0.000
3.	Equity interests:						
	3.1 Investments in mutual funds	0	0.000	0	0	0	0.000
	3.2 Preferred stocks:						
	3.21 Affiliated	0	0.000	0	0	0	0.000
	3.22 Unaffiliated	0	0.000	0	0	0	0.000
	3.3 Publicly traded equity securities (excluding preferred stocks):						
	3.31 Affiliated	0	0.000	0	0	0	0.000
	3.32 Unaffiliated	0	0.000	0	0	0	0.000
	3.4 Other equity securities:						
	3.41 Affiliated	0	0.000	0	0	0	0.000
	3.42 Unaffiliated	0	0.000	0	0	0	0.000
	3.5 Other equity interests including tangible personal property under lease:						
	3.51 Affiliated	0	0.000	0	0	0	0.000
	3.52 Unaffiliated	0	0.000	0	0	0	0.000
4.	Mortgage loans:						
	4.1 Construction and land development	0	0.000	0	0	0	0.000
	4.2 Agricultural	0	0.000	0	0	0	0.000
	4.3 Single family residential properties	0	0.000	0	0	0	0.000
	4.4 Multifamily residential properties	0	0.000	0	0	0	0.000
	4.5 Commercial loans	0	0.000	0	0	0	0.000
	4.6 Mezzanine real estate loans	0	0.000	0	0	0	0.000
5.	Real estate investments:						
	5.1 Property occupied by company	0	0.000	0	0	0	0.000
	5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
	5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
6.	Contract loans	0	0.000	0	0	0	0.000
7.	Derivatives	0	0.000	0	0	0	0.000
8.	Receivables for securities	84,375	0.052	84,375	0	84,375	0.052
9.	Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.000	0	XXX	XXX	XXX
10.	Cash, cash equivalents and short-term investments	31,937,171	19.612	31,937,171	0	31,937,171	19.612
11.	Other invested assets	0	0.000	0	0	0	0.000
12.	Total invested assets	162,844,111	100.000	162,844,111	0	162,844,111	100.000

See accompanying independent auditors'

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Aetna Better Health® of Louisiana Audited Financial Statements 2017

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Financial Statements - Statutory Basis

Aetna Better Health, Inc.
(a Louisiana corporation)

Years Ended December 31, 2017 and 2016
with Independent Auditors' Report

KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Aetna Better Health, Inc. (a Louisiana corporation)

Report on the Financial Statements

We have audited the accompanying financial statements of Aetna Better Health, Inc. (a Louisiana corporation), which comprise the statutory statements of assets, liabilities, capital and surplus as of December 31, 2017 and 2016, and the related statutory statements of revenue and expenses, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Louisiana Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by Aetna Better Health, Inc. (a Louisiana corporation) using statutory accounting practices prescribed or permitted by the Louisiana Department of Insurance, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

The effects on the financial statements of the variances between the statutory accounting practices described in Note 2 and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting practices and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Aetna Better Health, Inc. (a Louisiana corporation) as of December 31, 2017 and 2016, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the assets, liabilities, and capital and surplus of Aetna Better Health, Inc. (a Louisiana corporation) as of December 31, 2017 and 2016, and the results of its operations and its cash flow for the years then ended, in accordance with statutory accounting practices prescribed or permitted by the Louisiana Department of Insurance described in Note 2.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the supplemental schedules titled Summary Investment Schedule and Supplemental Investment Risks Interrogatories is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Louisiana Department of Insurance. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

KPMG LLP

May 25, 2018

Aetna Better Health, Inc.
(a Louisiana corporation)
As of December 31, 2017 and 2016

Statutory Statements of Assets

	Current Year			Prior Year
	Assets	Nonadmitted Assets	Net Admitted Assets	Net Admitted Assets
01 Bonds (Schedule D)	$156,655,106	$0	$156,655,106	$130,822,565
02.1 Preferred stocks (Schedule D)	0	0	0	0
02.2 Common stocks (Schedule D)	0	0	0	0
03.1 Mortgage loans on real estate: First liens	0	0	0	0
03.2 Mortgage loans on real estate: Other than first liens	0	0	0	0
04.1 Properties occupied by the company	0	0	0	0
04.2 Properties held for the production of income	0	0	0	0
04.3 Properties held for sale	0	0	0	0
05 Cash ($502,623 in 2017 and $4,287,013 in 2016), cash equivalents ($5,999,318 in 2017 and $27,398,733 in 2016) and short-term investments ($0 in 2017 and $251,425 in 2016)	6,501,941	0	6,501,941	31,937,171
06 Contract loans	0	0	0	0
07 Derivatives (Schedule DB)	0	0	0	0
08 Other invested assets (Schedule BA)	0	0	0	0
09 Receivables for securities	84,375	0	84,375	84,375
10 Securities lending reinvested collateral assets (Schedule DL)	0	0	0	0
11 Aggregate write-ins for invested assets	0	0	0	0
12 Subtotals, cash and invested assets (Lines 1 to 11)	163,241,422	0	163,241,422	162,844,111
13 Title plants (for Title insurers only)	0	0	0	0
14 Investment income due and accrued	758,058	0	758,058	501,774
15.1 Uncollected premiums and agents' balances in the course of collection	49,553,035	0	49,553,035	47,348,249
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due	0	0	0	0
15.3 Accrued retrospective premiums and contracts subject to redetermination	0	0	0	0
16.1 Amounts recoverable from reinsurers	0	0	0	45,536
16.2 Funds held by or deposited with reinsured companies	0	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0	0
17 Amounts receivable relating to uninsured plans	0	0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	6,700,122	0	6,700,122	0
18.2 Net deferred tax asset	2,641,327	43,890	2,597,437	27,617
19 Guaranty funds receivable or on deposit	0	0	0	0
20 Electronic data processing equipment and software	0	0	0	0
21 Furniture and equipment, including health care delivery assets	0	0	0	0
22 Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23 Receivables from parent, subsidiaries and affiliates	0	0	0	0
24 Health care ($1,334,972 in 2017 and $1,009,300 in 2016) and other amounts	5,022,763	3,687,791	1,334,972	1,009,300
25 Aggregate write-ins for other than invested assets	385,305	0	385,305	0
26 Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	228,302,032	3,731,681	224,570,351	211,776,587
27 From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28 Total (Lines 26 and 27)	$228,302,032	$3,731,681	$224,570,351	$211,776,587

Details of Write-Ins				
2501 State income tax receivables	$385,305	$0	$385,305	$0
2502	0	0	0	0
2503	0	0	0	0
2598 Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599 Totals (Lines 2501 thru 2503) (Line 25 above)	$385,305	$0	$385,305	$0

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
As of December 31, 2017 and 2016

Statutory Statements of Liabilities, Capital and Surplus

		Current Year	Prior Year
		Total	Total
01	Claims unpaid	$93,805,112	$109,181,413
02	Accrued medical incentive pool and bonus amounts	571,678	0
03	Unpaid claim adjustment expenses	1,189,739	1,524,381
04	Aggregate health policy reserves, including the liability of $0 in 2017 and 2016 for medical loss ratio rebate per the Public Health Service Act	0	0
05	Aggregate life policy reserves	0	0
06	Property/casualty unearned premium reserves	0	0
07	Aggregate health claim reserves	0	0
08	Premiums received in advance	0	0
09	General expenses due or accrued	14,683,216	19,990,878
10.1	Current federal and foreign income tax payable and interest thereon	0	469,280
10.2	Net deferred tax liability	0	0
11	Ceded reinsurance premiums payable	0	0
12	Amounts withheld or retained for the account of others	0	0
13	Remittances and items not allocated	362,390	259,133
14	Borrowed money and interest thereon	0	0
15	Amounts due to parent, subsidiaries and affiliates	25,748,083	17,313,429
16	Derivatives	0	0
17	Payable for securities	0	0
18	Payable for securities lending	0	0
19	Funds held under reinsurance treaties	0	0
20	Reinsurance in unauthorized and certified	0	0
21	Net adjustments in assets and liabilities due to foreign exchange rates	0	0
22	Liability for amounts held under uninsured plans	0	0
23	Aggregate write-ins for other liabilities	264,146	69,620
24	Total liabilities (Lines 1 to 23)	136,624,364	148,808,134
25	Aggregate write-ins for special surplus funds	11,880,000	0
26	Common capital stock	0	0
27	Preferred capital stock	0	0
28	Gross paid in and contributed surplus	87,000,000	87,000,000
29	Surplus notes	0	0
30	Aggregate write-ins for other than special surplus funds	0	0
31	Unassigned surplus	(10,934,013)	(24,031,547)
32.1	Less treasury stock, at cost: 0 shares common	0	0
32.2	Less treasury stock, at cost: 0 shares preferred	0	0
33	Total capital and surplus (Lines 25 to 31 minus Line 32)	87,945,987	62,968,453
34	Total liabilities, capital and surplus (Lines 24 and 33)	$224,570,351	$211,776,587

Details of Write-Ins			
2301	Escheat payable	$264,146	$69,620
2302		0	0
2303		0	0
2398	Summary of remaining write-ins for Line 23 from overflow page	0	0
2399	Totals (Lines 2301 thru 2303) (Line 23 above)	$264,146	$69,620
2501	Estimated Health Insurer Fee accrual	$11,880,000	$0
2502		0	0
2503		0	0
2598	Summary of remaining write-ins for Line 25 from overflow page	0	0
2599	Totals (Lines 2501 thru 2503) (Line 25 above)	$11,880,000	$0

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
For years ended December 31, 2017 and 2016

Statutory Statements of Revenue and Expenses

	Current Year Total	Prior Year Total
01 Line not used		
02 Net premium income	$591,957,999	$421,937,923
03 Change in unearned premium reserves and reserve for rate credits	0	0
04 Fee-for-service	0	0
05 Risk revenue	0	0
06 Aggregate write-ins for other health care related revenues	0	625
07 Aggregate write-ins for other non-health revenues	0	0
08 Total revenues (Lines 2 to 7)	591,957,999	421,938,548
09 Hospital/medical benefits	315,142,394	271,724,278
10 Other professional services	5,370,492	4,987,775
11 Outside referrals	19,049,549	17,231,867
12 Emergency room and out-of-area	41,157,402	22,227,103
13 Prescription drugs	113,654,855	54,590,753
14 Aggregate write-ins for other hospital and medical	0	0
15 Incentive pool, withhold adjustments and bonus amounts	221,526	0
16 Subtotal (Lines 9 to 15)	494,596,218	370,761,776
17 Net reinsurance recoveries	322,618	467,279
18 Total hospital and medical (Lines 16 minus 17)	494,273,600	370,294,497
19 Non-health claims (net)	0	0
20 Claims adjustment expenses	12,706,078	12,902,017
21 General administrative expenses	57,957,196	46,132,830
22 Increase in reserves for life and accident and health contracts	0	(475,465)
23 Total underwriting deductions (Lines 18 through 22)	564,936,874	428,853,879
24 Net underwriting gain (loss) (Lines 8 minus 23)	27,021,125	(6,915,331)
25 Net investment income earned	3,293,500	604,219
26 Net realized capital gains (losses) less capital gains (losses) tax of $(275,566) in 2017 and $16,823 in 2016	76,558	(1,775,264)
27 Net investment gains (losses) (Lines 25 plus 26)	3,370,058	(1,171,045)
28 Net gain or (loss) from agents' or premium balances charged off	0	0
29 Aggregate write-ins for other income or expenses	524,000	(1,320,000)
30 Net gain (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	30,915,183	(9,406,376)
31 Federal and foreign income tax benefits incurred (recovered)	8,160,926	(1,552,686)
32 Net income (loss)	$22,754,257	($7,853,690)

Details of Write-Ins		
601 Other income	$0	$625
602	0	0
603	0	0
698 Summary of remaining write-ins for Line 6 from overflow page	0	0
699 Totals (Lines 0601 thru 0603) (Line 6 above)	$0	$625
2901 Regulatory fines and penalties	$524,000	($1,320,000)
2902	0	0
2903	0	0
2998 Summary of remaining write-ins for Line 29 from overflow page	0	0
2999 Totals (Lines 2901 thru 2903) (Line 29 above)	$524,000	($1,320,000)

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
For years ended December 31, 2017 and 2016

Statutory Statements of Changes in Capital and Surplus

		Current Year	Prior Year
33	Capital and surplus prior reporting year	$62,968,453	$23,494,662
34	Net lincome (loss) from Line 32	22,754,257	(7,853,690)
35	Change in valuation basis of aggregate policy and claim reserves	0	0
36	Change in net unrealized capital gains or (losses) less capital gains tax	0	0
37	Change in net unrealized foreign exchange capital gain or (loss)	0	0
38	Change in net deferred income tax	2,613,710	27,617
39	Change in nonadmitted assets	(390,433)	(2,700,136)
40	Change in unauthorized and certified reinsurance	0	0
41	Change in treasury stock	0	0
42	Change in surplus notes	0	0
43	Cumulative effect of changes in accounting principles	0	0
44.1	Capital Changes: Paid in	0	0
44.2	Transferred from surplus (Stock Dividend)	0	0
44.3	Transferred to surplus	0	0
45.1	Surplus adjustments: Paid in	0	50,000,000
45.2	Transferred to capital (Stock Dividend)	0	0
45.3	Transferred from capital	0	0
46	Dividends to stockholders	0	0
47	Aggregate write-ins for gains or (losses) in surplus	0	0
48	Net change in capital and surplus (Lines 34 to 47)	24,977,534	39,473,791
49	Capital and surplus end of reporting period (Line 33 plus 48)	$87,945,987	$62,968,453

See accompanying notes to statutory financial statements.

Aetna Better Health, Inc.
(a Louisiana corporation)
For years ended December 31, 2017 and 2016

Statutory Statements of Cash Flows

		Current Year	Prior Year
01	Premiums collected net of reinsurance	$589,753,213	$402,352,808
02	Net investment income	2,963,956	76,321
03	Miscellaneous income (loss)	0	(2,707,169)
04	Total (Lines 1 to 3)	592,717,169	399,721,960
05	Benefit and loss related payments	509,704,901	308,115,003
06	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0
07	Commissions, expenses paid and aggregate write-ins for deductions	76,166,883	43,101,300
08	Dividends paid to policyholders	0	0
09	Federal and foreign income taxes paid (recovered)	15,054,762	(3,043,976)
10	Total (Lines 5 through 9)	600,926,546	348,172,327
11	Net cash from operations (Line 4 minus Line 10)	(8,209,377)	51,549,633
12.1	Proceeds - Bonds	39,354,595	11,473,125
12.2	Stocks	0	0
12.3	Mortgage loans	0	0
12.4	Real estate	0	0
12.5	Other invested assets	0	0
12.6	Net losses on cash, cash equivalents and short-term investments	(17)	(1,148)
12.7	Miscellaneous proceeds	0	0
12.8	Total investment (Lines 12.1 to 12.7)	39,354,578	11,471,977
13.1	Cost of investments - Bonds	65,312,866	117,867,623
13.2	Stocks	0	0
13.3	Mortgage loans	0	0
13.4	Real estate	0	0
13.5	Other invested assets	0	0
13.6	Miscellaneous applications	0	84,375
13.7	Total investments acquired (Lines 13.1 to 13.6)	65,312,866	117,951,998
14	Net increase or (decrease) in contract loans and premium notes	0	0
15	Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	(25,958,288)	(106,480,021)
16.1	Surplus notes, capital notes	0	0
16.2	Capital and paid in surplus, less treasury stock	0	50,000,000
16.3	Borrowed funds	0	0
16.4	Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5	Dividends to stockholders	0	0
16.6	Other cash provided	8,732,435	3,393,685
17	Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	8,732,435	53,393,685
18	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	(25,435,230)	(1,536,703)
19.1	Cash, cash equivalents and short term investments - Beginning of year	31,937,171	33,473,874
19.2	Cash, cash equivalents and short term investments - End of period (Line 18 plus Line 19.1)	$6,501,941	$31,937,171

See accompanying notes to statutory financial statements.

1. Organization and operation

Aetna Better Health, Inc. (a Louisiana corporation) (the "Company") is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is Aetna Inc. ("Aetna").

The Company was incorporated in the State of Louisiana on July 27, 2010. Effective February 1, 2015, the Company began administering a health plan for individuals who qualify for Medicaid coverage in the State of Louisiana. The contract with the Louisiana Department of Health and Hospitals is for a term through December 31, 2019.

2. Summary of significant accounting policies

Accounting practices

The accompanying statutory financial statements of the Company have been prepared in conformity with accounting practices prescribed or permitted by the Louisiana Department of Insurance ("Louisiana Department") ("Louisiana Accounting Practices"). The Louisiana Department recognizes only statutory accounting practices prescribed or permitted by the State of Louisiana for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP"). The Company's net income (loss) and capital and surplus as stated on a NAIC SAP basis and on the basis of practices prescribed or permitted by the State of Louisiana were the same as of and for the years ended December 31, 2017 and 2016.

The Louisiana Accounting Practices vary from U.S. generally accepted accounting principles ("GAAP"). The primary differences include the following:

- Certain assets, designated as non-admitted assets (other receivables, which are non-admitted in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 4 - *Assets and Non-admitted Assets*) are not recorded as assets, but are charged to surplus. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the Statutory Statements of Assets, and are, therefore, considered non-admitted;
- Bonds are recorded at amortized cost except for those with an NAIC designation of 3 through 6, which are reported at the lower of amortized cost or fair value. Therefore, changes in unrealized gains and losses for those securities held at amortized cost are not reflected in the financial statements. Under GAAP, bonds classified as available for sale are recorded at fair value, and related changes in unrealized gains and losses are recorded as a component of equity, net of deferred federal income taxes;
- Deferred tax assets and liabilities are determined and admitted in accordance with SSAP No. 101 - *Income Taxes* ("SSAP No. 101"). Changes in net deferred tax assets and liabilities are reflected as changes in surplus, whereas under GAAP, changes in such assets and liabilities are reflected in net income. In addition, statutory accounting requires consideration of a statutory allowance adjustment in the calculation of adjusted gross deferred tax assets and an admissibility test for deferred tax assets; and
- Reinsurance recoverables on unpaid losses are reported as a reduction of liability for unpaid claims and claims adjustment expenses, while under GAAP, they are reported as an asset.

There were no permitted practices by the State of Louisiana for the years ended December 31, 2017 and 2016.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Louisiana Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenues and expenses. Actual results could differ from those estimates.

Significant accounting policies

The Company applies the following significant accounting policies:

Cash, cash equivalents and short-term investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value.

Bonds

Bonds, which include special deposits as discussed more fully in Note 4, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections at December 31, 2017 and 2016. Bonds include all investments whose maturity is greater than one year when purchased.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities ("LB&SS"), an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For LB&SS, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations and the risk that facts and circumstances factored into our assessment may change with the

passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

For the Company's bonds and LB&SS that provide for a prepayment penalty or acceleration fee in the event the bond is liquidated prior to its scheduled termination date, the Company reports such fees as investment income when earned.

Investment income due and accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2017 and 2016, the Company did not have any non-admitted investment income due and accrued.

Premiums and amounts due and unpaid

Premium revenue for prepaid health care products is recognized as income in the month in which enrollees are entitled to health care services.

Non-admitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances.

Hospital and medical costs and claims adjustment expenses and related reserves

Hospital and medical costs consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health claim reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Statutory Statements of Assets and Liabilities, Capital and Surplus date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, contract requirement changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in hospital and medical costs in the Statutory Statements of Revenue and Expenses in the period they are determined. Capitation costs, which are recorded in hospital and medical expenses in the Statutory Statements of Revenue and Expenses, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.
Claims adjustment expenses, which include cost containment expenses, represent the costs incurred related to the claim settlement process such as costs to record, process and adjust claims. These expenses are included in the Company's management agreement with an affiliate described in Note 7.

Aggregate health policy reserves and related expenses

Premium deficiency reserves ("PDR") are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Where allowed, anticipated investment income is considered in the calculation of any PDR. For purposes of

calculating a PDR, contracts are grouped in manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts. The Company had no PDR at December 31, 2017 and 2016, respectively.

Fees Paid to the Federal Government by Health Insurers

SSAP No. 106 – *Affordable Care Act Section 9010 Assessment* ("SSAP No. 106") required (1) that the health insurer fee be recognized in full on January 1 of the fee year (the calendar year in which the assessment must be paid to the federal government), in the operating expense category of insurance taxes, licenses and fees, excluding federal income taxes and (2) that in each data year preceding a fee year a reporting entity pro-ratably accrue by reclassifying from unassigned funds (surplus) to aggregate write-ins for special surplus funds an amount equal to its estimated subsequent fee year assessment. This reclassification has no impact on total capital and surplus and is reversed in full on January 1 of the fee year. In December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the health insurer fee. As interpreted in INT 16-01: ACA Section 9010 Assessment 2017 Moratorium, because there was not an ACA Section 9010 fee due in September 2017, there was not an accrual of a liability on January 1, 2017 based on 2016 data year net written premiums. Accrual of a liability on January 1, 2018 for the ACA Section 9010 assessment based on 2017 data year net written premiums and the reclassification from unassigned funds (surplus) to aggregate write-ins for special surplus funds equal to the estimated 2018 fee year assessment accrued in data year 2017 both continued as prescribed under SSAP No. 106. See Note 17 for disclosure of all amounts related to the health insurer fee for the Company.

Federal income taxes

The Company is included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries pursuant to the terms of a tax sharing agreement. In accordance with a written tax sharing agreement with an affiliate, the Company's current federal income tax provisions are generally computed as if the Company were filing a separate federal income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent realized in the consolidated return. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets ("DTAs") and liabilities ("DTLs") represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized ("adjusted gross DTAs"). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a. b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Service ("IRS") tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the statutory balance sheet adjusted to

exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains (losses)", also a separate component of gains and losses in surplus.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "TCJA") was enacted. Among other things, the TCJA reduced the federal corporate income tax rate to 21 percent effective January 1, 2018. See Note 9 for the impact that the TCJA had on the Company.

Reinsurance

In the normal course of business, the Company seeks to reduce the loss that may arise from catastrophes or other events that cause unfavorable underwriting results and to help balance its risks and capital by reinsuring certain levels of risk with other insurance enterprises. The reinsurance coverage does not relieve the Company of its primary obligations. Reinsurance premiums and reserves related to reinsured business are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts. Premiums ceded for medical losses and the related unpaid reserves have been reported as reductions of these items. The reinsurance agreements are more fully discussed in Note 10.

Reclassifications

Certain reclassifications have been made to the 2016 audited financial statements to conform with the classifications used in 2017.

Going concern

As of May 25, 2018, management evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

3. Accounting changes and corrections of errors

The Company did not have any accounting changes in the years ended December 31, 2017 and 2016 or corrections of errors in the year ended December 31, 2017.

During 2016, the Company recorded a correction to its nonadmitted healthcare receivables in the amount of $2,119,801. This adjustment is further discussed in Note 16.

4. Special deposits

Special deposits, included in bonds, consist of U.S. Treasury Notes, at amortized cost, which approximates fair value of $1,000,000 at December 31, 2017 and 2016. These assets are restricted in accordance with certain state requirements relating to health maintenance organizations ("HMO").

5. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments receiving bond treatment, which include special deposits, cash equivalents and short-term investments, at December 31, 2017 and 2016:

December 31, 2017

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$79,059,550	$79,059,550	$81,468	($149)	$79,140,869
U.S. states, territories and possessions (direct and guaranteed)	12,384,088	12,384,088	555,787	-	12,939,875
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	4,555,199	4,555,199	170,059	-	4,725,258
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	25,549,129	25,549,129	566,495	(13,148)	26,102,476
Industrial and miscellaneous (unaffiliated)	41,106,458	41,106,458	80,201	(168,449)	41,018,210
Total	$162,654,424	$162,654,424	$1,454,010	($181,746)	$163,926,688

December 31, 2016

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$128,840,975	$128,840,975	$375,202	-	$129,216,177
U.S. states, territories and possessions (direct and guaranteed)	8,097,059	8,097,059	44,630	($51,279)	8,090,410
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	11,757,953	11,757,953	64,383	(2,384)	11,819,952
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	8,776,736	8,776,736	144,639	-	8,921,375
Industrial and miscellaneous (unaffiliated)	1,000,000	1,000,000	-	-	1,000,000
Total	$158,472,723	$158,472,723	$628,854	($53,663)	$159,047,914

Summarized below are the Company's bonds and other financial instruments, which include special deposits, with unrealized losses at December 31, 2016, along with the related fair values, aggregated by the length of time the investments have been in an unrealized loss position:

December 31, 2017

	Less than 12 months			Greater than 12 months		
	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses
United States Government	1	$9,088,523	($149)	-	-	-
Special Revenue and Assessment	3	8,489,590	(13,148)	-	-	-
Industrial & Miscellaneous	17	25,389,354	(168,449)	-	-	-
Total	21	$42,967,467	($181,746)	-	-	-

	Total		
	Number of Securities	Fair Value	Unrealized Losses
United States Government	1	$9,088,523	($149)
Special Revenue and Assessment	3	8,489,590	(13,148)
Industrial & Miscellaneous	17	25,389,354	(168,449)
Total	21	$42,967,467	($181,746)

December 31, 2016

	Less than 12 months			Greater than 12 months		
	Number of Securities	Fair value	Unrealized losses	Number of Securities	Fair value	Unrealized losses
U.S. states, territories and possessions (direct and guaranteed)	1	$5,844,750	($51,279)	-	-	-
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	1	2,685,517	(2,384)	-	-	-
Total	2	$8,530,267	($53,663)	-	-	-

	Total		
	Number of Securities	Fair value	Unrealized losses
U.S. states, territories and possessions (direct and guaranteed)	1	$5,844,750	($51,279)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	1	2,685,517	(2,384)
Total	2	$8,530,267	($53,663)

The Company has reviewed the investments in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by external rating agencies and internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Furthermore, the Company has no intention to sell the investments in the table above at December 31, 2017 and 2016 before their cost can be recovered and for LB&SS the Company has the ability and intent to hold these securities for a period of time sufficient to recover the amortized cost; therefore, no OTTI was determined to have occurred on these investments during the years December 31, 2017 and 2016. In determining if the Company needs to sell before full recovery of value, the Company considers the forecasted recovery period, expected investment returns relative to other funding sources, projected cash flow and capital requirements, regulatory obligations, and other factors. Unrealized losses at December 31, 2017 and 2016 were generally caused by widening of market credit spreads for these securities relative to interest rates on U.S. Treasury securities.

The contractual or expected maturities of bonds, cash equivalents and short-term investments at December 31, 2017 were as follows:

	Carrying value	Fair value
Due one year or less	$15,837,991	$15,837,842
Due after one year through five years	94,463,986	94,417,007
Due after five years through ten years	47,970,429	48,922,494
Due after ten years	4,382,018	4,749,345
	$162,654,424	$163,926,688

The maturity for a mortgage pass-through security, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated

utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association and Government National Mortgage Association pools.

Proceeds from the sales of bonds and other financial instruments were $37,854,595 and $11,473,125 in 2017 and 2016, respectively. Proceeds from the maturities of bonds in were $1,500,000 and $0 in 2017 and 2016, respectively. Gross realized gains on sales of bonds were $161,299 and $51,866 in 2017 and 2016, respectively. Gross realized losses on sales of bonds were $32,699 and $0 in 2017 and 2016, respectively. Included in net realized capital losses for 2017 and 2016 were $329,309 and $1,810,687, respectively, of OTTI charges on debt securities that were in an unrealized loss position. The Company conducts regular reviews of its bond investments to assess whether a decline in fair value below carrying value is an OTTI. The Company will also recognize an OTTI on debt securities when the Company intends to sell a security that is in an unrealized loss position. Declines deemed to be OTTI are recognized as realized capital losses. The Company had no individually material realized capital losses on debt or equity securities that impacted its results of operations in 2017 or 2016.

The Company's unrealized loss position on LB&SS held by the Company at December 31, 2017 is as follows:

December 31, 2017

a.	The aggregate amount of unrealized losses:			
		1.	Less than 12 months	$23,186
		2.	12 months or longer	-
b.	The aggregate related fair value of securities with unrealized losses:			
		1.	Less than 12 months	$4,976,138
		2.	12 months or longer	-

There were no securities in an unrealized loss position in 2016.

The Company has reviewed the LB&SS in accordance with SSAP No. 43R - *Loan-Backed and Structured Securities* ("SSAP No. 43R") in the table above and have concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at December 31, 2017 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

There was no investment income due and accrued excluded from surplus at December 31, 2017 and 2016.

Restricted assets (including pledged)

The Company had $1,000,000 on deposit with other regulatory bodies, which represented 0.45% and 0.47% of total admitted assets at December 31, 2017 and 2016, respectively.

The Company did not have any assets pledged as collateral not captured in other categories at December 31, 2017 and 2016.

The Company did not have any other restricted assets at December 31, 2017 and 2016.

Prepayment Penalty and Acceleration Fees

	General Account
Number of Cusips	1
Aggregate Amount of Investment Income	$15,000

6. Financial instruments

Financial instruments measured at fair value in the financial statements

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The statutory carrying values and estimated fair values of the Company's financial instruments at December 31, 2017 and 2016 were as follows:

December 31, 2017

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3	Not practicable (carrying value)
Bonds, short-term investments and cash equivalents	$163,926,688	$162,654,424	$79,139,238	$84,787,450	-	-
Total	$163,926,688	$162,654,424	$79,139,238	$84,787,450	-	-

December 31, 2016

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3	Not practicable (carrying value)
Bonds, short-term investments and cash equivalents	$159,047,914	$158,472,723	$129,214,752	$29,833,162	-	-
Total	$159,047,914	$158,472,723	$129,214,752	$29,833,162	-	-

The valuation methods and assumptions used by the Company in estimating the fair value of debt securities are discussed in Note 2.

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets during 2017 or 2016. There were no transfers between the Company's Level 1 or 2 financial assets during 2017 or 2016.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

7. Information concerning Parent, subsidiaries, and affiliates

As of and for the years ended December 31, 2017 and 2016, the Company had the following significant transactions with affiliates:

The Company and Aetna Medicaid Administrators, LLC ("AMA"), an indirectly wholly-owned subsidiary of Aetna, are parties to an administrative services agreement, under which AMA provides certain administrative services, including accounting and processing of premiums and claims. Under this agreement, the Company will remit a percentage of its earned premium revenue, as applicable, to AMA as a fee. For these services, the Company was charged $38,744,284 in 2017 and $31,302,565 in 2016. The agreement also provides for interest on all intercompany balances. There was no interest earned (incurred) on amounts due from (to) affiliates in 2017 or 2016.

Prior to March 1, 2016, the Company had coverage for certain litigation exposures ($10,000,000 per claim and in the aggregate including defense costs) through an affiliated captive insurance company.

As explained in Note 2, the Company participates in a tax sharing agreement with Aetna and Aetna's other subsidiaries. All federal income tax receivables/payables were due from/due to Aetna.

Amounts due to and due from affiliates shown in the accompanying Statutory Statements of Assets, Liabilities, Capital and Surplus include the Company's net receipts and disbursements processed by affiliates and transactions related to its administrative services agreement with AMA.

At December 31, 2017 and 2016, the Company had no amounts due from affiliates and the following amounts due to affiliates:

	December 31	
	2017	2016
Amounts due to affiliates:		
Aetna Medicaid Administrators LLC	$10,522,578	$3,230,743
Aetna Inc.	15,225,486	13,582,380
Others not individually listed	19	500,306
	$25,748,083	$17,313,429

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

8. Health care receivables

Pharmaceutical rebates

The Company receives pharmaceutical rebates through an arrangement with Aetna Health Management, LLC ("AHM"), indirectly a wholly-owned subsidiary of Aetna. AHM has contractual agreements with pharmaceutical companies for rebates, which cover the Company's membership as well as the membership of other Aetna affiliates. The Company receives those rebates from AHM (either directly or through intercompany arrangements with other Aetna affiliates) that relate to the Company's membership. The Company estimates pharmaceutical rebate receivables based upon the historical payment trends, actual utilization and other variables. Actual rebates collected are applied to the collection periods below, using a first in, first out methodology. The Company had admitted pharmaceutical rebate receivables of $732,169 and $453,001 at December 31, 2017 and 2016, respectively. (Refer to the Company's accounting practices related to pharmaceutical rebate receivables in Note 2).

The following table discloses the quarterly revenue and subsequent cash collections relating to the pharmaceutical rebates:

Quarter	Estimated pharmacy rebates as reported on financial statements	Pharmacy rebates as invoiced/ confirmed	Actual rebates collected within 90 days of invoicing/ confirmation	Actual rebates collected within 91 to 180 days of invoicing/ confirmation	Actual rebates collected more than 180 days after invoicing/ confirmation
12/31/2017	$732,169	-	-	-	-
9/30/2017	632,953	$732,169	-	-	-
6/30/2017	438,408	632,953	$188,967	-	-
3/31/2017	424,111	438,407	123,440	$312,237	-
12/31/2016	$453,001	$424,110	$144,710	$275,258	$394
9/30/2016	364,342	363,229	161,366	178,397	134
6/30/2016	167,062	167,028	44,026	83,680	35,745
3/31/2016	142,155	142,122	83,063	40,304	15,036
12/31/2015	$138,640	$140,137	$61,099	$49,907	$25,732
9/30/2015	126,685	122,763	36,348	68,449	13,682
6/30/2015	92,635	91,541	21,139	55,620	7,285
3/31/2015	49,466	47,311	22,742	18,368	6,196

9. Income taxes

The components of the net DTAs recognized in the Company's Statutory Statements of Assets and Liabilities, Capital and Surplus are as follows:

	December 31, 2017		
	Ordinary	Capital	Total
(a) Gross DTAs	$2,437,654	$271,210	$2,708,864
(b) Statutory valuation allowance adjustment	-	-	-
(c) Adjusted gross DTAs	2,437,654	271,210	2,708,864
(d) DTAs non-admitted	-	(43,890)	(43,890)
(e) Subtotal net admitted DTAs	2,437,654	227,320	2,664,974
(f) DTLs	-	(67,537)	(67,537)
(g) Net admitted DTAs/(DTLs)	$2,437,654	$159,783	$2,597,437

	December 31, 2016		
	Ordinary	Capital	Total
(a) Gross DTAs	$4,085,476	$720,547	$4,806,023
(b) Statutory valuation allowance adjustment	(4,085,476)	(654,122)	(4,739,598)
(c) Adjusted gross DTAs	-	66,425	66,425
(d) DTAs non-admitted	-	-	-
(e) Subtotal net admitted DTAs	-	66,425	66,425
(f) DTLs	-	(38,808)	(38,808)
(g) Net admitted DTAs/(DTLs)	-	$27,617	$27,617

	Change		
	Ordinary	Capital	Total
(a) Gross DTAs	($1,647,822)	($449,337)	($2,097,159)
(b) Statutory valuation allowance adjustment	4,085,476	654,122	4,739,598
(c) Adjusted gross DTAs	2,437,654	204,785	2,642,439
(d) DTAs non-admitted	-	(43,890)	(43,890)
(e) Subtotal net admitted DTAs	2,437,654	160,895	2,598,549
(f) DTLs	-	(28,729)	(28,729)
(g) Net admitted DTAs/(DTLs)	$2,437,654	$132,166	$2,569,820

The amount of admitted gross DTAs admitted under each component of SSAP No. 101:

	December 31, 2017		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$2,421,022	$27,235	$2,448,257
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of 2(b)1 and 2(b)2 below)	16,632	132,548	149,180
1. Adjusted gross DTAs expected to realized following the balance sheet date	16,632	132,548	149,180
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	12,802,283
(c) Adjusted gross DTAs (excluding the amount of DTAs from 2(a) and 2(b) above) offset by gross DTLs	-	67,537	67,537
(d) DTAs admitted as the result of application of SSAP No. 101	$2,437,654	$227,320	$2,664,974

	December 31, 2016		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	-	$27,617	$27,617
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of 2(b)1 and 2(b)2 below)	-	-	-
1. Adjusted gross DTAs expected to realized following the balance sheet date	-	-	-
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	9,759,096
(c) Adjusted gross DTAs (excluding the amount of DTAs from 2(a) and 2(b) above) offset by gross DTLs	-	38,808	38,808
(d) DTAs admitted as the result of application of SSAP No. 101	-	$66,425	$66,425

	Change		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$2,421,022	($382)	$2,420,640
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of 2(b)1 and 2(b)2 below)	16,632	132,548	149,180
1. Adjusted gross DTAs expected to realized following the balance sheet date	16,632	132,548	149,180
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	3,043,187
(c) Adjusted gross DTAs (excluding the amount of DTAs from 2(a) and 2(b) above) offset by gross DTLs	-	28,729	28,729
(d) DTAs admitted as the result of application of SSAP No. 101	$2,437,654	$160,895	$2,598,549

	2017	2016
(a) Ratio percentage used to determine recovery period and threshold limitation amount	435%	433%
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in 2(b)2 above	$85,348,550	$64,894,225

The impact of tax planning strategies is as follows:

	December 31, 2017		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$2,437,654	$271,210	$2,708,864
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	5%	5%
3. Net admitted adjusted gross DTAs	2,437,654	227,320	$2,664,974
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	5%	5%

	December 31, 2016		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	-	$66,425	$66,425
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	0%	0%
3. Net admitted adjusted gross DTAs	-	$66,425	$66,425
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	0%	0%

	Change		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$2,437,654	$204,785	$2,642,439
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	5%	5%
3. Net admitted adjusted gross DTAs	$2,437,654	$160,895	$2,598,549
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	5%	5%

The Company's tax-planning strategies did not include the use of reinsurance.

There are no DTLs that were not recognized at December 31, 2017 or 2016.

The (benefit) provision for income taxes for the years ended December 31, 2017 and 2016 were as follows:

	December 31		
	2017	2016	Change
Federal income tax benefit on operations	$8,160,926	($1,552,686)	$9,713,612
Federal income tax expense on net capital gains	(275,566)	16,823	(292,389)
Federal income tax benefit incurred	$7,885,360	($1,535,863)	$9.421.223

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2017 and 2016 were as follows:

	2017	2016	Change
DTAs:			
Ordinary			
Claims unpaid	$1,663,218	$2,916,040	($1,252,822)
Provider advances – non-admitted	774,436	1,169,436	(395,000)
Total ordinary DTAs	2,437,654	4,085,476	(1,647,822)
Statutory valuation allowance adjustment	-	(4,085,476)	4,085,476
Non-admitted ordinary DTAs	-	-	-
Admitted ordinary DTAs	2,437,654	-	2,437,654
Capital			
Investments - impairment	271,210	720,547	(449,337)
Total capital DTAs	271,210	720,547	(449,337)
Statutory valuation allowance adjustment	-	(654,122)	654,122
Non-admitted capital DTAs	(43,890)	-	(43,890)
Admitted capital DTAs	227,320	66,425	160,895
Admitted DTAs	2,664,974	66,425	2,598,549
DTLs:			
Ordinary			
Ordinary DTLs	-	-	-
Capital			
Investments	67,537	38,808	28,729
Capital DTLs	67,537	38,808	28,729
Total DTLs	67,537	38,808	28,729
Net admitted DTAs	$2,597,437	$27,617	$2,569,820

The change in net deferred income taxes is comprised of the following:

	2017	2016	Change
Total DTAs	$2,708,864	$66,425	$2,642,439
Total DTLs	(67,537)	(38,808)	(28,729)
Net DTAs/(DTLs)	2,641,327	27,617	2,613,710
Tax effect of unrealized gains (losses)			-
Change in net deferred income tax			$2,613,710

The valuation allowance adjustment to gross DTAs was $0 and $4,739,598 at December 31, 2017 and 2016, respectively

The benefit for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference are as follows:

	December 31, 2017	Effective tax rate	December 31, 2016	Effective tax rate
Provision (benefit) computed at statutory rate	$10,723,866	35.0%	($3,286,344)	35.0%
Health Insurer Fee	-	-	1,130,668	(12.0)%
Transfer pricing adjustment	(2,149,445)	(7.0)%	(1,982,297)	21.1%
Tax exempt interest	(272,281)	(0.9)%	(16,407)	0.2%
Change in non-admitted assets	(121,291)	(0.4)%	(945,046)	10.1%
Prior year true-up	252,915	0.8%	(44,975)	0.5%
Change in statutory valuation allowance adjustment	(4,739,598)	(15.5)%	3,118,921	(33.2)%
Impact on deferred tax for enacted rate change	1,760,884	5.7%	-	-
Non-deductible penalties	(183,400)	(0.6)%	462,000	(5.0)%
Other	(1)	0.1%	-	-
Total	$5,271,650	17.2%	($1,563,480)	16.7%
Federal and foreign income tax (benefit) expense	$7,885,360	25.7%	($1,535,863)	16.4%
Change in net deferred income taxes	(2,613,710)	(8.5)%	(27,617)	0.3%
Total statutory income taxes	$5,271,650	17.2%	($1,563,480)	16.7%

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm's length prices as compared to what would be charged to an unrelated entity, which results in a permanent deduction for tax reporting purposes.

At December 31, 2017 and 2016, the Company had no net capital loss or net operating loss carryforwards for tax purposes.

The amount of federal income taxes incurred that are available for recoupment in the event of future net losses are:

Year	Ordinary	Capital	Total
2017	$7,328,125	-	$7,328,125
2016	-	18,286	18,286
2015	-	8,949	8,949
Total	$7,328,125	$27,235	$7,355,360

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2017 and 2016.

At December 31, 2017, the Company's Federal Income Tax Return was consolidated with the following entities:

Aetna Inc.
@ Credentials Inc.
Active Health Management Inc.
American Health Holding, Inc.
AUSHC Holdings, Inc.
Broadspire National Services, Inc.

Adminco, Inc.
Administrative Enterprises, Inc.
AE Fourteen Incorporated
Aetna ACO Holdings, Inc.
Aetna Better Health Inc. (Connecticut)
Aetna Better Health Inc. (Georgia)
Aetna Better Health Inc. (Illinois)
Aetna Better Health Inc. (New Jersey)
Aetna Better Health Inc. (New York)
Aetna Better Health Inc. (Ohio)
Aetna Better Health Inc. (Pennsylvania)
Aetna Better Health Inc. (Tennessee)
Aetna Better Health of California Inc.
Aetna Better Health of Iowa Inc.
Aetna Better Health of Kansas, Inc.
Aetna Better Health of Kentucky Insurance Company
Aetna Better Health of Michigan, Inc.
Aetna Better Health of Missouri LLC
Aetna Better Health of Nevada Inc.
Aetna Better Health of North Carolina, Inc.
Aetna Better Health of Oklahoma Inc.
Aetna Better Health of Texas, Inc.
Aetna Better Health of Washington, Inc.
Aetna Better Health, Inc. (Louisiana)
Aetna Dental Inc. (New Jersey)
Aetna Dental Inc. (Texas)
Aetna Dental of California Inc.
Aetna Florida Inc. (fka Aetna Better Health Inc. (Florida))
Aetna Health and Life Insurance Company
Aetna Health Inc. (Connecticut)
Aetna Health Inc. (Florida)
Aetna Health Inc. (Georgia)
Aetna Health Inc. (Louisiana)
Aetna Health Inc. (Maine)
Aetna Health Inc. (Michigan)
Aetna Health Inc. (New Jersey)
Aetna Health Inc. (New York)
Aetna Health Inc. (Pennsylvania)
Aetna Health Inc. (Texas)
Aetna Health Insurance Company
Aetna Health Insurance Company of New York
Aetna Health of California, Inc.
Aetna Health of Iowa Inc. (fka Aetna Health Inc. (Iowa))
Aetna Health of Utah, Inc.
Aetna HealthAssurance Pennsylvania, Inc.
Aetna Insurance Company of Connecticut
bswift, LLC
Carefree Insurance Services, Inc.
Claims Administration Corporation
Cofinity, Inc.
Continental Life Insurance Company of Brentwood, Tennessee
Corporate Benefit Strategies, Inc.
Coventry Consumer Advantage, Inc.
Coventry Health and Life Insurance Company
Coventry Health Care National Accounts, Inc.
Coventry Health Care National Network, Inc.
Coventry Health Care of Florida, Inc.
Coventry Health Care of Illinois, Inc.
Coventry Health Care of Kansas, Inc.
Coventry Health Care of Missouri, Inc.
Coventry Health Care of Nebraska, Inc.
Coventry Health Care of Virginia, Inc.
Coventry Health Care of West Virginia, Inc.
Coventry Health Care Workers' Compensation, Inc.
Coventry Health Plan of Florida, Inc.
Coventry HealthCare Management Corporation
Coventry Prescription Management Services, Inc.
Coventry Rehabilitation Services, Inc.
Coventry Transplant Network, Inc.
Delaware Physicians Care, Incorporated
Echo Merger Sub, Inc.
First Health Group Corp.
First Health Life and Health Insurance Company
First Script Network Services, Inc.
Florida Health Plan Administrators, LLC
FOCUS Healthcare Management, Inc.
Group Dental Service of Maryland, Inc.
Group Dental Service, Inc.
Health and Human Resource Center, Inc.
Health Data & Management Solutions, Inc.
Health Re, Incorporated
HealthAssurance Pennsylvania, Inc.
Managed Care Coordinators, Inc.
Medicity Inc.
Mental Health Associates, Inc.
Mental Health Network of New York IPA, Inc.
Meritain Health, Inc.
MetraComp, Inc.
MHNet Life and Health Insurance Co.
MHNet of Florida, Inc.
Niagara Re, Inc.
PayFlex Holdings, Inc.
PayFlex Systems USA, Inc.
Performax, Inc.

Aetna Integrated Informatics, Inc.
Aetna International Inc.
Aetna Ireland Inc.
Aetna Life & Casualty (Bermuda) Ltd.
Aetna Life Assignment Company
Aetna Life Insurance Company
Aetna Risk Assurance Company of. Connecticut, Inc.
Aetna Student Health Agency Inc.
AHP Holdings, Inc.
Allviant Corporation
American Continental Insurance Company
Precision Benefit Services, Inc.
Prime Net, Inc.
Prodigy Health Group, Inc.
Professional Risk Management, Inc.
Resources for Living, LLC
Schaller Anderson Medical Administrators, Incorporated
Strategic Resource Company
The Vasquez Group Inc.
U.S. Health Care Properties, Inc.
Work and Family Benefits, Inc.

As explained in Note 2, the Company participates in a tax sharing agreement with its parent and affiliates.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

The Company is subject to Louisiana premium taxes. Premium tax expenses were recorded in general administrative expenses in the Statutory Statements of Revenue and Expenses. Premium tax expenses were $32,046,093 and $23,560,150 for the years ended December 31, 2017 and 2016, respectively. The Company had premium taxes payable of $14,681,631 and $19,234,270 at December 31, 2017 and 2016, respectively, which was recorded as general expenses due or accrued in the Statutory Statements of Liabilities.

10. Reinsurance

Effective February 1, 2017, the Company and Berkley Life and Health Insurance Company ("Berkley") entered into an excess loss reinsurance agreement. Under this agreement, Berkley is liable for 90% of covered expenses in excess of the specific deductible of $500,000 per covered member, with a maximum reimbursement of $5,000,000 per member per agreement year. The Company paid reinsurance premiums of $350,464 in 2017 and $574,667 in 2016. In 2017 and 2016, the Company realized reinsurance recoveries of $322,618 and $467,279, respectively.

11. Change in claims unpaid, unpaid claims adjustment expense, and aggregate health claim reserves

The following table shows the components of the change in claims unpaid, unpaid claims adjustment expense and aggregate health claim reserves for the years ended December 31, 2017 and 2016:

	2017	2016
Balance, January 1	$110,705,794	$46,407,227
Health care receivable	(1,001,642)	-
Balance, January 1, net of health care receivable	109,704,152	46,407,227
Incurred related to:		
Current year	540,829,707	$394,571,509
Prior years	(33,850,029)	(11,374,995)
Total incurred	506,979,678	383,196,514
Paid related to:		
Current year	456,636,325	286,666,821
Prior years	69,503,739	33,232,768
Total paid	526,140,064	319,899,589
Balance, December 31, net of health care receivable	90,543,766	109,704,152
Health care receivable	5,022,763	1,001,642
Balance, December 31	$95,566,529	$110,705,794

In 2017, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' decreased by $33,850,029 from $110,705,794 in 2016 to $76,855,765 in 2017. In 2016, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' decreased by $11,374,995 from $46,407,227 in 2015 to $35,032,232 in 2016. The lower than anticipated health care cost trend rates observed in 2017 and 2016 for claims incurred in 2016 and 2015 were generally due to the result of ongoing analysis of recent loss development trends. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends.

Net coordination of benefits is implicit in the claims incurred but not reported calculation and could not be specifically identified.

12. Capital and surplus, shareholder's dividend restrictions and quasi-reorganizations

The Company had 10,000 shares of common stock with no par value authorized, with 1,000 shares issued and outstanding at December 31, 2017 and 2016.

The Company did not have any preferred stock outstanding at December 31, 2017 and 2016.

Dividend restrictions

No domestic stock insurer shall declare and pay any dividends to its stockholders unless its capital is fully paid in cash and is unimpaired and it has a surplus beyond its capital stock and the initial minimum surplus required and all other liabilities equal to fifteen percent of its capital stock, provided that this restriction shall not apply to an insurer when its paid-in capital and surplus exceed the minimum required by the Louisiana Department Code by one hundred percent or more.

At December 31, 2017 and 2016, there was $22,677,699 and $0, respectively, of the Company's net income less realized capital gains that may be paid as ordinary dividends to stockholders.

The Company did not pay any dividends in 2017 or 2016. The Company did not receive any capital contributions in 2017. The Company received capital contributions in the amounts of $10,000,000, $20,000,000 and $20,000,000 from its parent on March 30, June 29 and September 28, 2016, respectively. The Louisiana Department approved these transactions on March 30, June 29 and September 28, 2016, respectively.

There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2017 or 2016, except as noted in Note 14.

The Company did not hold any stock for any special purposes at December 31, 2017 or 2016.

Changes in the balances of special surplus funds from the prior year are due to the accrual of estimated ACA health insurer fees reclassified from unassigned funds or surplus to aggregate write-ins for special surplus funds as discussed more fully in Notes 2 and 17.

At December 31, 2017 and 2016, there was no portion of unassigned funds or surplus that was represented or reduced by unrealized gains and losses.

13. Contingencies

Litigation and Regulatory Proceedings

The following description of litigation and regulatory proceedings covers Aetna Inc. and certain of its subsidiaries, including the Company (collectively, "we", "our" or "us"). Certain of the proceedings described below may not impact the Company directly but may have an indirect impact on the Company as the Company is a member of the Aetna holding company group.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, the Centers for Medicare and Medicaid Services ("CMS"), the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the

Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our withdrawal from certain states' health insurance exchanges ("Public Exchanges") for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from attorneys general. We also have produced documents and information to the Civil Division of the Department of Justice in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "*Other Litigation and Regulatory Proceedings*," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Litigation exposure coverage

The Company has coverage for certain litigation exposures ($10,000,000 per claim and in the aggregate including defense costs) through an unaffiliated insurance company.

14. Minimum capital and surplus

Pursuant to the laws of Louisiana, each health maintenance organization shall establish prior to the issuance of any certificate of authority, and shall maintain as long as it does business in Louisiana as a health maintenance organization, capital and surplus in the amount of three million dollars. At December 31, 2017 and 2016, the Company's capital and surplus exceeded all such requirements.

The NAIC and the State of Louisiana adopted risk-based capital ("RBC") standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company's adjusted capital and surplus to its required capital and surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of the company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2017 and 2016, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

15. Medicaid

The Company's Medicaid products also are heavily regulated by state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with contracts and regulations. The Company's Medicaid products and Children's Health Insurance Program ("CHIP") contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services the Company provides to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and the Company's Medicaid program compliance efforts will continue to require significant resources. State Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid products, exclude the Company from participating in one or more Medicaid program and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with state regulations or the Company's contractual requirements. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or financial results, but the effects could be materially adverse.

16. Reconciliation to statutory financial statements as filed with the Louisiana Department

There were no reconciling differences between the amounts previously reported to state regulatory authorities in the 2017 Annual Statement and those reported in the accompanying statutory financial statements.

The Company's non-admitted health care receivables were understated on the statutory financial statements for December 31, 2016.

The following is a reconciliation of December 31, 2016 total assets as reflected in the accompanying Statutory Statements of Assets to amounts reported to the Louisiana Department (statutory reports) in the Company's 2016 annual statement:

Total assets as reflected in the accompanying Statutory Statements of Assets	$211,776,587
Decrease in health care receivables	2,119,801
Total assets as reported in the annual statement	$213,896,388

The following is a reconciliation of December 31, 2016 capital and surplus as reflected in the accompanying Statutory Statements of Liabilities, Capital and Surplus to amounts reported to the Louisiana Department (statutory reports) in the Company's 2016 annual statement:

Capital and surplus as reflected in the accompanying Statutory Statements of Liabilities, Capital and Surplus	$62,968,453
Increase in current federal and foreign tax recoverable and interest thereon	2,119,801
Statutory capital and surplus as reported in the annual statement	$65,088,254

17. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through May 25, 2018.

The Company had no known reportable recognized subsequent events.

Type II – Non-recognized subsequent events

Subsequent events have been considered through May 25, 2018.

On January 1, 2018, the Company will be subject to an annual fee under the Section 9010 of the Federal Affordable Care Act ("ACA"). This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2017, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2018, and estimates its portion of the annual health insurance industry fee to be payable on September 30, 2018 to be $11,880,000. This amount is reflected in aggregate write-ins for special surplus funds and was estimated based on premiums written subject to the ACA assessment of $592,308,464. The Company's total adjusted capital before and after the special surplus adjustment was $87,945,987 and $76,065,987, respectively. The Company's total authorized control level both before and after the special surplus adjustment was estimated to be $19,641,636. As a result, this assessment is expected to impact RBC by 14%. Reporting the ACA assessment as of December 31, 2017 would not have triggered an RBC action level.

As discussed in Note 2, in December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the health insurer fee. As a result, there was no annual health insurance industry fee payable on September 30, 2017 and there were no amounts reflected in the Company's aggregate write-ins for special surplus funds related to this payable at December 31, 2016 as a result. There was also no resulting impact to the Company's RBC to assess as of December 31, 2016 as a result of this suspension.

In January 2018, the annual fee was suspended for 2019.

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings 1 Amount	Gross Investment Holdings 2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1.	Bonds:						
	1.1 U.S. treasury securities	79,057,920	48.430	79,057,920	0	79,057,920	48.430
	1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
	1.21 Issued by U.S. government agencies	0	0.000	0	0	0	0.000
	1.22 Issued by U.S. government sponsored agencies	0	0.000	0	0	0	0.000
	1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	0	0.000	0	0	0	0.000
	1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
	1.41 States, territories and possessions general obligations	12,384,088	7.586	12,384,088	0	12,384,088	7.586
	1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	4,555,199	2.790	4,555,199	0	4,555,199	2.790
	1.43 Revenue and assessment obligations	25,549,129	15.651	25,549,129	0	25,549,129	15.651
	1.44 Industrial development and similar obligations	0	0.000	0	0	0	0.000
	1.5 Mortgage-backed securities (includes residential and commercial MBS):						
	1.51 Pass-through securities:						
	1.511 Issued or guaranteed by GNMA	0	0.000	0	0	0	0.000
	1.512 Issued or guaranteed by FNMA and FHLMC	0	0.000	0	0	0	0.000
	1.513 All other	2,055,189	1.259	2,055,189	0	2,055,189	1.259
	1.52 CMOs and REMICs:						
	1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	0	0.000	0	0	0	0.000
	1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	0	0.000	0	0	0	0.000
	1.523 All other	4,999,324	3.063	4,999,324	0	4,999,324	3.063
2.	Other debt and other fixed income securities (excluding short-term):						
	2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	27,055,777	16.574	27,055,777	0	27,055,777	16.574
	2.2 Unaffiliated non-U.S. securities (including Canada)	998,480	0.612	998,480	0	998,480	0.612
	2.3 Affiliated securities	0	0.000	0	0	0	0.000
3.	Equity interests:						
	3.1 Investments in mutual funds	0	0.000	0	0	0	0.000
	3.2 Preferred stocks:						
	3.21 Affiliated	0	0.000	0	0	0	0.000
	3.22 Unaffiliated	0	0.000	0	0	0	0.000
	3.3 Publicly traded equity securities (excluding preferred stocks):						
	3.31 Affiliated	0	0.000	0	0	0	0.000
	3.32 Unaffiliated	0	0.000	0	0	0	0.000
	3.4 Other equity securities:						
	3.41 Affiliated	0	0.000	0	0	0	0.000
	3.42 Unaffiliated	0	0.000	0	0	0	0.000
	3.5 Other equity interests including tangible personal property under lease:						
	3.51 Affiliated	0	0.000	0	0	0	0.000
	3.52 Unaffiliated	0	0.000	0	0	0	0.000
4.	Mortgage loans:						
	4.1 Construction and land development	0	0.000	0	0	0	0.000
	4.2 Agricultural	0	0.000	0	0	0	0.000
	4.3 Single family residential properties	0	0.000	0	0	0	0.000
	4.4 Multifamily residential properties	0	0.000	0	0	0	0.000
	4.5 Commercial loans	0	0.000	0	0	0	0.000
	4.6 Mezzanine real estate loans	0	0.000	0	0	0	0.000
5.	Real estate investments:						
	5.1 Property occupied by company	0	0.000	0	0	0	0.000
	5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
	5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
6.	Contract loans	0	0.000	0	0	0	0.000
7.	Derivatives	0	0.000	0	0	0	0.000
8.	Receivables for securities	84,375	0.052	84,375	0	84,375	0.052
9.	Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.000	0	XXX	XXX	XXX
10.	Cash, cash equivalents and short-term investments	6,501,941	3.983	6,501,941	0	6,501,941	3.983
11.	Other invested assets	0	0.000	0	0	0	0.000
12.	Total invested assets	163,241,422	100.000	163,241,422	0	163,241,422	100.000

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SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2017
(To Be Filed by April 1)

Of The Aetna Better Health, Inc. (a Louisiana corporation)

ADDRESS (City, State and Zip Code) Blue Bell , PA 19422

NAIC Group Code 0001 NAIC Company Code 15616 Federal Employer's Identification Number (FEIN) 80-0629718

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 224,570,351

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	LOUISIANA STATE REF-SER B	Bond	$ 7,996,976	3.6 %
2.02	SAN JOSE CA REDEV AGY REF-SUB-SER B	Bond	$ 6,019,956	2.7 %
2.03	METROPOLITAN TRANSN AUTH N Y REF-TRANSPTRN-SUBSER C-1	Bond	$ 5,165,759	2.3 %
2.04	SACRAMENTO CA MUNI UTIL DIST REF SER E	Bond	$ 5,012,074	2.2 %
2.05	DOUGLAS CNTY NE SCH DIST 1	Bond	$ 4,555,199	2.0 %
2.06	COLUMBIA DIST OF SER D	Bond	$ 4,387,112	2.0 %
2.07	ALABAMA ECON SETTLEMENT AUTH BP SETTLEMENT REV-SER A	Bond	$ 4,382,018	2.0 %
2.08	WESTAR ENERGY INC	Cash Equivalent	$ 3,999,794	1.8 %
2.09	AMERICAN EXPRESS CREDIT SR UNSECURED	Bond	$ 3,003,673	1.3 %
2.10	CAPITAL ONE MULTI-ASSET EXE TR SERIES 2017-A1 CLASS A1	Bond	$ 2,999,509	1.3 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 151,597,000	67.5 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 11,055,793	4.9 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 998,480	0.4 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 0	0.0 %
5.02	Countries designated NAIC-2	$ 0	0.0 %
5.03	Countries designated NAIC-3 or below	$ 0	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1:	$ 0	0.0 %
6.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
6.03	Country 1:	$ 0	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01			$ 0	0.0 %
10.02			$ 0	0.0 %
10.03			$ 0	0.0 %
10.04			$ 0	0.0 %
10.05			$ 0	0.0 %
10.06			$ 0	0.0 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

Aetna Form 10-K 2016

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2016

or

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

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☑ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☑ No

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☑Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) ☐Yes ☑No

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2016) was $41.8 billion.
There were 351.7 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2017.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement related to Aetna Inc.'s 2017 Annual Meeting of Shareholders, to be filed on or about April 7, 2017 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

Aetna Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2016

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FORWARD-LOOKING INFORMATION

The Private Securities Litigation Reform Act of 1995 (the "1995 Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We want to take advantage of these safe harbor provisions.

Certain information contained in this Annual Report on Form 10-K is forward-looking within the meaning of the 1995 Act or SEC rules. This information includes, but is not limited to: "Outlook for 2017" and "Regulatory Environment" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Part II, Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Part II, Item 7A, and "Risk Factors" included in Part I, Item 1A. In addition, throughout this Annual Report on Form 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions, when we intend to identify forward-looking statements:

· *Expects*	· *Intends*	· *Seeks*	· *Will*	· *Potential*
· *Projects*	· *Plans*	· *Estimates*	· *Should*	· *Continue*
· *Anticipates*	· *Believes*	· *May*	· *Could*	· *View*
· *Outlook*	· *Guidance*	· *Predict*	· *Likely*	· *Probable*
· *Forecast*	· *Can*	· *Explore*	· *Evaluate*	· *Might*

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these uncertainties and other factors are outside our control. Certain of these uncertainties and other factors are described under "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K. You should not put undue reliance on forward-looking statements. Any forward-looking statement speaks only as of the date of this report, and we disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events, uncertainties or otherwise.

Unless the context otherwise requires, references to the terms "we", "our" or "us" used throughout this Annual Report on Form 10-K refer to Aetna Inc. (a Pennsylvania corporation) ("Aetna") and its subsidiaries (collectively, the "Company").

Part I

Item 1. Business

General

We are one of the nation's leading diversified health care benefits companies, serving an estimated 46.7 million people. We have the information and resources to help our members, in consultation with their health care professionals, make better informed decisions about their health care. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, medical management capabilities, Medicaid health care management services, Medicare Advantage and Medicare Supplement plans, workers' compensation administrative services and health information technology ("HIT") products and services. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates.

2016 Accomplishments

We are working to build healthier communities, a healthier nation and a healthier world. Our operational, financial and strategically important accomplishments during 2016 included:

- Continued strong performance in our Government businesses including;
    - Expanding our presence in Government programs through membership growth in Medicare Advantage, Medicare Supplement and Medicaid as well as through programs for members who are dually eligible for both Medicare and Medicaid ("Duals").
    - Increasing our percentage of Medicare Advantage members in plans with 2017 star ratings of at least 4.0 stars for the third consecutive year to 92 percent, based on our membership as of December 31, 2016, the highest percentage among our publicly traded peers.
- Delivering solid results in our Commercial ASC and fee-based businesses driven by positive fee yields and a focus on cost control.
- Successfully advancing our strategy to help transform the healthcare system from volume-based payment models to ones that reward the quality and value provided. We formed multiple collaborations with healthcare providers that span a wide spectrum of value-based care models, including two new joint venture relationships. We carried that momentum into 2017 with the announced signing of a new joint venture with Allina Health in Minneapolis. We made solid progress in 2016, with over 45 percent of Aetna's medical spend currently flowing through some form of value-based care model, positioning us to achieve our 2020 goal of 75 percent.
- Participating in a number of private health insurance exchanges ("Private Exchanges") in 2016. We continue to believe that Private Exchanges are an efficient way for plan sponsors to shift towards a defined contribution model for employee health benefits, and we expect to continue our participation in 2017.
- Making progress in developing a portfolio of products and tools that will help to transform the health benefits industry to a retail model that is consumer-centric, affordable and convenient. In 2016, we signed an agreement with Apple that we believe will improve our members' health experience by combining the power of iOS apps and the renowned user experience of Apple products, including Apple Watch, iPhone and iPad, with Aetna's analytics-based wellness and care management programs.

Terminated Acquisition of Humana Inc. ("Humana") and Terminated Divestiture to Molina

On July 2, 2015, we entered into a definitive agreement (the "Merger Agreement") to acquire Humana (the "Humana Acquisition") in a transaction valued at approximately $37 billion, based on the closing price of Aetna common shares on July 2, 2015, including the assumption of Humana debt and Humana cash and cash equivalents.

On July 21, 2016, the U.S. Department of Justice (the "DOJ") and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that the Humana Acquisition would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Acquisition. On February 14, 2017, Aetna and Humana entered into a mutual termination agreement (the "Termination Agreement") pursuant to which the parties thereto (collectively the "Parties") agreed to terminate the Merger Agreement, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby, entered pursuant thereto or entered in connection therewith (other than certain confidentiality agreements) (collectively with the Merger Agreement, the "Transaction Documents"), effective immediately as of February 14, 2017 (the "Termination Date"). Under the Termination Agreement, Aetna agreed to

pay Humana the Regulatory Termination Fee (as defined in the Merger Agreement) of $1.0 billion in cash in full satisfaction of any amounts required to be paid by Aetna under the Merger Agreement. The Parties also agreed to release each other from any and all liability, claims, rights, actions, causes of action, suits, liens, obligations, accounts, debts, demands, agreements, promises, liabilities, controversies, costs, charges, damages, expenses and fees, however arising, in connection with, arising out of or related to the Transaction Documents, the transactions contemplated therein or thereby or certain related matters. We paid Humana the Regulatory Termination Fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes (as defined below).

In June 2016, we issued $13.0 billion of senior notes to partially fund the Humana Acquisition (collectively, the "2016 senior notes"). In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for $10.2 billion aggregate principal amount of certain of the 2016 senior notes (collectively, the "Special Mandatory Redemption Notes") at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem the Special Mandatory Redemption Notes on or about March 16, 2017, and we expect to fund the redemption with the proceeds of the 2016 senior notes. As a result of the redemption of the Special Mandatory Redemption Notes, in the first quarter of 2017, we will recognize on a pretax basis in our net income the entire approximately $420 million unamortized portion of the related cash flow hedge losses, debt issuance costs and debt issuance discounts and the entire approximately $100 million redemption premium paid on the Special Mandatory Redemption Notes upon such redemption.

In order to address the DOJ's perceived competitive concerns regarding Medicare Advantage relating to the Humana Acquisition, on August 2, 2016, we entered into a definitive agreement (the "Aetna APA") to sell for cash to Molina Healthcare, Inc. ("Molina") certain of our Medicare Advantage assets. On February 14, 2017, Aetna and Molina entered into a Termination Agreement (the "APA Termination Agreement") pursuant to which Aetna terminated the Molina APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, Aetna agreed to pay Molina in cash (a) a termination fee of $53 million and (b) approximately 70% of Molina's transaction costs. We paid Molina the termination fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes. We expect to pay Molina the applicable transaction costs during the first quarter of 2017.

Heath Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") made broad-based changes to the U.S. health care system. On January 20, 2017, the President signed an executive order that gives the regulatory agencies that enforce the ACA the authority to interpret regulations issued under the ACA in a way that limits fiscal burdens on states and financial or regulatory burdens on individuals, providers, health insurers and others. The practical implications of that order are unclear, and the future of the ACA is uncertain. While we anticipate efforts in 2017 and beyond to substantially modify, repeal or replace the ACA, we expect aspects of the ACA to continue to significantly impact our business operations and operating results, including our pricing, our medical benefit ratios ("MBRs") and the geographies in which our products are available. The ACA has presented us with business opportunities, but also with financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, including public health insurance exchanges ("Public Exchanges" and together with Private Exchanges, "Insurance Exchanges"), required minimum Medical Loss Ratios ("MLRs") in Commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's Centers for Medicare & Medicaid Services ("CMS") quality performance ratings or "star ratings." The effects of these changes are reflected in our operating results. If the ACA is not amended, repealed or replaced certain of its components will continue to be phased in until 2020. For additional information on federal and state health care reform, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K and for a discussion of certain factors that may cause our actual results to differ from currently anticipated results in connection with health care reform, see "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K.

Reportable Segments

Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. We derive our revenues primarily from insurance premiums, administrative service fees, net investment income and other revenue. Refer to MD&A included in Part II, Item 7 and Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K regarding revenue and profit information for each of our business segments and revenue and asset information about geographic areas. The following is a description of each of our business segments.

Health Care Segment

Products and Services

We refer to insurance products (where we assume all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care products and services consist of the following:

- ***Commercial Medical:*** We offer point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Our Commercial medical products also include health savings accounts ("HSAs") and Aetna HealthFund®, consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Our principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates.
- ***Government Medical:*** In select geographies, we offer Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participate in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participate in Duals demonstration projects. These Government products are further described below:
    - *Medicare:* Through annual contracts with CMS, we offer HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over Original Medicare fee-for-service coverage, including reduced cost-sharing for preventive care, vision and other services. We offered network-based HMO and/or PPO plans in 1,093 counties in 39 states and Washington, D.C. in 2016. We are expanding to 1,213 counties in 40 states and Washington, D.C. in 2017. We are a national provider of the Medicare Part D Prescription Drug Program ("PDP") in all 50 states and Washington, D.C. to both individuals and employer groups. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. For certain qualifying employer groups, we offer our Medicare PPO products nationally. When combined with our PDP product, these national PPO plans form an integrated national fully-insured Medicare product for employers that provides medical and pharmacy benefits.
    - *Medicare Supplement:* For certain Medicare eligible members, we offer supplemental coverage for certain health care costs not covered by Original Medicare. The products included in our Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. We offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2016.
    - *Medicaid and CHIP*: We offer health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. We offered these services on an Insured or ASC basis in 16 states in 2016.
    - *Duals:* We provide health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. We coordinate 100% of the care for these members and may provide them with additional services in order to manage their health care costs. During 2016, we offered services on an Insured basis to members who were dually eligible in four states under demonstration projects.
- ***Dental:*** We offer managed dental plans on an Insured and ASC basis. We are one of the nation's largest providers of dental coverage, based on membership at December 31, 2016.
- ***Behavioral Health:*** Our behavioral health and employee assistance products provide members who experience stress, depression and other types of mental health related illness with integrated behavioral health benefit administration, access to a network of providers and innovative wellness programs. We provide customized behavioral health solutions to members in all 50 states.
- ***Provider Network Access ("First Health" and "Cofinity"):*** Through our First Health and Cofinity products, we provide access to health care provider networks to other insurance companies, third-party administrators, health plans and employers. First Health products are marketed nationally, while Cofinity products are marketed in certain states.
- ***Stop Loss:*** We offer medical stop loss insurance coverage for certain employers who elect to self insure their health benefits. Under this product, we assume risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.

- ***Aetna Vision℠ Preferred:*** We offer vision benefits that provide members with access to one of the largest vision networks in the U.S. The Aetna Vision Preferred program can be customized with a wide range of benefit levels and co-payments.
- ***Workers' Compensation Administrative Services:*** Our workers' compensation administrative services products and services consist of fee-based, managed care services, such as provider network access, cost containment services, pharmacy benefit management, durable medical equipment and ancillary services, and care management services to underwriters and administrators of workers' compensation insurance.
- ***Consumer Health and Services:*** We have a portfolio of products aimed at creating an holistic and integrated approach to individual health and wellness, including products previously marketed under the Healthagen® brand. These products and services complement our Commercial, Medicare and Medicaid products.
    - *Pharmacy:* We offer pharmacy benefit management services and specialty and mail order pharmacy services to our members. Our pharmacy fulfillment services are delivered by Aetna Specialty Pharmacy ("ASP") and Aetna Rx Home Delivery®. ASP dispenses specialty medications and offers certain support services associated with specialty medications. Specialty medications include injectable or infused medications that may not be readily available at local pharmacies. Aetna Rx Home Delivery® provides mail order prescription drug services. CaremarkPCS Health, L.L.C. performs the administration of selected functions for our retail pharmacy network contracting and claims administration; mail order and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services for us. Another supplier also provides certain pharmacy benefit management services to us and our customers.
    - *Advanced Provider Models ("APM"):* We are focused on growing membership in our medical products through provider collaborations that are designed to lower medical costs for us and our customers and make our products more affordable. These collaboration models include joint ventures and accountable care organizations ("ACOs"). We offer a suite of solutions designed to facilitate delivery system reform and help reduce the cost of care by enabling population health management for providers. Our APM products facilitate providers changing their business model from episodic acute care to patient population management which allows them to convert from volume-based reimbursement to value-based reimbursement. Our APM products deploy Aetna's population health management assets to collaborate with providers in new ways to improve the quality and efficiency of care for all patients, whether they are Aetna members or members of other payors. In 2016, we continued expanding our offering of APM products and services to employers and individuals in more geographic areas to create mutually beneficial relationships with providers through a variety of methods, including alignment of financial incentives based on cost and quality, implementation of innovative HIT and deploying leading care management programs. Our APM relationships include joint ventures with Allina Health, Banner Health Network, Inova Health System and Texas Health Resources.
    - *ActiveHealth Management:* Through the use of our patented CareEngine® system, our ActiveHealth Management products provide evidence-based medical management and data analytics products and services to a broad range of customers, including health plans, employers and others. ActiveHealth Management also is a key component of our APM solutions.
    - *Medicity:* Medicity is a health information exchange company and a key component of our APM and provider enablement solutions. Medicity offers a set of convenient, easy-to-access technology solutions for physicians, hospitals and other health care providers. These capabilities allow us to further the adoption of electronic health records and contribute to initiatives that foster administrative simplicity in health care, a key issue for consumers, patients and providers. Medicity provides customers clinical data integration and secure data exchange capabilities.
    - *Consumer:* We believe the role of the consumer in health care is changing and that consumers will become the primary decision makers when it comes to choosing their health-related benefits. As a result, we are developing a portfolio of products and tools, including bswift and iTriage, that are designed for a retail model in the health benefits industry that is consumer-centric, affordable and convenient. Our Consumer business is focusing on developing a simplified, integrated offering to help consumers navigate the health care system and manage their health care costs.
        - *bswift:* bswift provides benefit administration technology and services to employers nationwide, streamlining the benefits process. bswift's technology also provides the shopping, buying and enrolling experience for Public Exchanges, Private Exchanges and individuals.

- *iTriage:* The iTriage application gives smart phone and computer users access to a symptom navigator which assists users in finding nearby health facilities or physicians that could help with their specific health issue. iTriage assists users in finding health care that is right for them.

Provider Networks

We contract with physicians, hospitals and other health care providers for services they provide to our members. The health care providers who participate in our networks are independent contractors and are neither our employees nor our agents, except for providers who work in our mail-order and specialty pharmacy facilities.

We use a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with health care providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with our providers, the development and implementation of guidelines for the appropriate utilization of medical services and the provision of data to providers to enable them to improve health care quality.

At December 31, 2016, Aetna's underlying nationwide provider network had approximately 1.3 million participating health care providers, including over 702,000 primary care and specialist physicians and approximately 5,700 hospitals.

- ***Advanced Provider Models:*** We collaborate with hospitals and other providers through our APM products. Our arrangements focus on high value narrow network solutions to provide high-quality, low-cost options in local geographies. We are able to help enhance our relationships with hospitals and other providers through a variety of methods, including a re-alignment of financial incentives for providing high quality care, total cost management initiatives and risk sharing arrangements.
- ***Primary Care Physicians:*** We compensate primary care physicians ("PCPs") participating in our networks on both a fee-for-service and capitated basis, with capitation generally limited to HMO products in certain geographic areas and representing approximately 4 percent of health care costs in both 2016 and 2015 and 5 percent of health care costs in 2014. In a fee-for-service arrangement, physicians are paid for health care services provided to the member based upon a set fee for the services provided. Under a capitation arrangement, physicians receive a monthly fixed fee for each member, regardless of the volume of health care services provided to the member. In some cases, PCPs who are paid on a fee-for-service or capitated basis also receive additional incentive fees if certain performance metrics are attained.
- ***Specialist Physicians:*** Specialist physicians participating in our networks are generally reimbursed at contracted rates per visit or per procedure.
- ***Hospitals:*** We typically enter into contracts with hospitals that provide for per-day and/or per-case rates, often with fixed rates for ambulatory, surgery and emergency room services. We also have hospital contracts that provide for reimbursement based on a percentage of the charges billed by the hospital. Our medical plans generally require notification of elective hospital admissions, and we monitor the length of hospital stays. Physicians who participate in our networks generally admit their patients in network-based products to participating hospitals using referral procedures that direct the hospital to contact our patient management unit in order to confirm the patient's membership status and facilitate the patient management process. This unit also assists members and providers with related activities, including, if necessary, the subsequent transition to the home environment and home care. Case management assistance for complex cases is provided by a special unit.
- ***Other Providers:*** Laboratory, imaging, urgent care and other freestanding health facility providers are generally paid under fee-for-service arrangements, except for certain laboratory services.

Quality Assessment

CMS uses a 5-star rating system to monitor plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. Refer to "Pricing" below in this Item 1 for further discussion of our star ratings.

We seek Health Plan accreditation for our Aetna HMO plans from the National Committee for Quality Assurance (the "NCQA"), a national organization established to review the quality and medical management systems of health care plans. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of Aetna, has received nationwide NCQA PPO Health Plan accreditation, through December 13, 2019. As of December 31, 2016, all of our Aetna Health Inc. Commercial HMO and ALIC PPO members who were eligible, participated in HMOs or PPOs that are accredited by the NCQA.

NCQA and URAC (formally known as American Accreditation HealthCare Commission, Inc.), are national organizations founded to establish standards for the health care industry. Purchasers and consumers look to URAC's and NCQA's accreditation and certification as an indication that a health care organization has the necessary structures and processes to promote high-quality care and preserve patient rights. In addition, regulators in over 80% of the states recognize NCQA's accreditation and certification standards.

Our provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, we are certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options through January 5, 2019. Our URAC CVO accreditation is valid through October 1, 2018.

Our quality assessment programs for contracted providers who participate in our networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by us or in some cases by the practitioner's affiliated group or organization. We generally require participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

We also offer quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Principal Markets and Sales

Our medical membership is dispersed throughout the U.S., and we serve a limited number of members in certain countries outside the U.S. Refer to Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our foreign customers. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, we market to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by U.S. and other geographic region and funding arrangement at December 31, 2016, 2015 and 2014:

	2016			2015			2014		
(Thousands)	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Northeast	**2,121**	**2,966**	**5,087**	2,166	2,952	5,118	2,314	2,905	5,219
Southeast	**2,260**	**3,076**	**5,336**	2,173	3,183	5,356	2,149	3,167	5,316
Mid-America	**2,506**	**2,673**	**5,179**	2,507	2,913	5,420	2,372	2,980	5,352
West	**1,954**	**4,848**	**6,802**	1,837	5,008	6,845	1,999	4,950	6,949
Other	**331**	**375**	**706**	440	308	748	452	260	712
Total medical membership	**9,172**	**13,938**	**23,110**	9,123	14,364	23,487	9,286	14,262	23,548

Additional information on Health Care's membership is included in the "Healthcare - Membership" section of the MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

We market both Commercial Insured and ASC products and services primarily to employers that sponsor our products (also called "plan sponsors") for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. We also sell Insured plans directly to individual consumers in a number of states, including through Public Exchanges. Some Health Care products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly.

We offer Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. We also offer Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care products are sold through our sales personnel; through independent brokers, agents and consultants who assist in the production and servicing of business; and Insurance Exchanges. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, we may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. In certain cases, our customer pays the broker for services rendered, and we may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. We support our marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

Pricing

For Commercial Insured plans, including our Public Exchange plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under our ASC plans are generally fixed for a period of one year.

We use prospective rating methodologies in determining the premium rates charged to the majority of employer groups, and we also use retrospective rating methodologies for a limited number of groups. Premium rates for customers with more than approximately 125 employees generally take into consideration the individual plan sponsor's historical and anticipated claim experience where permitted by law. Some states may prohibit the use of one or more of these rating methods for some customers, such as small employer groups, or all customers.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We typically cannot recover unanticipated increases in health care costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Our future operating results could be adversely affected if the premium rates we request are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the actual claim costs and other expenses are less than expected, we may issue a refund to the plan sponsor based on this favorable experience. If the experience is unfavorable, in certain instances we may recover the resulting deficit through contractual provisions or consider the deficit in setting future premium levels. However, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating may be used for Commercial Insured plans that cover more than approximately 300 lives.

We have Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays us a fixed capitation payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. Our PDP contracts also provide a risk-sharing arrangement with CMS to limit our exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to us under the Medicare arrangements are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Premiums paid to us for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some of our Medicare Advantage products and all of our PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial products, Medicare contracts generate higher per member per month revenues and health care costs.

The ACA ties a portion of each Medicare Advantage plan’s reimbursement to the plan’s “star ratings.” Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released our 2017 star ratings in October 2016. Our 2017 star ratings will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2018. Based on our membership at December 31, 2016, 92% of our Medicare Advantage members were in plans with 2017 star ratings of at least 4.0 stars, compared to 85% of our Medicare Advantage members being in plans with 2016 star ratings of at least 4.0 stars based on our membership at December 31, 2015.

Rates for our Medicare Supplement products are regulated at the state level and vary by state and plan.

Under our Insured Medicaid contracts, state government agencies pay us fixed monthly rates per member that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. We also receive fees from our customers where we provide services under ASC Medicaid contracts. Our ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and our financial risk share obligations are typically limited to a percentage of the fees otherwise payable to us. Payments to us under our Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under our Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if we fail to comply with CMS regulations or other contractual requirements.

We offer HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes. In December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the ACA's health insurer fee (the "HIF"). Refer to Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the ACA fees, assessments and taxes. Our goal is to collect in premiums and fees or solve for all of these estimated fees, assessments and taxes.

Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Public and Private Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated herein by reference, are for illustrative or comparison purposes only and do not indicate that these companies are our only competitors or are our closest competitors.

We believe that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. We believe that we are competitive on each of these factors. Our ability to increase the number of persons covered by our plans or to increase our revenues is affected by our ability to differentiate ourselves from our competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Our Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. Our largest competitor in our Medicare products is Original Medicare. Additional competitors include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures, technology firms, financial services firms that are distributing competing products on their

proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. Our ability to increase the number of persons enrolled in our Insured products also is affected by the desire and ability of employers to self-fund their health coverage.

Our ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and third-party administrators.

Our international products compete with local, global and U.S. based health plans and commercial health care benefit insurance companies, many of whom have a longer operating history and better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and provider solutions and HIT products are evolving rapidly. We compete for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many of our information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting our ability to obtain new customers or retain existing customers, our membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the U.S. and industries where our membership is concentrated.

Reinsurance

We currently have several reinsurance agreements with non-affiliated insurers that relate to Health Care insurance policies. We entered into these contracts to reduce the risk of catastrophic losses which in turn reduces our capital and surplus requirements. We frequently evaluate reinsurance opportunities and refine our reinsurance and risk management strategies on a regular basis.

Group Insurance Segment

Principal Products

Group Insurance products consist primarily of the following:

- ***Life Insurance:*** Our life insurance products principally consist of group term life insurance, the amounts of which may be fixed or linked to individual employee wage levels. We also offer voluntary spouse and dependent term life insurance, and group universal life and accidental death and dismemberment insurance. We offer life insurance products on an Insured basis.
- ***Disability Insurance:*** Our Disability products provide employee income replacement benefits for both short-term and long-term disability (and products which combine both). Similar to Health Care products, we offer disability benefits on both an Insured and employer-funded basis. We also provide absence management services to employers, including short-term and long-term disability administration and leave management.
- ***Long-Term Care Insurance:*** Our Long-Term Care Insurance products provide benefits to cover the cost of care in private home settings, adult day care, assisted living or nursing facilities. We no longer solicit or accept new long-term care customers. Long-term care benefits were offered primarily on an Insured basis. The product was available on both a service reimbursement and disability basis.

Principal Markets and Sales

We offer our Group Insurance products in 49 states as well as Washington, D.C., Guam, Puerto Rico, the U.S. Virgin Islands and Canada. Depending on the product, we market to a range of customers from small employer groups to large, multi-site and/or multi-state employer programs.

We market Group Insurance products and services primarily to employers that sponsor our products for the benefit of their employees and their employees' dependents. Frequently, employers offer employees a choice of benefits, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Group Insurance products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly.

Group Insurance products are sold through our sales personnel, as well as through independent brokers, agents and consultants who assist in the production and servicing of business. For large plan sponsors, independent consultants and brokers are frequently involved in employer plan selection decisions and sales. We pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. We support our marketing and sales efforts with an advertising program that may include direct marketing efforts as well as television, radio, billboards, print media and social media, supplemented by market research.

Pricing

For Insured and employer-funded Group Insurance plans, employer group contracts containing the pricing and other terms of the relationship are generally established in advance of the policy or contract period. We use prospective and retrospective rating methodologies to determine the premium rates charged to employer groups on our Insured products. Contracts are typically offered with rate guarantees that generally range from one to five years.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We typically cannot recover unanticipated increases in mortality or morbidity costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the actual claim costs and other expenses are less than expected, we may issue a refund to the plan sponsor based on this favorable experience. If the experience is unfavorable, we consider the deficit in setting future premium levels, and in certain instances, we may recover the deficit through contractual provisions such as offsets against refund credits that develop for future policy periods. However, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating is most often used for Insured plans that cover more than approximately 3,000 lives.

Competition

For the group insurance industry, we believe that the significant factors that distinguish competing companies are cost, quality of service, financial strength of the insurer, comprehensiveness of coverage, and product array and design. We believe we are reasonably competitive on each of these factors; however, some of our competitors have greater scale, financial and other resources, better brand recognition and lower expenses. The group life and group disability marketplaces remain highly competitive.

Reinsurance

We currently have several reinsurance agreements with non-affiliated insurers that relate to both life and long-term disability products. Certain of our reinsurance arrangements are established on a case-by-case basis, and a subset of our reinsurance agreements cover closed blocks of business and canceled cases. We also have a reinsurance arrangement to mitigate long-term disability claim severity risk at the individual claim level, and another reinsurance arrangement that provides a limited degree of catastrophic risk protection for certain of our life products. We frequently evaluate reinsurance opportunities and refine our reinsurance and risk management strategies on a regular basis.

Large Case Pensions Segment

Principal Products

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. We do not actively market Large Case Pensions products, but continue to accept deposits from existing customers and manage the run-off of our existing business. Contracts provide non-guaranteed, experience-rated and guaranteed investment options through general and separate account products. Large Case Pensions products that use separate accounts provide contract holders with a vehicle for investments under which the contract holders primarily assume the investment risk. Large Case Pensions earns a management fee on these separate accounts.

In 1993, we discontinued our fully-guaranteed Large Case Pensions products. Refer to Note 19 “Discontinued Products” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

Other Matters

Access to Reports and Other Information

Our reports to the U.S. Securities and Exchange Commission (the "SEC"), including our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and any amendments to those reports are available without charge on our website at www.aetna.com as soon as practicable after they are electronically filed with or furnished to the SEC. The information on or linked to our website is neither a part of nor incorporated by reference in this Annual Report on Form 10-K or any of our other SEC filings. Copies of these reports are also available, without charge, from Aetna's Investor Relations Department, 151 Farmington Avenue, Hartford, CT 06156.

You also can download from our website our articles of incorporation, by-laws and corporate governance policies, including our Corporate Governance Guidelines, the charters of the key standing Committees of our Board of Directors and our Code of Conduct. Copies of these documents are also available, without charge, from Aetna's Corporate Secretary, 151 Farmington Avenue, RW61, Hartford, CT 06156.

Our transfer agent, Computershare Trust Company, N.A., can help with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person or other administrative services. Shareholders can write to our transfer agent by mail at P.O. Box 30170, College Station, TX 77842-3170 or contact them by telephone at 1-800-446-2617.

Regulation

For information regarding significant regulation that affects us, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K and for a discussion of certain factors that may cause our actual results to differ from currently anticipated results in connection with regulation that affects us, see "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K.

Patents and Trademarks

We own a number of trademarks and patents that are important to Aetna. Some of the trademarks include Aetna, as well as the corresponding Aetna design logo, Aetna Navigator®, ActiveHealth®, bswift®, CareEngine®, Coventry®, DocFind®, Healthagen®, Healthy Merits®, iTriage®, Medicity®, Meritain Health®, NeoCare Solutions®, PayFlex®, Practice IQ®, Prodigy Health Group®, Springboard Marketplace® and Wellmatch®. Some of our patents include the CareEngine patent that expires in 2021 and the Master Patient Index patent that expires in 2029. We consider these patents and trademarks and our other patents, trademarks and trade names important in the operation of our business. However, our business, including that of each of our individual segments, is not dependent on any individual patent, trademark or trade name.

Employees

We had approximately 49,500 employees at December 31, 2016.

Customer Concentration

The U.S. federal government is a significant customer of both the Health Care segment and the Company as described below:

- Premiums and fees and other revenue paid by the federal government accounted for 34% of the Health Care segment's revenue and 33% of our consolidated total revenue in 2016.

- Contracts with CMS for coverage of Medicare-eligible individuals accounted for 82% of our federal government premiums and fees and other revenue, with the balance coming from federal employee-related benefit programs and ACA programs. No other individual customer, in any of our segments, accounted for 10% or more of our consolidated total revenue in 2016.

- Our Medicaid products accounted for 13% of both the Health Care segment's revenue and our consolidated total revenue in 2016. However, no individual state government agency accounted for more than 10% of our consolidated total revenue or the Health Care segment's revenue in 2016.

Other than our contracts with CMS, our segments are not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of a segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on our earnings or the earnings of any of our segments. Refer to Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

Item 1A. Risk Factors

Risk Factors

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this Annual Report on Form 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this Annual Report on Form 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect our business. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, these events or circumstances could have a material adverse effect on our business, cash flows, financial position or operating results. In that case, the trading price of our common stock could decline materially, among other effects on us.

Effectiveness of our enterprise strategy, talent management and alignment of talent to our business needs and risks to our brand and reputation present overarching risks to our enterprise in 2017.

We expect to face significant business challenges and uncertainties in 2017. Effectiveness of our enterprise strategy, talent management and alignment of talent to our business needs and risks to our brand and reputation present overarching risks to our enterprise in 2017. There can be no assurance regarding the effectiveness of our enterprise strategy, our ability to manage and align our talent to our business needs or our ability to avoid harm to our brand and reputation. In addition, there can be no assurance that U.S. government fiscal policy, the implementation of the ACA, repeal or other changes to the ACA or additional changes to the U.S. health care system will not require us to revise the ways in which we conduct business, put us at risk of loss of business or materially adversely affect our business, cash flows, financial position or operating results.

While we consider the foregoing to be the overarching risks we face in 2017, they are not the only material risks we face. We face numerous other challenges, as described elsewhere in this Annual Report, including below in this "Risk Factors" discussion, and other unanticipated risks may develop.

Our enterprise strategy may not be an effective response to the changing dynamics in the health and related benefits industry, or we may not be able to implement our strategy and related strategic projects.

Our strategy includes effectively investing our capital and human resources in appropriate strategic projects, current operations and acquisitions to transform our business in response to the changing dynamics in the health and related benefits industry, including the evolution toward a direct-to-consumer marketing and operating model, the declining number of commercially insured people and the potential shift to a defined contribution model for health benefits. Our strategic projects include, among other things: significant investments in human and technology resources to expand our Consumer Health and Services product line, including to develop and expand our consumer business, and compete effectively in a direct-to-consumer marketplace; transforming our business model through consumer engagement, joint ventures, ACOs and collaborative provider networks; participating in select Public Exchanges and Private Exchanges (collectively, "Insurance Exchanges"); optimizing our business platforms; managing certain significant technology projects; further improving relations with health care providers; negotiating contract changes with customers and providers; and implementing other business process improvements. Implementing our strategic initiatives will require significant investments of capital and human resources. Among other things, we will need to simultaneously acquire and develop new personnel, products and systems to serve existing and new customers with existing and new products, our consumer business, which began serving members on January 1, 2016, and enhance our existing customer service, information technology, control and compliance processes and systems. The future performance of our businesses will depend in large part on our ability to design and implement our strategic initiatives, some of which will occur over several years. If these initiatives do not achieve their objectives, our operating results could be adversely affected.

Our enterprise strategy may not be an effective response to the changing dynamics in the health and related benefits industry, and we may fail to recognize and position ourselves to capitalize upon market opportunities. We may not have sufficient advance notice and resources to develop and effectively implement an alternative strategy. Competitors who develop a superior strategy, or more effectively implement their strategy, may develop capabilities, competitive advantages and competitive positions that are difficult to match or overcome.

We are dependent on our ability to recruit, retain and develop a very large and diverse workforce. We must transform our culture in order to successfully grow our business.

Our products and services and our operations require a large number of employees. A significant number of employees have joined us in recent years as a result of our acquisitions and our entry into new businesses. Our success is dependent on our ability to transform our culture, align our talent with our business needs, engage our employees and inspire our employees to be open to change, to innovate and to maintain consumer-focus when delivering services to our customers. Our business would be adversely affected if we fail to adequately plan for succession of our executives and senior management; or if we fail to effectively recruit, integrate, retain and develop key talent and/or align our talent with our business needs, in light of the current rapidly changing environment. While we have succession plans in place and we have employment arrangements with a limited number of key executives, these do not guarantee that the services of these or suitable successor executives will continue to be available to us. In addition, as we expand internationally, we face the challenge of recruiting, integrating, educating, managing, retaining and developing a more culturally diverse workforce.

Our brand and reputation are two of our most important assets; negative public perception of the health and related benefits industry, or of the industry's or our practices, can adversely affect our operating results.

The health and related benefits industry regularly is negatively perceived by the public and subject to negative publicity, including as a result of the ongoing public debate over the future of the ACA, proposed transactions in our industry (including the Humana Acquisition and related litigation), governmental investigations and actual or perceived shortfalls regarding the industry's or our own products and/or business practices (including withdrawing from participation in Public Exchanges and social media activities). This risk may be increased as the federal government continues to consider alternatives to amend, repeal and/or replace the ACA (including Medicaid expansion) and as states seek to maintain, replace or repeal elements of the ACA such as Public Exchanges and Medicaid expansion within increasingly challenging budget constraints. This risk will increase further if we implement significant increases in premium rates to price for additional risk and/or expanded benefits resulting from, and fees, assessments and taxes imposed by, the federal and state governments as well as any acceleration in medical cost inflation. This risk may be increased as states and the federal government continue to debate the ACA and implement any amendment, repeal or replacement of the ACA, as we continue to offer products that make greater use of data and products (including products for people who are eligible for Medicare or Medicaid or dually eligible for Medicare and Medicaid) beyond those in our core Commercial business and as our business model becomes more focused on consumers and direct-to-consumer sales, including as a result of us developing and expanding our Consumer Health and Services product line, competing for sales on select Insurance Exchanges and withdrawing from participation on most individual Public Exchanges. Significant reductions or interruptions in funding for government health programs we serve also may lead us to reduce our exposure to these programs, which could adversely affect our brand and reputation.

Negative public perception and/or publicity of the health and related benefits industry in general, or us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our operating results and our stock price by:

- Adversely affecting our brand and reputation;
- Adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- Requiring us to change our products and/or services; and/or
- Increasing or significantly changing the regulatory and legislative requirements with which we must comply.

Changes in Public Policy and Other Legal and Regulatory Risks

We are subject to potential changes in public policy (in respect of the ACA or otherwise) that can adversely affect the markets for our products and services and our business, operations and operating results.

The political environment in which we operate remains uncertain, including as a result of the new U.S. presidential administration and the control of the U.S. Congress by a single political party. It is reasonably possible that our business operations and operating results could be materially adversely affected by public policy changes at the state or federal level, which include amendment, repeal or replacement of the ACA but also extend to many other public policy initiatives. Such changes may present us with new financial and other challenges, which may, for example, cause membership in our health plans to decrease or make doing business in particular states less attractive. If we fail to adequately respond to such changes, including by implementing effective operational and strategic initiatives, or do not do so as effectively as our competitors, our business, operations and operating results may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our business. At the federal level these proposals include changes in the funding levels and/or design of federally-supported benefit programs, changes in payment methodologies for health plans and/or providers under Medicare and substantial change in the regulations governing our business. At the state level, these proposals include mandating pharmacy benefits; expanded provider network requirements; significant new fees, assessments and taxes on payors, including in response to reduced federal funding or other state budgetary pressures; mandating lower out of pocket costs for members; and raising Medicaid minimum MLR thresholds above 85%, instituting profit caps on Medicaid contracts and changing the designs of state Medicaid programs. The federal and many state governments are also considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including substantial changes to federal funding of state Medicaid programs. At the state level, all 50 U.S. states and the District of Columbia will hold regular legislative sessions in 2017. In 2016, state legislatures focused on state budgets and taxes (including new assessments on health care premiums), provider network composition and provider directory accuracy requirements, pharmacy benefit and drug coverage requirements, Medicaid reforms and health care delivery system transformation. We expect state legislatures to focus on these issues again in 2017, as well as the adverse impact of expected changes to the ACA and other federal programs on state programs and budgets.

We cannot predict the enactment or content of new legislation and regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or operating results, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of our industry. Examples of such change include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, or dual eligible programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes is increasing due to state and federal budgetary pressures, and our business and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence. For more information on these matters, refer to “Regulatory Environment” of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

The ACA may be repealed or amended. If the ACA is not amended or repealed, certain aspects of the ACA as currently enacted have yet to take full effect, are unclear, or are subject to effective amendment through the implementation process, making their practical effects difficult to predict. Our business and operating results may be materially and adversely affected by the ACA and/or changes to the ACA even if we correctly predict their effects.

If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2020. Potential repeal of the ACA, ongoing legislative and regulatory changes to the ACA, other pending efforts in the U.S. Congress to amend or restrict funding for various aspects of the ACA (including risk corridors and the ACA’s Cost Sharing Subsidy program), the results of the 2016 presidential, congressional and state level elections, pending litigation challenging aspects of the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Examples of recent legislative and regulatory changes include: the January 20, 2017 executive order relating to the ACA; the November 2016 HHS announcement that risk corridor collections for the 2015 program year will be applied first to amounts owed to plans for the 2014 program year; the May 2016 final regulations relating to the ACA’s non-discrimination requirements; the December 2015 suspension of the ACA’s health insurer fee (the “HIF”) for 2017 and two year delay of the “Cadillac” tax on high-cost employer-sponsored health coverage; the October 2015 PACE, which leaves groups with 51 to 100 employees within the large group category for each state unless the state exercises its option to include these groups within the small group category; and the October 2015 HHS announcement that ACA risk corridor receivables for the 2014 program year would only be funded at 12.6%.

We expect the 2017 suspension of the HIF to adversely affect our 2017 revenues and MBRs compared to 2016 as this change was reflected in reduced premiums for 2017 medical customer renewals. In addition, there is some uncertainty whether we will be able to include all of our portion of the industry-wide $14.3 billion 2018 HIF (as currently enacted) in our premium rates beginning with 2017 medical customer renewals that have member months in 2018, particularly following the HIF suspension for 2017.

The pending litigation challenging the ACA includes the House of Representatives’ challenge to HHS’s ability to make payments under the ACA’s Cost Sharing Subsidy program without an explicit appropriation. The time frame for conclusion, final outcome and ultimate impact of this litigation are uncertain. A final ruling that adversely impacts the Cost Sharing Subsidy program could cause significant adverse selection in individual Public Exchange products and instability in the individual Public Exchange marketplace and could have a material adverse effect on our business, cash flows, financial condition and operating results as well as hinder our ability to offer Public Exchange products.

While most of the significant aspects of the ACA became effective during or prior to 2014, as currently enacted, certain components of the ACA will continue to be phased in through 2020. In addition, significant parts of the ACA, including aspects of non-discrimination requirements, continue to evolve through the promulgation of executive orders, regulations and guidance. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing state and federal budgetary pressures make it more likely that any changes, including changes at the state level in response to repeal or replacement of or changes to the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us.

Accordingly, even in the absence of any amendment or repeal, many of the specific aspects and impacts of the ACA as currently enacted will not be known for several years, and given the inherent difficulty of foreseeing how individuals and businesses will respond to the choices afforded to them by the ACA, we cannot predict the full effect of the ACA or the impact of future changes to the ACA on us. Further, even if we correctly predict how parts of the ACA will develop or change and affect us, our business and operating results may still be materially and adversely affected. For example, we anticipate that some aspects of the ACA and other existing measures and new measures, if enacted, could materially adversely affect our Health Care and/or Group Insurance operations and/or operating results by, among other things:

- Reducing our ability to obtain adequate premium rates for the risk we assume (including denial of or delays in obtaining regulatory approval for and implementation of those rates);
- Significantly reducing the level or changing the design of Medicare and/or Medicaid program payments;
- Adversely affecting the stability of the individual insurance marketplace;
- Restricting our ability to price for the risk we assume and/or reflect reasonable costs or profits in our pricing, and/or limiting the level of margin we can earn, including by mandating minimum medical loss ratios;
- Reducing our ability to manage health care or other benefit costs (including by mandating benefits, restricting our ability to manage our provider network and/or capping member cost sharing or otherwise limiting members' financial responsibility for health care or other covered services they utilize and thus increasing our medical costs);
- Increasing health care or other benefit costs and operating expenses (including duplicate expenses resulting from changes in regulations during implementation);
- Increasing our exposure to lawsuits and other adverse legal proceedings;
- Adversely affecting our product mix;
- Imposing new or increasing existing taxes and financial assessments; and/or
- Increasing the general and administrative expenses of our Group Insurance business relative to its competitors.

Legislative and regulatory changes could create significant challenges to our Medicare Advantage and PDP revenues and operating results, and proposed changes to these programs could create significant additional challenges. Starting in 2017, federal funding for Medicaid expansion will decrease. Entitlement program reform, if it occurs, could have a material adverse effect on our business, operations or operating results.

From time to time the federal government alters the level of funding for government health care programs, including Medicare. Under the Budget Control Act of 2011 (the "BCA") and the American Taxpayer Relief Act of 2012 (the "ATRA"), significant, automatic across-the-board budget cuts (known as sequestration) to several federal government programs started in March 2013. These include Medicare spending cuts of up to 2% of total program costs per year through 2024. The ATRA also contained additional reductions to Medicare reimbursements to health plans that commenced in April 2013 and eliminated funding for certain ACA programs. These reductions could adversely affect us, our customers and our providers.

Medicare Advantage payment rates to health plans have been cut over the last several years, with additional reductions to be phased in through 2017. CMS's April 2016 final notice for Medicare Advantage benchmark payment rates (the "Final Notice") provides for rate cuts to the employer group waiver program that will begin in 2017 and be fully phased in for 2018 as well as adverse changes to the risk adjustment mechanism for dual eligible beneficiaries and the Medicare Advantage star rating program. Overall, we project the benchmark rates for 2017 in the Final Notice will decrease funding for our Medicare Advantage business by less than 1 percent in 2017 compared to 2016. This 2017 rate decrease adds to the challenge we face from the impact of the increasing cost of medical care, the HIF beginning in 2018 (as currently enacted) and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on the Medicare Advantage program and our Medicare Advantage operating results. We cannot predict

future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare operating results.

In addition, the "star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by compliance issues that arise in our Medicare operations, such as our distribution of inaccurate information regarding which pharmacies were part of our Medicare network and related $1 million civil monetary penalty in 2015 and notices of non-compliance and warning letters in 2016. During 2016, our star ratings resulted in additional revenue of approximately $560 million, inclusive of bonus payments and rebates. If our star ratings fall below 4 for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues and operating results may be significantly adversely affected.

In April 2016, CMS issued a final rule that overhauls the entire Medicaid managed care delivery system. The final rule represents the first update to Medicaid managed care regulations since 2002. Among other things the final rule requires Medicaid managed care products to have a minimum MLR of 85%; establishes a Medicaid managed care quality rating system; and establishes provider network adequacy requirements. The minimum MLR requirements are effective beginning in 2017.

Beginning in 2017, federal funding for expanded Medicaid coverage is decreasing, which is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our Government medical benefit ratio and our operating results.

We anticipate extensive debate concerning entitlement program reform in 2017, particularly over the federal government's funding of the Medicaid program. If entitlement program reform occurs, it could have a material adverse effect on our business, operations or operating results, particularly on our Medicare and/or Medicaid revenues, medical benefit ratios and operating results.

We may not be able to obtain adequate premium rate increases, which would have an adverse effect on our revenues, medical benefit ratios and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases of 10% or more (or another state-specific threshold set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins and operating results of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. The risk of increases in utilization of medical and/or other covered services and/or in health care and other benefit costs is particularly acute during and following periods, when utilization has been below recent historical levels, during periods of changing economic conditions and/or employment levels and in products where there is significant turnover in our membership each year, such as Public Exchanges. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and/or CHIP premium rates is limited due, among other things, to the budgetary pressures currently facing many state governments. This could magnify the adverse impact on our operating margins and operating results of increases in utilization of medical and other covered services, health care and other benefit costs and/or medical cost trends that exceed our projections.

Since 2013, HHS has issued determinations to health plans that their rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in a number of states also have conducted hearings on proposed premium rate increases, which can result, in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. We requested significant increases in our premium rates in our individual and small group Health Care businesses for 2017 and expect to continue to request significant increases in those rates for 2018 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for the applicable products (also

known as “adverse selection”) in our products, particularly in individual and small group products, which we expect to continue and potentially worsen in 2017 with the expiration of the ACA’s risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory reaction and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured business. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in any product line or geography. If we are unable to obtain adequate rates and/or rate increases, it could materially and adversely affect our operating margins and our ability to earn adequate returns on Insured business in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured, Medicare Insured and Medicaid Insured businesses while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.

The ACA requires us to pay minimum MLR rebates each year with respect to prior years. The ACA’s minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. Refer to “Revenue Recognition” in Note 2 “Summary of Significant Accounting Policies” included in Part II, Item 8 of this Annual Report on Form10-K for more information. Certain portions of our Medicaid and Federal Employees Health Benefits (“FEHB”) program business are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the rebate reporting requirements are detailed. Federal and state auditors are challenging our Commercial business compliance with the ACA’s minimum MLR requirements, and our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years (including on a retrospective basis), it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years (including on a retrospective basis), it will be terminated by CMS. Federal auditors also are challenging our FEHB plans’ compliance with the Office of Personnel Management’s (“OPM’s”) FEHB program specific minimum MLR requirements. Additional challenges to our methodology and/or reports relating to minimum MLR rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our operating results.

Additionally, we are required to pay minimum MLR rebates in a number of states in which we offer Medicaid coverage. In 2017, there also are pending proposals in a number of states to raise Medicaid minimum MLR thresholds above 85% and/or institute profit caps on state Medicaid contracts. These rebates and proposals are not required by the ACA; they are mandated by our Medicaid contracts or applicable state laws or regulations.

We may be subject to regulatory actions or suffer brand and reputational harm if we do not or cannot adequately implement the ACA, any amendment, repeal or replacement of the ACA and/or related legislation or regulations, which may have a material adverse effect on our business.

We are dedicating, and will continue to be required to dedicate significant resources and incur significant expenses to implement and comply with the ACA as currently enacted and any amendment, repeal or replacement of the ACA and/or related legislation or regulations at both the state and federal level, including complying with the implementation timeframe set by the government each year for developing and pricing our Public Exchange products for the following year and implementing as well as complying with future legislation and regulations that will provide guidance on and clarification of and changes to significant parts of the legislation. If we fail to effectively implement the ACA and changes to, or repeal or replacement of, the ACA and/or related legislation or regulations and our related operational and strategic initiatives, or do not do so as effectively as our competitors, our business, operating results, brand and reputation may be materially adversely affected, we may lose customers and we may be subject to penalties, sanctions or other regulatory actions.

If we are unable to include the significant assessments, fees and taxes imposed on us by the ACA or otherwise by federal or state governments in our premiums and fees or otherwise solve for them, our operating results, financial position and/or cash flows would be materially and adversely affected. The inclusion of these assessments, fees and taxes in our premiums also could adversely affect our ability to grow and/or maintain our medical membership.

The ACA imposes significant assessments, fees and taxes on us and other health insurers, health plans and other industry participants. There is some uncertainty whether we will be able to include all of these assessments, fees and taxes in our premium rates. It may be particularly challenging to be able to include all of our portion of the industry-wide $14.3 billion 2018 HIF (as currently enacted) in our premium rates beginning with 2017 medical customer renewals that have member months in 2018 because of the HIF suspension for 2017. Our ability to reflect the ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and CHIP rates is limited due, among other things, to the budgetary pressures currently facing many state governments.

We cannot predict the nature or extent of any new or increased federal or state assessments, fees or taxes associated with changes in the ACA or state actions in 2017 or thereafter. Those new or increased assessments, fees or taxes may be significant. If we are unable to include assessments, fees and taxes in our premiums and fees or otherwise adjust our business model to solve for them, these assessments, fees and taxes could have a material adverse effect on our operating results, financial position and/or cash flows. The increases in our prices caused by including all of these assessments, fees and taxes in our premiums and fees also could adversely affect our ability to profitably grow and/or maintain our medical membership, for example, if our competitors do not seek to include all or a significant portion of these assessments, fees and taxes in their premiums or fees.

Our business activities are highly regulated. Our Medicare, Medicaid, specialty and mail order pharmacy, Public Exchange and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our business. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.

Our business is subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently (as evidenced by amendments to, and possible repeal or replacement of, the ACA and the continuing administrative changes in, and pending litigation regarding, the implementation of the ACA as well as other new federal and state laws and regulations), and can be inconsistent or conflicting. In general, these laws and regulations are designed to benefit and protect members and providers rather than us or our investors. In addition, the governmental authorities that administer our business have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year.

Our Medicare, Medicaid, dual eligible, Public Exchange, specialty pharmacy and mail order pharmacy products are more highly regulated than our other Health Care products. The laws and regulations governing participation in Medicare, Medicaid and dual eligible programs are complex, are subject to interpretation and can expose us to penalties for non-compliance, including penalties under the federal false claims act (the "False Claims Act") and state false claims acts. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products sold on Public Exchanges. The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit. If we are convicted of fraud or other criminal conduct in the performance of a health program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare, Medicaid and dual eligible programs, and we also may be required to pay significant fines and/or other monetary penalties.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare, Medicaid, dual eligible and other programs, cash flows, financial position and operating results. For example, CMS assessed a civil monetary penalty of $1 million against us in 2015 for distributing inaccurate information regarding which pharmacies were part of our Medicare network. Also, from April 2010 through June 2011, we were subject to intermediate sanctions that CMS imposed on us that required us to suspend the enrollment of and marketing to new members of all Aetna Medicare Advantage and PDP contracts. As a result of these sanctions, our 2011 Medicare membership and operating results were adversely affected because we did not participate in the annual enrollment process for 2011 and were not again eligible to receive automatic assignments of low income subsidy PDP members from CMS until September 2012.

Our products providing PBM and specialty and mail order pharmacy services are subject to:

- The risks inherent in the dispensing, packaging and distribution of pharmaceuticals and other health care products, including claims related to purported dispensing and other operational errors (any failure by us or one of our PBM

services suppliers to adhere to the laws and regulations applicable to the dispensing of pharmaceuticals could subject our PBM and/or pharmacy subsidiaries to civil and criminal penalties).

- Federal and state anti-kickback and other laws that govern our relationship with pharmaceutical manufacturers, customers and consumers.
- Compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings.
- Federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices, including the management and breadth of provider networks, the regulation of the development and use of drug formularies (such as the 2014 regulatory activity requiring us and certain other payors to place certain high cost drugs in preferred positions in our drug formularies) and/or maximum allowable cost list pricing, legislation, regulations or regulatory activity increasing the regulation of prescription drug pricing, imposing additional rights to access to drugs for individuals enrolled in health care benefit plans or reducing the cost of such drugs to those individuals, the receipt or required disclosure of rebates from pharmaceutical manufacturers, and restrictions on the use of average wholesale prices.

Our business, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations, including new legislation or regulations that apply to Private Exchanges. For more information regarding these matters, refer to “Regulatory Environment” of MD&A included in Part II, Item 7 and “Litigation and Regulatory Proceedings” in Note 17 “Commitments and Contingencies” included in Part II, Item 8 of this Annual Report on Form10-K.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices, and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national health and related benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. Several such audits, investigations and reviews currently are pending, some of which may be resolved in 2017, and the results of which may be adverse to us.

There continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry’s business and reporting practices, including premium rate increases, provider network adequacy, provider network directories, pharmacy formulary tiering, pharmacy network structures, utilization management and payment of providers with whom the payor does not have a contract and other health and life insurance claim payment practices. In addition, a significant number of states are investigating life insurers’ and health insurers’ claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlement agreements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance and health insurance claim payment and related escheat practices. Given the judicial, legislative and regulatory uncertainty with respect to life insurance and health insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows. For additional information on these life insurance matters, refer to “Regulatory Environment - Life and Disability Insurance” of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other market participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our self-insured customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. For example, CMS assessed a civil monetary penalty of $1 million against us in 2015. Any of these audits, investigations or reviews could have a material adverse effect on our financial position, operating results or business or result in significant liabilities and negative publicity for our company. Federal and state auditors are challenging our Commercial business compliance with the ACA's minimum MLR requirements. Our Commercial business has been subject to audits related to the ACA's risk adjustment and reinsurance data since those programs were implemented in 2014. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years (including on a retrospective basis), it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years (including on a retrospective basis), it will be terminated by CMS. Federal auditors are also challenging our FEHB plans' compliance with the OPM's FEHB program specific minimum MLR requirements. For more information on certain CMS and other audits, see *"We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS"* on page 25.

For more information regarding these matters, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 and "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K..

If our compliance systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our business, cash flows, operating results or financial position.

Our businesses are subject to extensive and complex regulations, and many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems in place to ensure that we comply with all applicable legal, regulatory and contractual requirements. These systems are frequently reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our business, cash flows, operating results or financial position.

Our litigation and regulatory risk profile is changing as we offer new products and expand in business areas beyond our historical core business of providing Commercial managed care and health insurance products in the United States. Changes in the ACA at the federal or state level could accelerate that change.

Historically, we focused primarily on providing Commercial managed care and health insurance products in the United States. In comparison, our Medicare and Medicaid products were significantly smaller. In 2016, our Medicare and Medicaid products accounted for 48% of total Health Care premiums. Our business continues to change due to the following:

- *Acquisitions:* Our 2014 acquisition of InterGlobal expanded our international business.
- *Expansion within the health care marketplace:* We are expanding or seeking to expand our presence in various sectors of the health care marketplace, including Medicare, Medicaid, dual eligibles, international, and certain customers who are not subject to ERISA's limits on state law remedies and working to deliver innovative products in those sectors.
- *Entry into new business and new product lines:* We are in the process of developing and seeking to expand our Consumer Health and Services product line. Over the last several years we have entered into new product lines, including Insurance Exchanges, dual eligible programs, support services for ACOs, data analytics, recruitment for clinical trials and HIT.
- *ACA Changes:* Changes in the ACA at the federal or state level may create new products or expose us to new or expanded regulatory and/or litigation risk.

The increased volume of business in areas beyond our historical core business and new products subject us to litigation and regulatory risks that are different from the risks of providing Commercial managed care and health insurance products and increase significantly our exposure to other risks.

We are routinely subject to litigation and adverse legal proceedings, including class actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our business and operating results.

We are routinely involved in numerous claims, lawsuits, regulatory audits, investigations and other legal proceedings arising in the ordinary course of our businesses. Certain of the lawsuits against us are purported to be class actions. The majority of these proceedings relate to the conduct of our health care operations and allege various violations of law. In addition, we operate in jurisdictions outside the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore more likely to be subject to dispute by customers, members, governmental authorities and others. We are incurring expenses to resolve these proceedings. The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur.

Litigation has been and may be brought against us by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit. When a private individual brings a whistleblower suit, the defendant often will not be made aware of the suit for many months or even years, until the government commences its own investigation or determines whether it will intervene. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided under the Dodd-Frank Wall Street Reform and Consumer Protection Act increase the risk of whistleblower suits.

Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. For example, since 2007, we have been in class action litigation with non-participating providers over our payments to them, and during 2009, we settled a matter with the New York Attorney General that caused us to transition to different databases to determine the amount we pay non-participating providers under certain benefit plan designs. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

Litigation and other adverse legal proceedings could materially adversely affect our business or operating results because of brand and reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. Refer to "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K

Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our business. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our members, customers and other constituents in the ordinary course of our business. Some of our information systems rely upon third party systems to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the European Union's ("EU's") General Data Protection Regulation which will apply across the EU effective May 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member information, whether by us, by one of our vendors or by another third party, could require us to expend significant resources to remediate any damage, interrupt our operations and damage our brand and reputation, and could also result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our business, brand, reputation, cash flows and operating results.

Our business depends on our members' and customers' willingness to entrust us with their health related and other sensitive personal information. Events that negatively affect that trust, including inadequate disclosure to our members or customers our

uses of their information, failing to keep our information technology systems and our members' and customers' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction or that of our business associates, vendors or other third parties, including our PBM services suppliers, could adversely affect our brand and reputation, membership and revenues and also expose us to mandatory disclosure to the media, litigation (including class action litigation) and other enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our business, cash flows, operating results or financial position. There can be no assurance that any such failure will not occur, or if any does occur, that we will detect it or that it can be sufficiently remediated.

We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS.

Premiums and/or fees for Medicare members, certain federal government employee groups and Medicaid beneficiaries are subject to retroactive adjustments and/or withholding by the federal and applicable state governments. Our Public Exchange business, including amounts payable to us or payable by us under the ACA's premium stabilization programs and our risk adjustment and reinsurance data, also is subject to audit by governmental authorities. CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members.

CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage plans for various contract years, including certain of the Company's plans for certain contract years, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The OIG also is auditing risk adjustment data of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers.

Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. In December 2015, CMS released a RFI for a significant expansion of the RADV audit program. As described in the RFI, CMS would use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would require us to change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years or the current contract year. For additional information, refer to "Regulatory Environment - Medicare" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our financial position, cash flows and operating results.

CMS has issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our operating results, financial position or cash flows.

Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results, cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

Any premium or fee refunds, adjustments or withholding resulting from regulatory audits, whether as a result of RADV, Public Exchange related, recovery audit program or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows. For more information see "Regulatory Environment" of MD&A included in Part II, Item 7 of this Annual Report on Form10-K.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid and dual eligible programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to litigation against us.

These risks are particularly high in our Medicare, Medicaid and dual eligible programs, where third parties perform pharmacy benefit management, medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our business, cash flows, operating results or financial position. For more information on these matters, see "*Our business activities are highly regulated. Our Medicare, Medicaid, specialty and mail order pharmacy, Public Exchange and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our business. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth*" on page 21.

Programs funded by the U.S. federal government account for a substantial portion of our revenue and operating earnings. A delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, operating results and cash flows.

The federal government's "debt ceiling", or the amount of debt the federal government is permitted to borrow to meet its legal obligations (including, among other things, interest on the national debt, Medicare and Medicaid premiums, Social Security benefits and contributions to the Federal Employees Health Benefits Program), is limited by statute and can only be raised by an act of Congress.

If Congress does not raise the debt ceiling before the federal government's current obligations approach or exceed its cash on hand and incoming receipts, federal government spending may be subject to delay, reduction, suspension or cancellation, including a federal government shutdown, which may be prolonged. A significant portion of our revenues are derived from health care coverage programs that are funded in whole or in part by the federal government, including the Medicare, Medicaid, and dual eligible programs, CHIP and the Federal Employees Health Benefits Program and subsidies for qualified individuals and families purchasing health insurance through Public Exchanges. If federal spending is delayed, suspended or curtailed, we would continue to receive claims from providers providing services to beneficiaries of these programs, and we could be liable for, and be required to fund, such claims. Furthermore, the terms of our disability products often provide that the benefits due to beneficiaries are reduced by the amount of certain federal benefits they receive, most notably Social Security Disability Insurance ("SSDI") payments. If such payments are suspended or reduced due to a failure to timely raise the debt ceiling, our disability payment obligations would be increased accordingly, and such increase could be material. If beneficiaries subsequently receive such payments from the federal government, we would seek reimbursement or attempt to offset a portion of such payments against future disability benefit payments. We may not be successful in recovering the amount sought. A failure to timely raise the debt ceiling could have a material adverse effect on our businesses, operating results, cash flows, brand and reputation and, in the case of a prolonged failure to raise the debt ceiling, our financial position.

If the United States defaults on its obligations due to a failure to timely raise the debt ceiling or otherwise, or its credit rating is downgraded by any of the credit rating agencies, interest rates could rise, financial markets could become volatile and/or the availability of credit (and short-term credit in particular) could be adversely affected, thereby increasing our borrowing costs, negatively impacting the value of our investment portfolio, and/or adversely affecting our ability to access the capital markets, which could have a material adverse effect on our operating results, financial position and cash flows and could adversely affect our liquidity.

Risks Related to Our Business

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our operating results. We may not able to obtain appropriate pricing on new or renewal business.

Premiums for our insured Health Care Products, which comprised 86% of our total consolidated revenues for 2016, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and healthcare utilization patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our operating results.

Our health care and other benefit costs can be affected by external events that we cannot forecast or project and over which we have little or no control, such as emerging changes in the economy and/or public policy, government mandated benefits or other regulatory changes, changes in our members' behavior and healthcare utilization patterns, changes in health care practices, new technologies, increases in the cost of prescription drugs, direct-to-consumer marketing by pharmaceutical companies, clusters of high cost cases, influenza related health care costs (which may be substantial and are currently projected to be approximately the same in 2016-2017 as in 2015-2016), epidemics, pandemics, terrorist attacks or other man-made disasters, natural disasters or other events that materially increase utilization of medical and/or other covered services, as well as changes in provider billing practices. Our health care and other benefit costs also can be affected by changes in our business mix, product designs, contracts with providers, medical management, underwriting, rating and/or claims processing methods and processes, and our medical management initiatives may not deliver the reduction in utilization and/or medical cost trend that we project.

It is particularly difficult to accurately anticipate, detect, forecast, manage and reserve for medical cost trends and utilization of medical and/or other covered services during and following periods when such utilization and/or trends are below recent historical levels, during periods of changing economic conditions and employment levels and for products with substantial membership turnover such as Public Exchange products. For example, in the second and third quarters of 2016, we recorded

premium deficiency reserves totaling $85 million related to anticipated future losses for the 2016 coverage year in our individual Commercial products. Similarly, during calendar year 2014, medical costs in our smaller middle market and individual businesses were higher than we projected, and during the calendar years 2010-2013, medical costs and members' utilization of medical and/or other covered services were lower than we projected and members' utilization was below recent historical levels. We expect utilization to increase in 2017 when compared to 2016.

We have implemented price increases for 2017. If health care and other benefit costs are higher than the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our prices will not reflect the risk we assume, and our operating results will be adversely affected. If health care and other benefit costs are lower than we predict, our prices may be higher than those of our competitors, which may cause us to lose membership. For more information, see "Critical Accounting Estimates - Health Care Costs Payable" of MD&A included in Part II, Item 7 of this Annual Report on Form10-K.

Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and operating results will be negatively affected.

Our customer contracts are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and operating results.

In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and operating results, although such elections also may reduce our health care and other benefit costs.

In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an adverse and/or uncertain economy. These actions may adversely affect our membership, revenues and operating results.

If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care business, our operating results, financial position and cash flows could be materially and adversely affected.

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the marketplace. Our businesses face significant competition in all of the geographies and product areas in which we operate. For example, our largest competitor in our Medicare products is Original Medicare. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods.

In our Health Care business, we compete on the basis of many factors, including perceived overall quality, quality of service, comprehensiveness of coverage, cost (including premium, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, providers available in such networks, and quality of member support and care management programs. Our competitors in our Health Care business include, among others, UnitedHealth Group Incorporated, Anthem, Inc., Humana Inc., Cigna Corporation, WellCare Health Plans, Inc., Centene Corporation, Molina Healthcare, Inc., Kaiser Permanente, health system owned health plans and new entrants into the marketplace, and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. Our largest competitor in our Medicare products is Original Medicare. Additional competitors in our businesses include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of

their members), third-party administrators, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefit plans, provider-owned health plans, new joint ventures, technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. In particular geographies, competitors may have greater capabilities, resources or membership; a more established reputation; superior supplier or health care professional arrangements; better business relationships; or other factors that give such competitors a competitive advantage. We compete for sales on Insurance Exchanges and are developing and expanding our Consumer Health and Services product line, where we face additional risks from existing and new competitors (including our vendors) who have lower cost structures, greater experience marketing to consumers and/or who target the higher margin portions of our business. Among our international and HIT competitors, many have longer operating histories, better brand recognition and greater market presence in many of the areas in which we are seeking to expand and more experience at rapidly innovating products. If we do not compete effectively in the geographies and product areas in which we operate, our business, operating results, financial position and cash flows could be materially and adversely affected.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our operating results and competitiveness will be adversely affected.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and healthcare utilization patterns, turnover in our membership, government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs such as new hepatitis C and cholesterol treatments and auto-immune therapies), direct-to-consumer marketing by pharmaceutical companies, the increasing influence of social media on our members' utilization and other behavior, changes in health care practices and inflation. In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers, have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, changes in health care practices, general economic conditions (such as inflation and employment levels), new technologies, clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

Our operating results and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and operating results.

The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or may make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs.

Our revenues from government-funded health and other programs, including our Medicare, Medicaid and dual eligible businesses and our government customers in our Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

For example, while the ACA provided substantial federal funding for the expansion of the number of people who qualify to enroll in Medicaid beginning in 2014, that funding is decreasing beginning in 2017, and the future of that funding is uncertain. As a result, in 2017, states are preparing for the adverse impact on their budgets and programs of expected changes to the ACA and other federal programs by seeking to reduce their Medicaid expenditures by raising minimum MLR thresholds, instituting profit caps and/or changing the design of their Medicaid programs. These changes could have a material adverse effect on the

revenues, medical benefit ratio and operating results of our Medicaid contracts and/or our ability to grow our Medicaid membership, revenues and operating results.

Our government customers also determine the eligibility criteria, premium levels and other aspects of Medicare, Medicaid and dual eligible programs that affect the number of persons enrolled in these programs, the services provided to enrollees under the programs, and our administrative and health care and other benefit costs under these programs. In the past, determinations of this type have at times adversely affected our operating results from and willingness to participate in such programs, and they may do so again in the future. For example, effective January 1, 2015, we terminated our Insured Medicaid contract in Delaware because we did not believe the premium level was adequate. If a government customer reduces premium levels or increases premiums by less than the increase in our costs (such as by not allowing us to recover ACA and other applicable fees, taxes and assessments), and we cannot offset the impact of these actions with supplemental premiums and/or changes in benefit plans, then our business and operating results could be adversely affected. In addition, if states allow certain programs to expire, reduce the number of firms with which they contract for Medicaid managed care services or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment or reduced Medicaid enrollment growth, which would adversely affect our business, revenues and operating results.

In addition, the terms of our disability products often provide that the benefits due to beneficiaries are reduced by the amount of certain federal benefits they receive, most notably SSDI payments. If such payments are suspended or reduced for any reason, including due to funding shortfalls for the SSDI program, our disability payment obligations would be increased accordingly, and such increase could be material.

Unanticipated increases in our Public Exchange and other individual Commercial product and our ACA compliant small group Commercial product health care benefit costs adversely affected our 2016 operating results and could adversely affect our operating results in 2017 and future years. Our individual Commercial products, including our Public Exchange products, were not profitable in 2016. There can be no assurance that our pricing or other actions will improve the profitability of our individual Commercial products, including our Public Exchange products, or our ACA compliant small group Commercial products in 2017. There can be no assurance that the future health care benefit costs of our individual Commercial products will not exceed our projections.

Unanticipated increases in our Public Exchange and other individual Commercial product and our ACA compliant small group Commercial product health care benefit costs adversely affected our 2016 operating results and could adversely affect our operating results in 2017 and future years. Our individual Commercial products, including our Public Exchange products, were not profitable in 2014, 2015 or 2016 due to higher than projected health care benefit costs. In 2016, we reported pretax losses of $450 million in our individual Commercial products. We project a reduced level of losses in those products in 2017.

We have set 2017 premium rates for our individual Commercial products, including our Public Exchange products, and our ACA compliant small group Commercial products based on our projections, including as to the health status and quantity of individual and small group Commercial product membership and utilization of medical and/or other covered services by individual and small group Commercial product members. The ACA's risk management programs will provide us with less protection in 2017 than 2016. The 2017 marketplace for individual Commercial products also may be less stable than in 2016 because, among other things, other health plans have changed or stopped offering their Public Exchange products in the states we are serving in 2017, which, among other things, increases our adverse selection risk. There can be no assurance that our pricing or other actions will improve the profitability of our individual Commercial products, including our Public Exchange products, or our ACA compliant small group Commercial products in 2017 or any future year.

The premium rates for our individual Commercial and ACA compliant small group Commercial products are set in advance and fixed for one-year periods. As a result, health care benefit costs in excess of the projections reflected in our pricing for those products cannot be recovered in the fixed premium period through higher premiums. The profitability of individual Commercial and ACA compliant small group Commercial products is particularly sensitive to the accuracy of our forecasts of health care benefit costs. Those forecasts were made several months before the fixed premium period began, require a significant degree of judgment and are dependent on our ability to detect medical cost trends as well as the accuracy of our projections used in setting our individual Commercial and ACA compliant small group Commercial product premium rates.

There can be no assurance regarding the accuracy of the health care benefit cost, membership or other projections reflected in our individual Commercial and ACA compliant small group Commercial product pricing. The risks related to the accuracy of projections reflected in our pricing are magnified by adverse selection among individuals who require or utilize more expensive medical and/or other covered services (such as those who purchase coverage during special election periods), other plans' withdrawals from participation in the Insurance Exchanges we serve and legislation, regulations, enforcement activity and/or judicial decisions that cause Insurance Exchanges or Insurance Exchange products to operate in a manner different than what

we projected in setting our Insurance Exchange product premium rates, such as ongoing initiatives in several states to require insurers to allow members to pay insurers less for certain high cost drugs than the amounts assumed in pricing of their Public Exchange products or situations where ACA co-op insolvencies have required and may in the future require us to take on Public Exchange membership that we did not anticipate or price for. In addition, the limited payments under the ACA's risk corridor program for the 2014 and 2015 program years created additional instability in the marketplace for individual Commercial products in 2016 and going forward by contributing to decisions by health plans to change or stop offering their Public Exchange products. 2016 was the last year for the ACA's rick corridor program. On-going uncertainty regarding the funding of ACA-related programs and subsidies can be expected to create additional instability in the marketplace. For additional information on certain of the medical cost trend, pricing and economic conditions risks associated with our Insurance Exchange and other Health Care products, see "*We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our operating results. We may not able to obtain appropriate pricing on new or renewal business*" on page 27; and "*We may not be able to obtain adequate premium rate increases, which would have an adverse effect on our revenues, medical benefit ratios and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes*" on page 19.

The reserves we hold for expected claims are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the ACA's, CMS's and OPM's minimum MLR rules and the amounts payable by us to, and receivable by us from, the U.S. federal government under the ACA's premium stabilization programs.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within health care costs. For example, in the second and third quarters of 2016, we recorded premium deficiency reserves totaling $85 million related to anticipated future losses for the 2016 coverage year in our individual Commercial products. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable at December 31, 2016 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any negative impact on our operating results. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, such as Public Exchanges, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Refer to "Critical Accounting Estimates - Health Care Costs Payable" of MD&A included in Part II, Item 7 of this Annual Report on Form10-K for more information.

Our medical membership remains concentrated in certain geographic areas and industries, exposing us to unfavorable changes in local benefit costs, reimbursement rates, competition and economic conditions.

Our medical membership remains concentrated in certain geographic areas in the United States and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our operating results. Our membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our membership geographically, by product type

or by customer industry, and our revenue and operating results may be disproportionately affected by adverse changes affecting our customers.

A change in our health care product mix may impact our profit margins.

Our health care products that involve greater potential risk generally tend to be more profitable than administrative services contract products. Individuals and small employer groups are more likely to purchase our higher-risk health care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government-sponsored programs also involve our higher-risk health care products and have lower profit margins than our Insured Commercial products, and our membership is projected to continue to shift towards higher revenue, higher MBR Government products in 2017. In 2014, 2015 and 2016, our individual Commercial products, including those sold on the Public Exchanges, were not profitable. In 2016, we reported pretax losses of $450 million in our individual Commercial products. We project a reduced level of losses in those products in 2017. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our operating results.

Bids for Government business in our Health Care segment are increasingly subject to challenge, which may adversely affect contracts initially awarded to us and may result in increased costs.

We continue to increase our focus on the government customers in our Health Care segment as part of our business growth and diversification strategy. We are seeking to substantially grow our Medicare, Medicaid and dual eligibles business over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders. For example, as of January 2017, certain of our winning Medicaid bids are being protested, and during 2016 we were not successful in retaining certain Medicaid contracts. As a result, we are seeking to improve our process for responding to Medicaid requests for proposal. Our ability to maintain and grow membership, revenues and operating results in our Medicaid products is dependent on our remaining competitive on price, performance and preparing successful bids. In cases where our bid is successful, we incur defense costs and may incur unreimbursed implementation and other costs to meet contractual deadlines even if we ultimately lose the challenge.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health), life insurance and disability costs and impact our business continuity. We cannot predict whether or when any such events will occur.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the U.S. economy in general, our industry and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health), life insurance and disability costs, which would also be affected by the government's actions and the responsiveness of public health agencies and other insurers. In addition, our life insurance members and our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our business, cash flows, and operating results, and, in the event of extreme circumstances, our financial position or viability.

Our business could also be adversely affected if we do not maintain adequate procedures for crisis management, disaster recovery and business continuity during and after such events. Other than obtaining insurance coverage for our facilities and limited reinsurance of our Health Care and/or Group Insurance liabilities, there are few, if any, commercial options through which to transfer the exposure from terrorism or other extreme events away from us.

Risks Related to Our Operations

Unless we are able to develop alternative sources of revenue and earnings and achieve transformational change in our business model, our ability to profitably grow our business could be adversely affected.

We operate in a highly competitive environment and in an industry that is subject to significant ongoing changes from marketplace pressures brought about by public policy forces, the ACA, changes to or repeal or replacement of the ACA, Insurance Exchanges, customer demands, demographic shifts, new and expanding health care capabilities, business consolidations, strategic alliances, new market entrants, legislative and regulatory changes and marketing practices. As a result of these and other factors, our ability to grow profitably through the sale of traditional Insured health care and related benefits products in the United States may be limited. In order to profitably grow our business in the future, we need to diversify the sources of our revenue and earnings and transform our business model, including through developing and expanding our

Consumer Health and Services product line, making investments in consumer engagement capabilities and our Consumer Health and Services' technology and other services for health systems and provider organizations (including joint ventures, ACOs and collaborative provider networks), optimizing our business platforms and expanding internationally.

Achieving these goals will require us to devote significant senior management and other resources to acquisitions or other transactions and to develop internally or acquire new products, solutions and technology before any significant revenues or earnings are generated from such initiatives. If we are not able to acquire and/or develop and launch new products and solutions, our ability to profitably grow our business could be adversely affected.

We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted virus infections, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, malware or injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. Although the impact of such attacks has not been material to our operations or operating results through December 31, 2016, we can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future. As we expand our Consumer Health and Services product line, including through our growth of ACS, Medicity, and ActiveHealth, increase the amount and types of data we acquire, generate and use, increase the amount of information we make available to members, consumers and providers on mobile devices, expand our use of vendors, expand internationally and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access to and/or disruption of our systems and the customer, member, provider, employee, ACO, joint venture, vendor and other third party information they contain, increases, and the cost of attempting to protect against these risks also increases.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our business, brand, reputation, cash flows and operating results.

We may not be able to effectively manage our general and administrative expenses to competitive levels, which may reduce our membership or profitability, or we may need to implement expense reduction measures that adversely affect our future growth potential.

Our operating results depend in part on our ability to manage our general and administrative expenses to competitive levels while delivering improved customer, member and provider service, expanding our marketplace presence and accomplishing our strategic initiatives, including developing, operating and expanding our Consumer Health and Services product line. Controlling general and administrative expenses is particularly important in our Health Care businesses that are subject to regulatory changes that may restrict our underwriting margins (calculated as premiums less health care costs), such as minimum MLR requirements. We have significant fixed costs, and our ability to reduce variable costs in the short term is limited. We attempt to manage general and administrative expenses by, among other things, making our processes more efficient, reducing the number of products we offer and controlling costs for salaries and related benefits, information technology and other general and administrative costs. However, we may not be successful in achieving the intended benefits of the cost-cutting and process improvement initiatives we undertake. In addition, our cost-cutting measures may adversely affect our ability to implement the ACA, changes to the ACA and other regulatory requirements, attract and retain key employees, maintain robust management practices and controls (including internal controls over financial reporting), implement improvements in technology and achieve our strategic goals, including profitable membership growth. Given the foregoing, we can provide no assurance that we will be able to manage our general and administrative expenses to competitive levels, which may reduce our membership, profitability and operating results and adversely affect our business and future growth potential.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, members and vendors, including our PBM services suppliers, in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the Consumer Health and Services products we are developing and seeking to expand and/or to meet current and developing industry and regulatory standards, including with regard to minimum MLR rebates, Insurance Exchanges, and various aspects of the ACA, and to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

Our business strategy involves providing customers with differentiated, easy to use, secure products and solutions that use information to meet customer needs. The types of technology and levels of service that are acceptable to customers and members today will not necessarily be acceptable in the future, requiring us to anticipate and meet marketplace demands for technology. Our success therefore is dependent in large part on our ability, within the context of a limited budget of human resources and capital and our existing and future business relationships, to timely secure, integrate, develop, redesign and enhance our (or contract with vendors to provide) technology systems that support our business strategy initiatives and processes in a compliant, secure, and cost and resource efficient manner. Integration of our acquisitions increases these challenges, and we may not be successful in integrating various systems in a timely or cost-effective manner.

Information technology projects are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care cost and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of providers, employer plan sponsors and members, developing and expanding our Consumer Health and Services product line or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

In order to remain competitive, we must further integrate our businesses, processes and systems. Pursuing multiple initiatives simultaneously could make this integration significantly more challenging.

Many of our businesses, processes and systems, both those we have acquired or will acquire, and those we have developed or are developing, are not integrated, are complex or require disproportionate resources in order to work together effectively. Businesses, processes and systems that are excessively complex or are not effectively integrated may adversely affect our ability to compete by, among other things, increasing our costs relative to competitors, reducing our flexibility and limiting our ability to react quickly to marketplace opportunities or changing circumstances. Accordingly, we must effectively and efficiently simplify and integrate these businesses, processes and systems to meet changing consumer and vendor needs and improve our productivity. This task is significantly more difficult when we pursue multiple transactions or other initiatives, such as significant acquisitions, strategic alliances, joint ventures and multi-year strategic projects (including developing, operating and seeking to expand our Consumer Health and Services product line and implementing new provider support programs), simultaneously. Our existing business partnership relationships and a limited budget of human resources and capital present further challenges.

If we are unable to successfully simplify and integrate our businesses, processes and systems, including those from acquisitions, to realize anticipated economic and other benefits in a timely manner, it could result in substantial costs or delays and adversely affect our business, operations and operating results.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop and seek to expand our Consumer Health and Services product line and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with health plan members in these areas.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We face a wide range of risks, and our success depends on our ability to identify, prioritize and appropriately manage our enterprise risk exposures.

As a large company operating in a complex industry and in many countries, we encounter a variety of risks. The risks we face include, among other matters, the range of industry, competitive, regulatory, financial, operational or external risks identified in this "Risk Factors" discussion. We continue to devote resources to further develop and integrate our enterprise-wide risk management processes. Failure to identify, prioritize and appropriately manage or mitigate these risks, including risk concentrations across different business lines, products (e.g., Insured vs. ASC), industries, customers and geographies, can adversely affect our operating results, our ability to retain or grow business, or, in the event of extreme circumstances, our financial position or business operations.

We also face other risks that could adversely affect our business, operating results or financial position, which include:

- Health care benefits fraud by providers and members that is not prevented or detected and impacts our medical cost trends or the medical expenses of our self-insured customers. In addition, in an adverse and/or uncertain economic environment, whether in the United States or abroad, our businesses may see increased fraudulent claims volume, which may lead to additional costs because of an increase in disputed claims and litigation;
- Assessments under guaranty fund laws for obligations of insolvent insurance companies (including Penn Treaty Network America Insurance Company and one of its subsidiaries as described in Note 17 "Commitments and Contingencies - Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools" included in Part II, Item 8 of this Annual Report on Form 10-K), HMOs, ACA co‑ops and other payors to policyholders and claimants;
- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;
- Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our operating results and/or a deterioration in the soundness and accuracy of our reported operating results;
- Financial loss from inadequate insurance coverage due to self-insurance levels or unavailability of insurance and reinsurance coverage for credit or other reasons;
- Failure to protect our proprietary information, including as a result of cyber-attacks on us, one or more providers and/or one or more of our vendors; and
- Failure to adequately manage our run-off businesses and/or our financial exposure to businesses we have sold.

Risks Related to Customer Perceptions of our Products and Services

In order to be competitive in the growing marketplace for direct-to-consumer sales and on public and private health insurance exchanges, we will need to develop our Consumer Health and Services products and make investments in consumer engagement, reduce our cost structure and face new competitors. If we are unsuccessful, our future growth and profitability may be adversely affected.

Historically, employers have been our most significant customers. Our direct-to-consumer sales have been limited, and our individual Health Care business has been small relative to the other businesses in our Health Care segment. We are developing and seeking to expand our Consumer Health and Services product line, and we are now competing for sales on Insurance Exchanges. To develop and expand our Consumer Health and Services product line and compete effectively on Insurance Exchanges, we will be required to develop or acquire the technology systems and tools and talent necessary to interact with Insurance Exchanges and engage individual consumers using Insurance Exchanges and social media, increase our focus on individual consumers and expand and improve our consumer-focused sales and marketing channels, customer interfaces, customer service and product offerings.

We also will have to respond to pricing and other actions taken by existing competitors and regulators as well as potentially disruptive new entrants which could reduce our profit margins. Due to the price transparency provided by Insurance Exchanges, when we market our individual and small group health insurance products we face competitive pressures from existing and new competitors (including our vendors) who have lower cost structures. Our competitors may bring their Insurance Exchange and other consumer products to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our business. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of Private Exchanges or encourage their employees to purchase health insurance on the Public Exchanges. We can provide no assurance that we will be able to develop or operate successful or profitable Consumer Health and Services products or compete successfully or profitably on Public Exchanges or Private Exchanges or that we will be able to benefit from any opportunities presented by Public Exchanges or Private Exchanges. If we do not develop and expand competitive and profitable Consumer Health and Services products, are not competitive on Insurance Exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely affected.

We may not be able to compete effectively in the HIT business and earn a profit. Our HIT business increases our risk of patent infringement and other intellectual property litigation and may become subject to significant regulation in the future.

With our current focus on consumer engagement, joint ventures, ACOs, collaborative provider networks and optimizing our business platforms and our 2014 acquisition of bswift, we have increased our commitment to HIT products and solutions, a business that is rapidly changing and highly competitive. There is no assurance that we will be able to successfully adapt to changes to the HIT marketplace, or compete effectively and earn a profit in our HIT business. Our technology products and solutions may not operate as intended. Moreover, we may not have identified and mitigated, or be able to identify and mitigate, the significant risks of pursuing the HIT business, including the risk that we will be unable to protect our proprietary rights and the risks of patent infringement and other intellectual property litigation against us. Certain of our HIT products and/or solutions are subject to patent litigation, which is often associated with significant litigations costs, damages and/or injunctions.

In addition, although the HIT industry is not currently subject to significant regulation, we face an uncertain and rapidly evolving federal, state and international legislative and regulatory framework, and certain of our HIT products and/or solutions could become subject to regulation. New legislation and/or regulations may make it difficult to achieve and maintain compliance and could adversely affect both our ability to compete in the HIT business and the operating results of our HIT business.

If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow profitable membership may be adversely affected.

We operate in a rapidly evolving industry. Our customers generally, and our larger customers in particular, are well-informed and organized and, along with our individual customers, can easily move between us and our competitors. These factors require us to differentiate our products and solutions, anticipate changes in customer and consumer preferences, anticipate and effectively compete with the products and solutions of new and existing competitors and innovate and deliver new and existing products and solutions that demonstrate value to our customers and members, particularly in response to marketplace changes from public policy. Differentiating our Insurance Exchange products is particularly challenging due to the standardization (for

example, network adequacy and standardization of benefits requirements) of these products. Any failure to do so may adversely affect our ability to retain or grow profitable membership, which can adversely affect our operating results.

If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership will be adversely affected.

Our ability to attract and retain membership is dependent upon providing cost effective, quality customer service operations (such as call center operations, claim processing, outsourced PBM functions, mail order pharmacy prescription delivery, specialty pharmacy prescription delivery, customer case installation and on-line access and tools) that meet or exceed our customers' and members' expectations. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customer and other service and performance. If we misjudge the effects of such measures, customer and other service may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. For example, CaremarkPCS Health, L.L.C. (and its predecessors, collectively, "CVS") and Express Scripts provide us with certain PBM services. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or growing profitable membership, which can adversely affect our operating results. For example, noncompliance with any privacy or security laws or regulations or any security breach involving one of our third party vendors could have a material adverse effect on our businesses, operating results, brand and reputation.

Our competitive position and ability to differentiate our products will be adversely affected if we cannot demonstrate that our products and processes result in our members receiving quality affordable care.

One of the key factors on which we compete for customers is the degree to which our products and processes (including our disease management and patient safety programs and our provider credentialing and other quality of care and information management initiatives) result in our members receiving quality affordable care from providers, our vendors (including our PBM services suppliers) and us. If our products and process do not result in our members receiving quality affordable care, or if we are unable to demonstrate that our members receive quality affordable care, then our competitive position and ability to differentiate our product and/or solution offerings from those of our competitors would be adversely affected, which in turn could adversely affect our operating results.

Risks Related to Our Relationships with Providers, Suppliers and Vendors

If we are unable to enter into joint ventures and other collaborative risk-sharing agreements with health care providers on satisfactory terms, it may have an adverse effect on our ability to enhance our provider networks, contain our medical costs, grow our business and/or develop alternative sources of revenue and earnings.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with health care providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow membership, and our ability to profitably grow our business and/or our operating results may be adversely affected.

While we believe joint ventures, ACOs and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our ACS and ACO strategies may not achieve the intended results, which could adversely affect our operating results and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint venture. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our operating results and cash flows.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other provider and health systems continue to consolidate across the industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain locations. These health systems are also increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other health care providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our business and operating results.

Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.

Our operating results are dependent in part upon our ability simultaneously to contract competitively with and develop and maintain favorable relationships with hospitals, physicians, pharmaceutical benefit management service providers, pharmaceutical manufacturers and other health care benefits providers. Our relationships with providers are affected by the rates we pay them for services rendered to our members (including financial incentives to deliver quality services in a cost-effective manner), by our business practices and processes, by our acquisitions and proposed acquisitions, and by our provider payment and other provider relations practices (including whether we include providers in the various provider network options we make available to our customers). Our relationships with providers are also affected by factors that impact those providers, but are not directly related to us, such as consolidations and strategic relationships among providers and/or among our competitors, changes in Medicare and/or Medicaid reimbursement levels to health care providers (including reductions due to the ATRA, sequestration and/or any repeal or amendment of the ACA), and increasing revenue and other financial pressures on providers, including increases in uncompensated care resulting from the any repeal or amendment of the ACA, ongoing reductions by CMS and state governments (including reductions due to recommendations of the Independent Payment Advisory Board, the ATRA, sequestration and/or any repeal or amendment of the ACA) in amounts payable to providers, particularly hospitals, for services provided to Medicare and Medicaid enrollees.

The breadth and quality of our networks of available providers and our ability to offer different provider network options are important factors when customers consider our products and services. Our customers, particularly our self-insured customers, also consider our hospital and other medical provider discounts when evaluating our products and services. For certain of our businesses, we must maintain provider networks that satisfy applicable access to care and/or network adequacy requirements. Regulators also consider the breadth and nature of our provider networks when assessing whether such networks meet network adequacy requirements which, in some cases, are becoming more stringent. For example, a 2016 CMS regulation established network adequacy requirements that apply to all Medicaid managed care plans. Our contracts with providers generally may be terminated by either party without cause on short notice.

The failure to maintain or to secure new cost-effective health care provider contracts, may result in a loss of or inability to grow membership, higher health care or other benefits costs (which we may not be able to reflect in our pricing due to rate reviews or other factors), health care provider network disruptions, less desirable products for our customers and/or difficulty in meeting regulatory or accreditation requirements, any of which could adversely affect our operating results.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our members.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these non-participating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, since 2007, we have been in class litigation with non-participating providers over our payments to them, and during 2009, we settled a matter with the New York Attorney General that caused us to transition to different databases to determine the amount we pay non-participating providers under certain benefit plan designs. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Certain of these matters are described in more detail in "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K.

We could become overly dependent on key service providers, which could expose us to operational risks and cause us to lose core competencies. If their services become unavailable, we may experience service disruptions, reduced service quality and increased costs and may be unable to meet our obligations to our customers.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. These third parties include our PBM services suppliers, information technology system providers, independent practice associations, accountable care organizations and call center and claim and billing service providers. Certain of these third parties provide us with significant portions of our requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. Certain third parties to whom we delegated selected functions, such as independent practice associations and specialty services providers, have experienced financial difficulties, including bankruptcy. Furthermore, certain legislative authorities have in recent years discussed or proposed legislation that would restrict outsourcing. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruption or unavailability, reduced service quality and effectiveness, increased or duplicative costs, an inability to meet our obligations to our customers or require us to seek alternative service providers on less favorable contract terms, any of which can adversely affect our business, brand, reputation and/or operating results. Furthermore, where our arrangements with these service providers are not acceptable to our customers, we must make alternate arrangements, which may be more costly and difficult to implement.

In particular, we have entered into agreements with our PBM services suppliers to provide us and certain of our customers and members with certain PBM services. If our PBM agreement with CVS or our agreements with our other PBM services supplier were to terminate for any reason or one of our PBM services supplier's ability to perform their respective obligations under their agreements with us were impaired, we may not be able to find an alternative supplier in a timely manner or on acceptable financial terms. As a result, our costs may increase, we would not realize the anticipated benefits of our PBM agreement with CVS or our other agreements for PBM services (including projected operating efficiencies), and we may not be able to meet the full demands of our customers, any of which could have a material adverse effect on our business, brand, reputation and/or operating results.

Risks Related to Our Acquisitions and International Operations

We expect to continue to pursue acquisitions and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing business, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to integration risks, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- We frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- The acquired and/or joint venture businesses may not perform as projected;
- The goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become non-recoverable;
- We may not obtain the projected synergies as we integrate the acquired businesses;
- We may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- We may experience difficulties in integrating acquired businesses into our existing operations (including our internal control environment), be unable to integrate acquired businesses successfully or as quickly as expected, and be unable to realize anticipated economic, operational and/or other benefits in a timely manner or at all, which could result in substantial costs and delays or other operational, technical or financial problems;
- The acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;

- We may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our shareholders;
- We may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- We may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of companies we acquire, which may be difficult or impossible to accomplish;
- We may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, material disruptions to our business and operations and negatively affect our brand and reputation;
- In order to complete a proposed acquisition, we may be required to divest certain portions of our business;
- We may be involved in litigation related to mergers or acquisitions, including for matters which occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- The integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

We expect joint ventures to be a critical part of our business model transformation and inorganic growth strategies. Joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, growing the joint venture's business in a manner acceptable to all the parties, maintaining positive relationships among the joint venture parties and the customer, and member and business disruption that may occur upon joint venture termination.

As we expand our international operations, we will increasingly face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations. Our exposure to these risks is expected to increase.

As we expand our international operations we will increasingly face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, privacy, data storage, location, protection and security.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the Bribery Act 2010) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and management, financial and other resources over a number of years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our business and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our business, operating results, financial position, brand, reputation and/or long-term growth.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, customs and employee relationships that can be difficult, less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business partners, which requires us to manage our partner relationships and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may have an impact on our revenues, operating results and cash flows from our international operations. Some

of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Our exposure to all of the above risks is expected to increase as we seek to grow our foreign operations over the next several years.

Financial Risks

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, business, cash flows, financial position and operating results.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by recognized rating organizations. Credit ratings issued by nationally-recognized organizations are broadly distributed and generally used throughout our industry. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our products to certain of our customers. In addition, our credit ratings impact the cost and availability of future borrowings, and accordingly our cost of capital.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Among other things, our ratings may be affected by the assumption and/or issuance of debt in connection with an acquisition. For example, following the announcement of the Humana Acquisition in July 2015, each of Standard & Poor's, A.M. Best, Fitch and Moody's placed certain of our debt, financial strength and other credit ratings under review for possible downgrade. Following the issuance of the 2016 senior notes, each of Standard & Poor's, A.M. Best and Moody's downgraded certain of our debt, financial strength and other credit ratings by one notch. Downgrades or potential downgrades in our ratings, should they occur, could adversely affect our brand and reputation, business, cash flows, financial position and operating results.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our operating results and/or our financial position.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the United States. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the United States, and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the United States credit markets, and governments' monetary policy, particularly United States monetary policy, can significantly and adversely affect the value of our investment portfolio, our operating results and/or our financial position by:

- Significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders' equity;
- Keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and operating results as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- Reducing the fair values of our investments if interest rates rise;
- Causing non-performance or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;

- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results; and
- Reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure to adequately do so could adversely affect our net income and our financial position and, in extreme circumstances, our cash flows.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our principal office is a building complex that is approximately 1.7 million square feet in size and is located at 151 Farmington Avenue, Hartford, Connecticut. Our principal office is used by all of our business segments. We also own or lease other space in the greater Hartford area, Bethesda, Maryland, Blue Bell, Pennsylvania, and various field locations in the U.S. and several foreign countries. Such properties are primarily used by our Health Care segment. We believe our properties are adequate and suitable for our business as presently conducted.

Item 3. Legal Proceedings

The Information contained under "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K is incorporated by reference herein.

Item 4. Mine Safety Disclosures

Not applicable.

Part II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

Our common shares ("common stock") are listed on the New York Stock Exchange, where they trade under the symbol AET. The following table presents high and low sales prices for our common stock for the periods indicated.

	High	Low
2016		
First quarter	**$ 114.19**	**$ 94.31**
Second quarter	**122.72**	**107.90**
Third quarter	**121.04**	**112.81**
Fourth Quarter	**134.90**	**105.20**
2015		
First quarter	$ 109.26	$ 87.60
Second quarter	132.60	106.08
Third quarter	128.90	105.30
Fourth Quarter	115.34	99.89

Holders of our Common Stock

At January 31, 2017, there were 6,467 record holders of our common stock.

Dividends

The quarterly cash dividend declared by Aetna's Board of Directors (our "Board") was $.25 per share in 2016 and 2015. In 2014, the quarterly cash dividend declared was $.225 for the first, second and third quarters and $.25 for the fourth quarter. On February 17, 2017, our Board declared a cash dividend of $.50 per common share that will be paid on April 28, 2017, to shareholders of record at the close of business on April 13, 2017.

Declaration and payment of future dividends is at the discretion of our Board and may be adjusted as business needs or marketplace conditions change. Information regarding restrictions on our present and future ability to pay dividends is included in "Liquidity and Capital Resources" of MD&A included in Part II, Item 7 and Note 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under our equity compensation plans is incorporated herein by reference to "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" included in Part III, Item 12 in this Annual Report on Form 10-K.

Issuer Purchase of Equity Securities

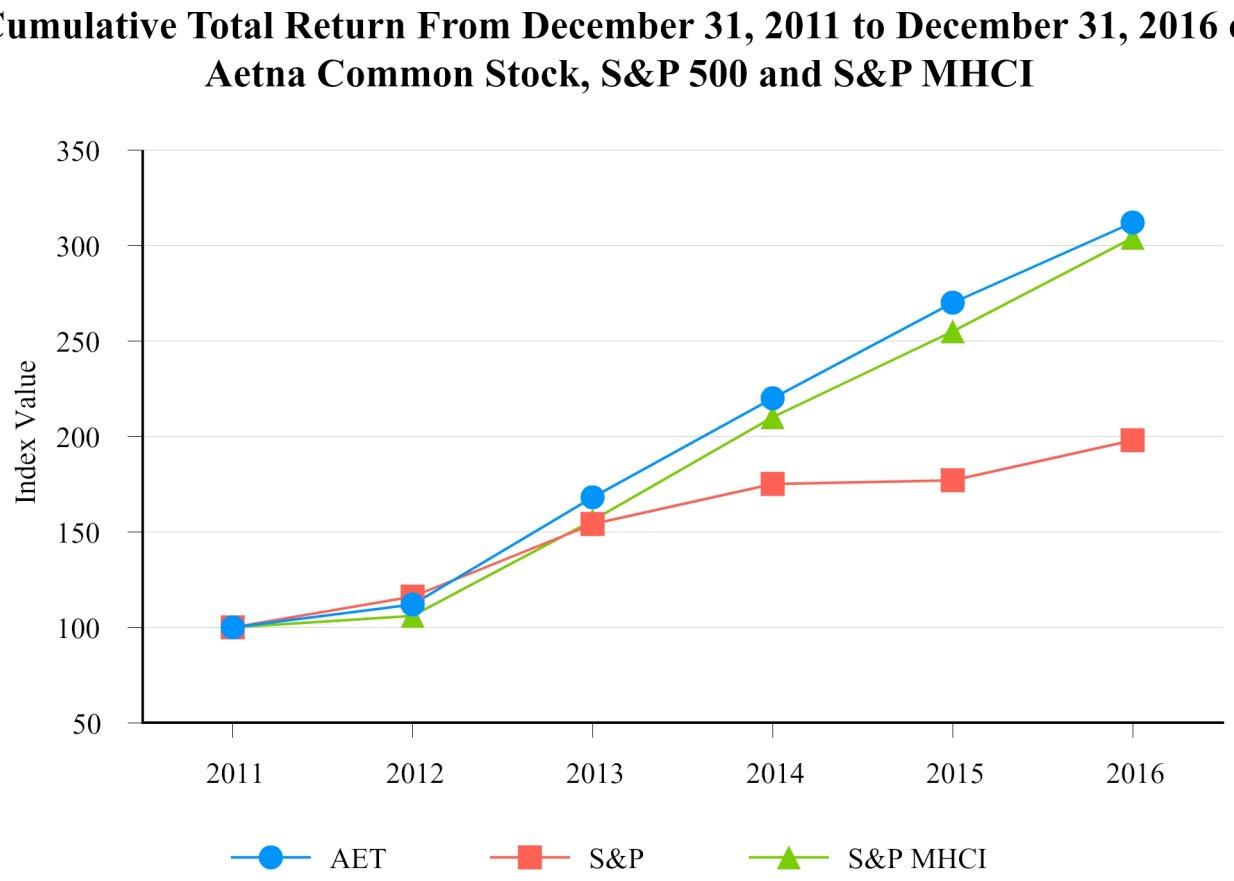
During the three months ended December 31, 2016, we did not repurchase any shares of common stock. At December 31, 2016, we had remaining authorization to repurchase an aggregate of up to approximately $1.1 billion of common stock under our November 21, 2014 and February 28, 2014 programs. On February 17, 2017, our Board approved a new share repurchase program that authorized us to repurchase up to $4.0 billion of our common stock.

Prior to the termination of the Humana Merger Agreement, our ability to repurchase shares of our common stock was limited.

Refer to Note 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K for information regarding our share repurchases including Board authorizations, shares repurchased during 2016 and our remaining share repurchase authorization as of December 31, 2016.

Corporate Performance Graph

The following graph compares the cumulative total shareholder return on our common stock (assuming reinvestment of dividends) with the cumulative total return on the published Standard & Poor's 500 Stock Index ("S&P 500") and the cumulative total return on the published Standard & Poor's Supercomposite Managed Health Care Index ("S&P MHCI") from December 31, 2011 through December 31, 2016. The graph assumes a $100 investment in shares of our common stock on December 31, 2011.



	December 31,					
	2011	2012	2013	2014	2015	2016
AET	$ 100	$ 112	$ 168	$ 220	$ 270	$ 312
S&P	100	116	154	175	177	198
S&P MHCI [1]	100	106	156	210	255	304

[1] At December 31, 2016, the companies included in the S&P MHCI were: Aetna Inc., Anthem, Inc., Centene Corporation, Cigna Corporation, HealthEquity, Inc., Humana Inc., Magellan Health, Inc., Molina Healthcare, Inc., UnitedHealth Group Incorporated and WellCare Health Plans, Inc.

Shareholder returns over the period shown on the corporate performance graph should not be considered indicative of future shareholder returns.

Item 6. Selected Financial Data

The table below provides selected consolidated financial data of Aetna. The information has been derived from our consolidated financial statements for each of the years in the five year period ended December 31, 2016. You should read this selected consolidated financial data in conjunction with MD&A included in Part II, Item 7 of this Annual Report on Form 10-K and the audited consolidated financial statements and notes as of and for the year ended December 31, 2016 included in Part II, Item 8 of this Annual Report on Form 10-K.

	As of and for the Years Ended December 31,				
(Millions, except per common share data)	**2016**	**2015**	**2014**	**2013** [1]	**2012**[1]
Income Statement Data					
Total revenue	**$ 63,155**	$ 60,337	$ 58,003	$ 47,295	$ 36,600
Net income attributable to Aetna	**2,271**	2,390	2,041	1,914	1,658
Net realized capital gains (losses), net of tax	**56**	(42)	52	(7)	71
Per Common Share Data					
Cumulative annual dividends declared	**$ 1.00**	$ 1.00	$ .925	$ .825	$ .725
Net income attributable to Aetna:					
Basic	**6.46**	6.84	5.74	5.38	4.87
Diluted	**6.41**	6.78	5.68	5.33	4.81
Balance Sheet Data					
Total assets [2]	**$ 69,146**	$ 53,509	$ 53,354	$ 49,723	$ 41,341
Short-term debt	**—**	—	500	—	—
Long-term debt [2]	**20,661**	7,785	8,033	8,210	6,435
Total Aetna shareholders' equity	**17,881**	16,114	14,483	14,026	10,406

(1) We acquired Coventry Health Care, Inc. ("Coventry") in May 2013, which impacts the comparability of operating results for the years ended December 31, 2013 to 2016 to prior periods.

(2) Amounts as of December 31, 2012 to 2015 have been retroactively restated to reflect the reclassification of debt issuance costs from other current and long-term assets to a reduction of long-term debt as a result of the adoption of new accounting guidance during the year ended December 31, 2016.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A")

OVERVIEW

We are one of the nation's leading diversified health care benefits companies, serving an estimated 46.7 million people. We have the information and resources to help our members, in consultation with their health care professionals, make better informed decisions about their health care. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, medical management capabilities, Medicaid health care management services, Medicare Advantage and Medicare Supplement plans, workers' compensation administrative services and health information technology ("HIT") products and services. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions.

The following MD&A provides a review of our financial condition at December 31, 2016 and December 31, 2015 and operating results for the years ended December 31, 2016, 2015 and 2014. This Overview should be read in conjunction with the entire MD&A, which contains detailed information that is important to understanding our operating results and financial condition, the consolidated financial statements and other data presented in this Annual Report on Form 10-K. This Overview is qualified in its entirety by the full MD&A.

Summarized Results

				Change			
				2016 vs. 2015		2015 vs. 2014	
(Millions, except total medical membership)	**2016**	**2015**	**2014**	**$**	**%**	**$**	**%**
Total revenue	**$ 63,155**	$ 60,337	$ 58,003	$ 2,818	5 %	$ 2,334	4 %
Net income attributable to Aetna	**2,271**	2,390	2,041	(119)	(5)%	349	17 %
Operating earnings [(1)]	**2,917**	2,717	2,405	200	7 %	312	13 %
Total medical membership (in thousands)	**23,110**	23,487	23,548	(377)	(2)%	(61)	— %
Cash flows from operations	**3,719**	3,866	3,373	(147)	(4)%	493	15 %

(1) Operating earnings excludes from net income attributable to Aetna net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K.

Our discussion of operating results for our reportable business segments is based on operating earnings, which is a non-GAAP measure of net income attributable to Aetna (the term "GAAP" refers to U.S. generally accepted accounting principles). Non-GAAP financial measures we disclose, such as operating earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. Refer to "Segment Results and Use of Non-GAAP Measures in this Document" below in this MD&A for a discussion of non-GAAP measures. Refer to Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K for a reconciliation of net income attributable to Aetna to operating earnings.

Commentary - 2016 compared to 2015

- *Net income attributable to Aetna* decreased $119 million in 2016 compared to 2015 primarily due to an increase in restructuring costs which include a $215 million ($330 million pre-tax) expense recorded during 2016 related to our previously announced voluntary early retirement program, higher transaction and integration-related costs and the favorable impact of litigation-related proceeds recorded during 2015. The decrease was partially offset by the increase in operating earnings described below, net realized capital gains during 2016 compared with net realized capital losses during 2015 and the favorable impact of the 2016 reduction of our reserve for anticipated future losses on discontinued products.
- *Operating earnings* increased $200 million in 2016 compared to 2015, primarily as a result of higher fees and other revenue in our Health Care segment.
- *Total revenue* increased approximately $2.8 billion during 2016 compared to 2015, primarily due to to higher premiums in our Health Care segment.

- *Total medical membership* at December 31, 2016 decreased 377 thousand members compared to December 31, 2015, primarily reflecting declines in our Commercial business, partially offset by growth in our Government business. Refer to "Health Care - Membership" below in this MD&A for further information.

Commentary - 2015 compared to 2014

- *Net income attributable to Aetna* increased $349 million in 2015 compared to 2014 primarily due to the increase in operating earnings described below and the loss on early extinguishment of long-term debt recorded in 2014, partially offset by net realized capital losses in 2015 compared with net realized capital gains in 2014.
- *Operating earnings* increased $312 million in 2015 compared to 2014 primarily as a result of higher underwriting margins (calculated as premiums less health care costs) and higher fees and other revenue in our Health Care segment, partially offset by an increase in general and administrative expenses.
- *Total revenue* increased $2.3 billion in 2015 compared to 2014 primarily due to membership growth in our Government business as well as higher Health Care premium yields, partially offset by membership losses in our group Commercial Insured products.
- *Total medical membership* at December 31, 2015 remained relatively flat compared to December 31, 2014, primarily reflecting declines in our Commercial Insured products substantially offset by growth in our Medicare and Medicaid products. Refer to "Health Care - Membership" below in this MD&A for further information.

During the past three years our cash flows supported both new and ongoing initiatives.
We generated substantial cash flows in the past three years, which we used to support our ordinary course operating activities; increase cash and cash equivalents in preparation for our then proposed acquisition of Humana Inc. (the "Humana Acquisition"); repurchase our common stock; repurchase our long-term debt; and pay shareholder dividends. During 2016, we issued $13 billion of senior notes to partially fund the Humana Acquisition. We did not repurchase any shares of our common stock in 2016. During 2015 and 2014, we repurchased 3 million and 16 million shares of our common stock, respectively, at a cost of $296 million and approximately $1.2 billion, respectively, under share repurchase programs authorized by our Board. Prior to the termination of the Merger Agreement (as defined below), our ability to repurchase shares of our common stock was limited. Refer to Note 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on share repurchases.

Refer to "Liquidity and Capital Resources" below in this MD&A for additional information on our primary sources and uses of cash flows.

Outlook for 2017
In August 2016, we announced that we would reduce our participation on the individual public health insurance exchanges established pursuant to the ACA ("Public Exchanges") to 242 counties for the 2017 plan year from the 778 counties we served in the 2016 plan year. We have maintained an on-Public Exchange presence for the 2017 plan year in Delaware, Iowa, Nebraska and Virginia. We have modified our off-Public Exchange product options for 2017 in the vast majority of counties where we offered individual Public Exchange products in 2016, which may adversely affect 2017 membership and premium in those counties. Based on our current view of open enrollment, we project first quarter 2017 Individual Commercial products membership will decline from approximately 965 thousand members at December 31, 2016 to approximately 240 thousand members at March 31, 2017.

We see the following opportunities in 2017:

- Projected growth in our Commercial business operating earnings, including a reduced level of losses in our Individual Commercial products;
- Projected continued Medicare top-line growth primarily due to continued strong growth in our Individual Medicare Advantage products; and
- The resumption of share repurchase activity.

In 2017, we also project the following challenges:

- The projected negative impact on operating earnings of known state Medicaid contract losses; and
- Lower projected Group Insurance segment operating earnings.

Refer to "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K for information regarding other important factors that may cause our actual results to differ from those currently projected and/or otherwise materially affect us.

Terminated Acquisition of Humana and Terminated Divestiture to Molina

On July 2, 2015, we entered into a definitive agreement (the "Merger Agreement") to acquire Humana Inc. ("Humana") in a transaction valued at approximately $37 billion, based on the closing price of Aetna common shares on July 2, 2015, including the assumption of Humana debt and Humana cash and cash equivalents.

On July 21, 2016, the U.S. Department of Justice (the "DOJ") and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that the Humana Acquisition would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Acquisition. On February 14, 2017, Aetna and Humana entered into a mutual termination agreement (the "Termination Agreement") pursuant to which the parties thereto (collectively, the "Parties") agreed to terminate the Merger Agreement, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby, entered pursuant thereto or entered in connection therewith (other than certain confidentiality agreements) (collectively with the Merger Agreement, the "Transaction Documents"), effective immediately as of February 14, 2017 (the "Termination Date"). Under the Termination Agreement, Aetna agreed to pay Humana the Regulatory Termination Fee (as defined in the Merger Agreement) of $1.0 billion in cash in full satisfaction of any amounts required to be paid by Aetna under the Merger Agreement. The Parties also agreed to release each other from any and all liability, claims, rights, actions, causes of action, suits, liens, obligations, accounts, debts, demands, agreements, promises, liabilities, controversies, costs, charges, damages, expenses and fees, however arising, in connection with, arising out of or related to the Transaction Documents, the transactions contemplated therein or thereby or certain related matters. We paid Humana the Regulatory Termination Fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes (as defined below).

In June 2016, we issued $13.0 billion of senior notes to partially fund the Humana Acquisition (collectively, the "2016 senior notes"). In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for $10.2 billion aggregate principal amount of certain of the 2016 senior notes (collectively, the "Special Mandatory Redemption Notes") at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem the Special Mandatory Redemption Notes on or about March 16, 2017, and we expect to fund the redemption with the proceeds of the 2016 senior notes. As a result of the redemption of the Special Mandatory Redemption Notes, in the first quarter of 2017, we will recognize on a pretax basis in our net income the entire approximately $420 million unamortized portion of the related cash flow hedge losses, debt issuance costs and debt issuance discounts and the entire approximately $100 million redemption premium paid on the Special Mandatory Redemption Notes upon such redemption.

In order to address the DOJ's perceived competitive concerns regarding Medicare Advantage relating to the Humana Acquisition, on August 2, 2016, we entered into a definitive agreement (the "Aetna APA") to sell for cash to Molina Healthcare, Inc. ("Molina") certain of our Medicare Advantage assets. On February 14, 2017, Aetna and Molina entered into a Termination Agreement (the "APA Termination Agreement") pursuant to which Aetna terminated the Molina APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, Aetna agreed to pay Molina in cash (a) a termination fee of $53 million and (b) approximately 70% of Molina's transaction costs. We paid Molina the termination fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes. We expect to pay Molina the applicable transaction costs during the first quarter of 2017.

Refer to Notes 3 "Acquisitions, Terminated Acquisition and Terminated Divestiture" and 9 "Debt" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the Humana Acquisition.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") has made broad-based changes to the U.S. health care system. On January 20, 2017, the President signed an executive order that gives the regulatory agencies that enforce the ACA the authority to interpret regulations issued under the ACA in a way that limits fiscal burdens on states and financial or regulatory burdens on individuals, providers, health insurers and others. The practical implications of that order are unclear, and the future of the ACA is uncertain. While we anticipate efforts in 2017 and beyond to substantially modify, repeal or replace the ACA, we expect aspects of the ACA to continue to significantly impact our business operations and operating results, including our pricing, our MBRs and the geographies in which our products are available. The ACA has presented us with business opportunities, but also with financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, including Public Exchanges, required minimum MLRs in Commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's CMS quality performance ratings or "star ratings." The effects of these changes are reflected in our operating results. If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2020.

During the years ended December 31, 2016, 2015 and 2014, we paid the following fees and contributions required by the ACA:

(Millions)	2016	2015	2014
Current year HIF	$ 837	$ 856	$ 605
Estimated current year ACA reinsurance contribution	114	185	298
Remaining portion of prior year ACA reinsurance contribution	62	60	—

In December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the ACA's health insurer fee (the "HIF").

Ongoing legislative and regulatory changes to the ACA, other pending efforts in the U.S. Congress to amend or restrict funding for various aspects of the ACA (including risk corridors), the results of the 2016 presidential, congressional and state level elections, pending litigation challenging aspects of the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Examples of recent legislative and regulatory changes include: the January 20, 2017 executive order relating to the ACA; the November 2016 HHS announcement that risk corridor collections for the 2015 program year will be applied first to amounts owed to plans for the 2014 program year; the May 2016 final regulations relating to the ACA's non-discrimination requirements; the December 2015 suspension of the HIF for 2017 and two year delay of the "Cadillac" tax on high-cost employer-sponsored health coverage; the October 2015 PACE, which leaves groups with 51 to 100 employees within the large group category for each state unless the state exercises its option to include these groups within the small group category; and the October 2015 HHS announcement that the ACA's risk corridor receivables for the 2014 program year would only be funded at 12.6%. With respect to pending litigation, in May 2016, the U.S. District Court for the District of Columbia ruled that the U.S. Department of Health and Human Services does not have the authority to make payments under the ACA's Cost Sharing Subsidy program. Implementation of this decision has been stayed pending appeal.

As described above, the availability of funding for the ACA's temporary risk corridor program is an example of this uncertainty. We continue to believe that receipt of any risk corridor payment from HHS for the 2016 or 2015 program year and receipt of such payments in excess of the announced prorated amount for the 2014 program year are uncertain. At December 31, 2016, we had an immaterial receivable for the remaining 2014 program year prorated amount that had not been collected from HHS and no receivable for either of the 2015 or 2016 program years. In addition, these limited risk corridor payments created additional instability in the marketplace for individual Commercial products in 2016 and going forward by contributing to decisions by health plans to change or stop offering their Public Exchange products. 2016 was the last program year for the ACA's risk corridor program. On-going uncertainty regarding the funding of ACA-related programs and subsidies can be expected to create additional instability in the marketplace.

The federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system. We cannot predict whether pending or future federal or state legislation or court proceedings, including future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or the ACA or the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

For additional information on the ACA, refer to "Regulatory Environment" below in this MD&A and Notes 2 "Summary of Significant Accounting Policies" and 8 "The ACA's Reinsurance, Risk Adjustment and Risk Corridor" included in Part II, Item 8 of this Annual Report on Form 10-K. For a discussion of certain factors that may cause our actual results to differ from currently anticipated results in connection with the ACA, refer to "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K.

Medicare Update
On April 5, 2016, CMS issued its final notice detailing final 2017 Medicare Advantage benchmark payment rates (the "Final Notice"). The Final Notice provides for rate cuts to the employer group waiver program that will begin in 2017 and be fully phased in for 2018 as well as adverse changes to the risk adjustment mechanism for dual eligible beneficiaries and the Medicare Advantage star rating program. Overall, we project the benchmark rates in the Final Notice will decrease funding for our Medicare Advantage business by less than 1 percent in 2017 compared to 2016.

The ACA ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released our 2017 star ratings in October 2016. Our 2017 star ratings will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2018. Based on our membership at December 31, 2016, 92% of our Medicare Advantage members were in plans with 2017 star ratings of at least 4.0 stars, compared to 85% of our Medicare Advantage members being in plans with 2016 star ratings of at least 4.0 stars based on our membership at December 31, 2015. During 2016, our star ratings resulted in additional revenue of approximately $560 million, inclusive of bonus payments and rebates.

Voluntary Early Retirement Program
In September 2016, we announced a voluntary early retirement program (the "Program"). Under the terms of the Program, eligible employees elected early retirement during the fourth quarter of 2016. In connection with the Program, we recorded an expense of $330 million pretax for the year ended December 31, 2016.

Management Update
Thomas J. Sabatino, Jr., Executive Vice President and General Counsel, joined Aetna in April 2016 and succeeded William J. Casazza who decided to retire and agreed to continue to serve as a strategic advisor to Aetna in connection with the Humana Acquisition until March 2017.

Segment Results and Use of Non-GAAP Measures in this Document
The following discussion of operating results is presented based on our reportable segments in accordance with the accounting guidance for segment reporting and is consistent with our segment disclosure included in Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment; it is added to our business segments to reconcile our segment reporting to our consolidated results. The Corporate Financing segment includes interest expense on our outstanding debt and the financing components of our pension and other postretirement employee benefit plans ("OPEB") expense (the service cost and prior service cost components of this expense are allocated to our business segments).

Operating earnings discussed in this Annual Report on Form 10-K exclude from net income attributable to Aetna reported in accordance with GAAP net realized capital gains or losses, amortization of other acquired intangible assets and other items, if any, that neither relate to the ordinary course of our business nor reflect our underlying business performance. Although the excluded items may recur, we believe excluding them from net income attributable to Aetna to arrive at operating earnings provides a more useful comparison of our underlying business performance from period to period. Net realized capital gains and losses arise from various types of transactions, primarily in the course of managing a portfolio of assets that support the payment of liabilities. Amortization of other acquired intangible assets relates to our acquisition activities, including Coventry Health Care, Inc. ("Coventry"), the InterGlobal Group ("InterGlobal") and bswift LLC ("bswift"). These transactions and amortization do not directly relate to the underwriting or servicing of products for our customers and are not directly related to the core performance of our business operations. Operating earnings is the measure reported to our Chief Executive Officer for purposes of assessing financial performance and making operating decisions, such as the allocation of resources among our business segments. In each business segment discussion in this MD&A, we provide a table that reconciles net income attributable to Aetna to operating earnings. Each table details the net realized capital gains or losses, amortization of other acquired intangible assets and any other items excluded from net income attributable to Aetna, and the footnotes to each table describe the nature of each other item and the reason we believe it is appropriate to exclude that item from net income

attributable to Aetna. Non-GAAP financial measures we disclose, such as operating earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

HEALTH CARE

Health Care consists of medical, pharmacy benefit management services, dental, behavioral health and vision plans offered on both an Insured basis (where we assume all or a majority of the risk for medical and dental care costs) and an employer-funded basis (where the plan sponsor under an administrative services contract ("ASC") assumes all or a majority of this risk) and emerging businesses products and services that complement and enhance our medical products. We also offer Medicare and Medicaid products and services and other medical products, such as medical management and data analytics services, medical stop loss insurance, workers' compensation administrative services and products that provide access to our provider networks in select geographies. We separately track premiums and health care costs for Government businesses (which represent our combined Medicare and Medicaid products). All other medical, dental and other Health Care products are referred to as Commercial.

Operating Summary

				Change			
				2016 vs. 2015		2015 vs. 2014	
(Millions)	**2016**	**2015**	**2014**	**$**	**%**	**$**	**%**
Premiums:							
Commercial	**$ 27,916**	$ 28,709	$ 28,563	$ (793)	(3)%	$ 146	1 %
Government	**26,200**	22,909	20,999	3,291	14 %	1,910	9 %
Total premiums	**54,116**	51,618	49,562	2,498	5 %	2,056	4 %
Fees and other revenue	**5,744**	5,585	5,115	159	3 %	470	9 %
Net investment income	**458**	408	368	50	12 %	40	11 %
Net realized capital gains (losses)	**52**	(50)	64	102	204 %	(114)	(178)%
Total revenue	**60,370**	57,561	55,109	2,809	5 %	2,452	4 %
Health care costs:							
Commercial	**22,896**	23,057	22,918	(161)	(1)%	139	1 %
Government	**21,359**	18,655	17,829	2,704	14 %	826	5 %
Total health care costs	**44,255**	41,712	40,747	2,543	6 %	965	2 %
Operating expenses:							
Selling expenses	**1,545**	1,490	1,537	55	4 %	(47)	(3)%
General and administrative expenses	**10,099**	9,766	8,801	333	3 %	965	11 %
Total operating expenses	**11,644**	11,256	10,338	388	3 %	918	9 %
Amortization of other acquired intangible assets	**247**	255	242	(8)	(3)%	13	5 %
Total benefits and expenses	**56,146**	53,223	51,327	2,923	5 %	1,896	4 %
Income before income taxes	**4,224**	4,338	3,782	(114)	(3)%	556	15 %
Income tax expense	**1,856**	1,908	1,587	(52)	(3)%	321	20 %
Net income including non-controlling interests	**2,368**	2,430	2,195	(62)	(3)%	235	11 %
Less: Net (loss) income attributable to non-controlling interests	**(15)**	3	2	(18)	(600)%	1	50 %
Net income attributable to Aetna for Health Care	**$ 2,383**	$ 2,427	$ 2,193	$ (44)	(2)%	$ 234	11 %

We calculate our medical benefit ratio ("MBR") by dividing health care costs by health care premiums. Our Commercial, Government and Total Health Care MBRs for the last three years were:

				Change (basis points)	
	2016	**2015**	**2014**	**2016 vs. 2015**	**2015 vs. 2014**
Commercial	**82.0%**	80.3%	80.2%	170	10
Government	**81.5%**	81.4%	84.9%	10	(350)
Total Health Care	**81.8%**	80.8%	82.2%	100	(140)

The table presented below reconciles net income attributable to Aetna to operating earnings [1] for our Health Care segment:

(Millions)	2016	2015	2014
Net income attributable to Aetna for Health Care	**$ 2,383**	$ 2,427	$ 2,193
Transaction and integration-related costs	**230**	208	201
Restructuring costs	**404**	15	—
Release of litigation-related reserve	**—**	—	(103)
Litigation-related proceeds	**—**	(110)	—
Amortization of other acquired intangible assets	**247**	255	242
Net realized capital (gains) losses	**(52)**	50	(64)
Income tax benefit	**(264)**	(133)	(92)
Operating earnings for Health Care	**$ 2,948**	$ 2,712	$ 2,377

[1] Operating earnings excludes net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K.

Commentary - 2016 compared to 2015

- *Net income attributable to Aetna for Health Care* decreased $44 million in 2016 compared to 2015, primarily as a result of an increase in restructuring costs and the favorable impact of litigation-related proceeds recorded during 2015, substantially offset by the increase in operating earnings described below and net realized capital gains during 2016 compared with net realized capital losses during 2015.
- *Operating earnings* increased by $236 million in 2016 compared to 2015, primarily as a result of higher underwriting margins in our Government business, higher fees and other revenue primarily due to higher average fee yields, and lower general and administrative expenses. The increase was partially offset by lower underwriting margins in Aetna's Commercial business.
- *Commercial premiums* were $793 million lower in 2016 than 2015, primarily as a result of membership losses in our Commercial Insured products, partially offset by higher premium yields.
- *Our Commercial MBR* increased 170 basis points over the prior year. The increase in our Commercial MBR is primarily due to higher medical costs in our Individual Commercial products and performance in our Middle Market Commercial products.
- *Government premiums* were approximately $3.3 billion higher in 2016 than 2015 primarily due to membership growth in our Government business.
- *Our Government MBR* remained consistent in 2016 compared to 2015 reflecting higher MBRs in our Medicaid products and lower favorable development of prior-year health care cost estimates in 2016, offset by improved performance in our Medicare products.
- *Health Care fees and other revenue* for 2016 increased $159 million compared to 2015 primarily due to higher average fee yields in 2016, partially offset by the favorable impact of $110 million pretax of net litigation-related proceeds recorded in 2015.
- *General and administrative expenses* increased by $333 million during 2016 compared to 2015 primarily due to an increase in restructuring costs, which include a $330 million expense recorded during 2016 related to our previously announced voluntary early retirement program.
- *Our effective tax rate* was 44 percent in both 2016 and 2015.

Commentary - 2015 compared to 2014

- *Net income attributable to Aetna for Health Care* increased by $234 million in 2015 compared to 2014, primarily as a result of the increase in operating earnings described below and the favorable impact of $110 million pretax of net litigation-related proceeds recorded in 2015, partially offset by net realized capital losses in 2015 compared with net realized capital gains in 2014, as well as 2014 net income including the favorable impact of the release of a litigation-related reserve.
- *Operating earnings* increased by $335 million in 2015 compared to 2014, primarily as a result of higher underwriting margins in our Government business and higher fees and other revenue, partially offset by an increase in general and administrative expenses.

- *Commercial premiums* were $146 million higher in 2015 than 2014, primarily as a result of higher premium yields partially offset by membership losses in our group Commercial Insured products and an increase in net ACA risk adjustment payables recorded in 2015.
- *Our Commercial MBR* increased 10 basis points in 2015 compared to 2014 primarily due to performance in our ACA compliant products substantially offset by improved performance in our group Commercial products.
- *Government premiums* were approximately $1.9 billion higher in 2015 compared to 2014 primarily due to membership growth in both our Medicare and Medicaid Insured products.
- Our *Government MBR* improved 350 basis points in 2015 compared with 2014 primarily as a result of actions impacting revenue and medical costs designed to solve for the gap between Medicare premiums and medical costs and other expenses and improved performance in our Medicaid products.
- *Health Care fees and other revenue* for 2015 increased $470 million compared to 2014 primarily as a result of higher average fee yields, the favorable impact of $110 million pretax of net litigation-related proceeds recorded in 2015 and growth in our Commercial ASC membership.
- *General and administrative expenses* increased by $965 million during 2015 compared to 2014 primarily due to higher employee-related costs, increased investment spend to support our growth initiatives and 2014 operating results including the favorable impact of the release a litigation-related reserve. Refer to Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the release of the litigation-related reserve.
- *Our effective tax rate* was 44 percent in 2015 compared to 42 percent in 2014. The increase in 2015 compared to 2014 primarily reflects a higher 2015 non-tax deductible HIF, partially offset by lower estimated state taxes.

Membership

Health Care's membership at December 31, 2016 and 2015 was:

	2016			2015			Change 2016 vs. 2015		
(Thousands)	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical:									
Commercial	**5,457**	**13,132**	**18,589**	5,777	13,593	19,370	(320)	(461)	(781)
Medicare Advantage	**1,362**	**—**	**1,362**	1,251	—	1,251	111	—	111
Medicare Supplement	**685**	**—**	**685**	566	—	566	119	—	119
Medicaid [1]	**1,668**	**806**	**2,474**	1,529	771	2,300	139	35	174
Total Medical Membership	**9,172**	**13,938**	**23,110**	9,123	14,364	23,487	49	(426)	(377)
Dental:									
Total Dental Membership	**6,086**	**8,386**	**14,472**	6,243	8,391	14,634	(157)	(5)	(162)
Pharmacy:									
Commercial			**9,400**			10,237			(837)
Medicare PDP (stand-alone)			**2,067**			1,466			601
Medicare Advantage PDP			**953**			863			90
Medicaid [1]			**2,783**			2,587			196
Total Pharmacy Benefit Management Services			**15,203**			15,153			50

[1] Medicaid membership includes members who are dually-eligible for both Medicare and Medicaid.

Commentary - 2016 compared to 2015

- *Total medical membership* at December 31, 2016 decreased 377 thousand members compared to December 31, 2015, primarily reflecting membership declines in our Commercial business, partially offset by growth in our Government business.
- *Total dental membership* at December 31, 2016 decreased 162 thousand members compared to December 31, 2015 primarily reflecting membership declines in our Insured dental products.

- T*otal pharmacy benefit management services membership* remained relatively flat at December 31, 2016 compared to December 31, 2015 primarily reflecting membership growth in our Government business, substantially offset by membership declines in our Commercial business.

GROUP INSURANCE

Group Insurance primarily includes group life insurance and group disability products. Group life insurance products are offered on an Insured basis. Group disability products are offered to employers on both an Insured and an ASC basis. Group Insurance also includes long-term care products that were offered primarily on an Insured basis. We no longer solicit or accept new long-term care customers.

Operating Summary

				Change			
				2016 vs. 2015		2015 vs. 2014	
(Millions)	**2016**	**2015**	**2014**	**$**	**%**	**$**	**%**
Premiums:							
Life	**$ 1,142**	$ 1,216	$ 1,241	$ (74)	(6)%	$ (25)	(2)%
Disability	**957**	879	825	78	9 %	54	7 %
Long-term care	**44**	44	44	—	— %	—	— %
Total premiums	**2,143**	2,139	2,110	4	— %	29	1 %
Fees and other revenue	**108**	101	104	7	7 %	(3)	(3)%
Net investment income	**226**	238	261	(12)	(5)%	(23)	(9)%
Net realized capital gains	**24**	—	15	24	100 %	(15)	(100)%
Total revenue	**2,501**	2,478	2,490	23	1 %	(12)	— %
Current and future benefits	**1,850**	1,837	1,798	13	1 %	39	2 %
Operating expenses:							
Selling expenses	**133**	121	116	12	10 %	5	4 %
General and administrative expenses	**353**	346	337	7	2 %	9	3 %
Total operating expenses	**486**	467	453	19	4 %	14	3 %
Amortization of other acquired intangible assets	**—**	—	2	—	— %	(2)	(100)%
Total benefits and expenses	**2,336**	2,304	2,253	32	1 %	51	2 %
Income before income taxes	**165**	174	237	(9)	(5)%	(63)	(27)%
Income tax expense	**26**	38	57	(12)	(32)%	(19)	(33)%
Net income attributable to Aetna for Group Insurance	**$ 139**	$ 136	$ 180	$ 3	2 %	$ (44)	(24)%

We calculate our group benefit ratio by dividing current and future benefits by total premiums. Our group benefit ratios for the last three years were:

				Change (basis points)	
	2016	**2015**	**2014**	**2016 vs. 2015**	**2015 vs. 2014**
Group benefit ratio	**86.3%**	85.9%	85.2%	40	70

The table presented below reconciles net income attributable to Aetna to operating earnings [1] for our Group Insurance segment:

(Millions)	2016	2015	2014
Net income attributable to Aetna for Group Insurance	**$ 139**	$ 136	$ 180
Amortization of other acquired intangible assets	**—**	—	2
Net realized capital gains	**(24)**	—	(15)
Income tax expense	**9**	—	4
Operating earnings for Group Insurance	**$ 124**	$ 136	$ 171

[1] Operating earnings excludes net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K.

Commentary - 2016 compared to 2015

- *Net income attributable to Aetna for Group Insurance* for 2016 remained relatively flat compared to 2015 primarily due to higher net realized capital gains in 2016, substantially offset by the decrease in operating earnings described below.
- *Operating earnings* for 2016 declined by $12 million compared to 2015, primarily due to lower underwriting margins (calculated as premiums less current and future benefits) in our disability products and higher operating expenses, partially offset by improved underwriting margins in our long-term care products.
- *Our group benefit ratio* increased by 40 basis points in 2016 over the prior year, primarily due to lower underwriting margins in our disability products, partially offset by improved underwriting margins in our long-term care products.

Commentary - 2015 compared to 2014

- *Net income attributable to Aetna for Group Insurance* for 2015 declined by $44 million compared to 2014 primarily due to the decrease in operating earnings described below and higher net realized capital gains in 2014.
- *Operating earnings* for 2015 declined by $35 million compared to 2014, primarily due to lower underwriting margins in our long-term care and life products as well as lower net investment income, partially offset by higher underwriting margins in our disability products.
- *Our group benefit ratio* increased by 70 basis points in 2015 over the prior year, primarily due to due to lower underwriting margins in our long-term care and life products partially offset by higher underwriting margins in our disability products.

LARGE CASE PENSIONS

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. These products provide a variety of funding and benefit payment distribution options and other services. The Large Case Pensions segment also includes certain discontinued products.

Operating Summary

				Change			
				2016 vs. 2015		2015 vs. 2014	
(Millions)	2016	2015	2014	$	%	$	%
Premiums	**$ 39**	$ 32	$ 76	$ 7	22 %	$ (44)	(58)%
Net investment income	**226**	271	317	(45)	(17)%	(46)	(15)%
Other revenue	**9**	10	10	(1)	(10)%	—	— %
Net realized capital gains (losses)	**10**	(15)	2	25	167 %	(17)	(850)%
Total revenue	**284**	298	405	(14)	(5)%	(107)	(26)%
Current and future benefits	**251**	284	367	(33)	(12)%	(83)	(23)%
General and administrative expenses	**13**	13	12	—	— %	1	8 %
Reduction of reserve for anticipated future losses on discontinued products	**(128)**	—	—	(128)	(100)%	—	— %
Total benefits and expenses	**136**	297	379	(161)	(54)%	(82)	(22)%
Income before income tax expense (benefit)	**148**	1	26	147	14,700 %	(25)	(96)%
Income tax expense (benefit)	**44**	(9)	1	53	589 %	(10)	(1,000)%
Net income including non-controlling interests	**104**	10	25	94	940 %	(15)	(60)%
Less: Net income attributable to non-controlling interests	**—**	2	3	(2)	(100)%	(1)	(33)%
Net income attributable to Aetna for Large Case Pensions	**$ 104**	$ 8	$ 22	$ 96	1,200 %	$ (14)	(64)%

The table presented below reconciles net income attributable to Aetna to operating earnings [(1)] for our Large Case Pensions segment:

(Millions)	2016	2015	2014
Net income attributable to Aetna for Large Case Pensions	**$ 104**	$ 8	$ 22
Net realized capital (gains) losses	**(10)**	15	(2)
Reduction of reserve for anticipated future losses on discontinued products	**(128)**	—	—
Income tax expense (benefit)	**48**	(6)	1
Operating earnings for Large Case Pensions	**$ 14**	$ 17	$ 21

(1) Operating earnings excludes net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K.

Commentary - 2016 compared to 2015

- *Total revenue* decreased by $14 million in 2016 compared to 2015, primarily as a result of lower net investment income, partially offset by net realized capital gains during 2016 compared with net realized capital losses during 2015.
- *Net income attributable to Aetna for Large Case Pensions* for 2016 increased by $96 million compared to 2015. The increase was primarily due to the 2016 reduction of our reserve for anticipated future losses on discontinued products, which was primarily due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve.

Commentary - 2015 compared to 2014

- *Total revenue* decreased by $107 million in 2015 compared to 2014, primarily as a result of lower net investment income in 2015 and lower premiums due to the discontinuance of certain services under an existing customer contract during 2014, which resulted in a corresponding reduction in current and future benefits during 2015.
- *Net income attributable to Aetna for Large Case Pensions* for 2015 declined by $14 million compared to 2014, primarily due to net realized capital losses in 2015 compared with net realized capital gains in 2014.

Discontinued Products
Prior to 1993, we sold single-premium annuities ("SPAs") and guaranteed investment contracts ("GICs"), primarily to employer sponsored pension plans. In 1993, we discontinued selling these products to Large Case Pensions customers, and now we refer to these products as discontinued products. We discontinued selling these products because they were generating losses for us, and we projected that they would continue to generate losses over their life (which is currently greater than 30 years for SPAs); so we established a reserve for anticipated future losses at the time of discontinuance. In November 2016, the last outstanding GIC matured.

The operating summary for Large Case Pensions above includes revenues and expenses related to our discontinued products, with the exception of net realized capital gains and losses which are recorded as part of current and future benefits. Since we established a reserve for anticipated future losses on discontinued products, as long as our expected future losses remain consistent with prior projections, the results of our discontinued products are applied against the reserve and do not impact net income attributable to Aetna. If actual or expected future losses are greater than we currently estimate, we may increase the reserve, which could adversely impact net income attributable to Aetna. If actual or expected future losses are less than we currently estimate, we may decrease the reserve, which could favorably impact net income attributable to Aetna. In those cases, we disclose such adjustment separately in the operating summary. Management reviews the adequacy of the discontinued products reserve quarterly. As a result of this review, $84 million ($128 million pretax) of the reserve was released in 2016, and no releases were made to the reserve in 2015 or 2014. This reserve release was primarily due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve. The current reserve reflects management's best estimate of anticipated future losses, and is included in future policy benefits on our balance sheet.

Refer to Note 19 "Discontinued Products" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the activity in the reserve for anticipated future losses on discontinued products during 2016, 2015 and 2014.

LIQUIDITY AND CAPITAL RESOURCES

Cash Flows
We meet our operating cash requirements by maintaining liquidity in our investment portfolio, using overall cash flows from premiums, fees and other revenue, deposits and income received on investments, issuing commercial paper, entering into repurchase agreements and obtaining cash advances from the Federal Home Loan Bank of Boston (the "FHLBB") from time to time. We monitor the duration of our investment portfolio of highly marketable debt securities and mortgage loans, and execute purchases and sales of these investments with the objective of having adequate funds available to satisfy our maturing liabilities. Overall cash flows are used primarily for claim and benefit payments, operating expenses, share and debt repurchases, repayment of debt, acquisitions, contract withdrawals and shareholder dividends. We have committed short-term borrowing capacity of $2.0 billion through a revolving credit facility agreement that expires in March 2020.

Presented below is a condensed statement of cash flows for each of the last three years. We present net cash flows used for operating activities and net cash flows provided by investing activities separately for our Large Case Pensions segment because changes in the insurance reserves for the Large Case Pensions segment (which are reported as cash used for operating activities) are funded from the sale of investments (which are reported as cash provided by investing activities). Refer to the Consolidated Statements of Cash Flows included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

				Change			
				2016 vs. 2015		2015 vs. 2014	
(Millions)	2016	2015	2014	$	%	$	%
Cash flows from operating activities							
Health Care and Group Insurance	**$ 3,988**	$ 4,388	$ 3,601	$ (400)	(9)%	$ 787	22 %
Large Case Pensions	**(269)**	(522)	(228)	253	48 %	(294)	(129)%
Net cash provided by operating activities	**3,719**	3,866	3,373	(147)	(4)%	493	15 %
Cash flows from investing activities							
Health Care and Group Insurance	**(628)**	(1,663)	(2,453)	1,035	62 %	790	32 %
Large Case Pensions	**247**	636	323	(389)	(61)%	313	97 %
Net cash used for investing activities	**(381)**	(1,027)	(2,130)	646	63 %	1,103	52 %
Net cash provided by (used for) financing activities	**12,134**	(1,735)	(1,235)	13,869	799 %	(500)	(40)%
Net increase (decrease) in cash and cash equivalents	**$ 15,472**	$ 1,104	$ 8	$ 14,368	1,301 %	$ 1,096	13,700 %

Commentary - 2016 compared to 2015

- *Cash flows provided by operating activities for Health Care and Group Insurance* decreased $400 million during 2016 compared to 2015 primarily due to a smaller increase in our health care costs payable liability in 2016 compared with 2015 and decreased operating performance primarily due to higher transaction and integration-related costs, partially offset by the timing of collections of premium receivables.
- *Cash flows used for investing activities* decreased $646 million in 2016 compared to 2015 primarily due to lower net purchases of investments in 2016.
- *Cash flows provided by financing activities* increased approximately $13.9 billion in 2016 compared to 2015 primarily due to the issuance of the 2016 senior notes. The increase is also driven by the repayment of debt, settlement of repurchase agreements and repurchases of common shares that occurred in 2015 and did not recur in 2016, partially offset by higher net repayment on interest rate derivatives in 2016.

Commentary - 2015 compared to 2014

- *Cash flows provided by operating activities for Health Care and Group Insurance* increased $787 million during 2015 compared to 2014 primarily due to improved operating performance and the receipt of our ACA reinsurance recoverables related to 2014, partially offset by the payment of our ACA risk adjustment payable related to 2014 and an increase in the amount we paid for the HIF in September 2015.
- *Cash flows used for investing activities* decreased $1.1 billion in 2015 compared to 2014 primarily due to lower net purchases of investments and a decline in cash used for acquisitions in 2015.
- *Cash flows used for financing activities* increased $500 million in 2015 compared to 2014 primarily attributable to the repayment of short-term debt issued in 2014 and net settlements from repurchase agreements in 2015 compared to net proceeds from repurchase agreements in 2014, partially offset by lower common share repurchases in 2015 compared to 2014.

Refer to Notes 9 “Debt” and 13 “Shareholders’ Equity” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information about debt issuances and repayments, share repurchases and dividend payments.

Termination of Merger Agreement and Aetna APA
As a result of the termination of the Merger Agreement, we paid Humana the applicable $1.0 billion Regulatory Termination Fee on February 16, 2017. As a result of the APA Termination Agreement, we paid Molina the applicable termination fee on February 16, 2017, and we expect to pay Molina the applicable transaction costs during the first quarter of 2017. We funded the February 16, 2017 payments with the proceeds of the 2016 senior notes.

2016 Senior Notes
In June 2016, we issued $13 billion of 2016 senior notes. At December 31, 2016, the approximately $13 billion of net proceeds related to the issuance of the 2016 senior notes are invested in highly rated money market fund investments and classified as cash and cash equivalents on our balance sheets. Additionally, in conjunction with the closing of the 2016 senior notes, we

terminated the Bridge Credit Agreement effective June 9, 2016. In accordance with the terms of the 2016 senior notes, on February 14, 2017, following the termination of the Merger Agreement, we issued a notice of redemption for the entire $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem the Special Mandatory Redemption Notes on or about March 16, 2017, and we expect to fund the redemption with the proceeds of the 2016 senior notes. As a result of such redemption, in the first quarter of 2017, we will recognize on a pretax basis in our net income the entire approximately $420 million unamortized portion of the related cash flow hedge losses, debt issuance costs and debt issuance discounts and the entire approximately $100 million redemption premium paid on the Special Mandatory Redemption Notes upon such redemption. Refer to Note 9 "Debt" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on these transactions.

Cash Flow Hedges
Prior to issuing the 2016 senior notes, we entered into various interest rate swaps and treasury rate locks that were designated as cash flow hedges against interest rate exposure related to the forecasted future issuance of fixed-rate debt to be primarily used to finance a portion of the purchase price of the Humana Acquisition. We terminated these hedges in conjunction with the issuance of the 2016 senior notes and paid an aggregate of $348 million to the hedge counterparties upon termination of these interest rate swaps and treasury rate locks. As a result of the redemption of the Special Mandatory Redemption Notes, in the first quarter of 2017, we will recognize the remaining approximately $330 million pretax unamortized portion of the related cash flow hedge losses in our net income upon such redemption. Refer to Note 9 "Debt" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on these transactions.

Other Liquidity Information
From time to time, we use short-term commercial paper borrowings, repurchase agreements and cash advances from the FHLBB to address timing differences between cash receipts and disbursements. At December 31, 2016 and 2015, we did not have any commercial paper outstanding or outstanding advances from the FHLBB. There were no commercial paper borrowings during 2016.

Our debt to capital ratio (calculated as the sum of all short- and long-term debt outstanding ("total debt") divided by the sum of total Aetna shareholders' equity plus total debt) was 54% and 33% at December 31, 2016 and 2015, respectively. We continually monitor existing and alternative financing sources to support our capital and liquidity needs, including, but not limited to, debt issuance, preferred or common stock issuance, reinsurance and pledging or selling of assets.

Interest expense was $604 million, $369 million and $334 million for 2016, 2015 and 2014, respectively. The increase in interest expense during 2016 compared to 2015 reflects financing activity associated with the Humana Acquisition. The increase in interest expense during 2015 compared to 2014 reflects the impact of the Bridge Credit Agreement and Term Loan Credit Agreement.

Our current funding strategy for our tax-qualified noncontributory defined benefit pension plan (the "Aetna Pension Plan") is to contribute an amount at least equal to the minimum funding requirement as determined under applicable law with consideration of factors such as the maximum tax deductibility of such amounts. Refer to Note 10 "Pension and Other Postretirement Plans" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information regarding our current funding strategy for the Aetna Pension Plan.

Contractual Obligations
The following table summarizes certain estimated future obligations by period under our various contractual obligations at December 31, 2016. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2016 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

The table below also does not include future payments related to the termination of the Merger Agreement, which we expect to make in the first quarter of 2017, including:

- 70% of Molina's transaction costs as specified in the Aetna APA Termination Agreement; and
- The redemption on or about March 16, 2017 of $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes at a redemption price equal to 101% of the aggregate principal amount of such notes, plus accrued and unpaid interest. Those notes are reflected at their respective maturities at issuance in the table below.

We believe that funds from future operating cash flows, together with cash, investments and other funds available under the Facility; from the FHLBB; and from public or private financing sources, will be sufficient to meet our existing commitments as well as our liquidity needs associated with future operations, including our strategic growth initiatives.

(Millions)	2017	2018-2019	2020-2021	Thereafter	Total
Long-term debt obligations, including interest	$ 2,345	$ 4,345	$ 4,870	$ 19,102	$ 30,662
Operating lease obligations	143	201	85	84	513
Purchase obligations	269	264	94	2	629
Other liabilities reflected on our balance sheet: [1]					
Future policy benefits [2]	645	1,230	958	3,741	6,574
Unpaid claims [2]	801	554	366	783	2,504
Policyholders' funds [2] [3]	917	83	91	454	1,545
Other liabilities [4]	5,661	314	84	199	6,258
Total	$ 10,781	$ 6,991	$ 6,548	$ 24,365	$ 48,685

[1] Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $4.0 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of our business.

[2] Total payments of future policy benefits, unpaid claims and policyholders' funds include $506 million, $35 million and $143 million, respectively, of reserves for contracts subject to reinsurance. We expect the assuming reinsurance carrier to fund these obligations and have reflected these amounts as reinsurance recoverable assets on our consolidated balance sheet.

[3] Customer funds associated with group life and health contracts of approximately $2.0 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt and equity securities supporting experience-rated products of $42 million, before tax, have been excluded from the table above.

[4] Other liabilities in the table above include general expense accruals and other related payables and exclude the following:

- Employee-related benefit obligations of $578 million, including our pension and other postretirement and post-employment benefit obligations and certain deferred compensation arrangements. These liabilities do not necessarily represent future cash payments we will be required to make, or such payment patterns cannot be determined. However, other long-term liabilities include expected benefit payments of $338 million over the next ten years for our non-qualified supplemental pension plan and our postretirement benefit plans, which we primarily fund when paid by the plans.
- Deferred gains of $50 million which will be recognized in our earnings in the future in accordance with GAAP.
- Net unrealized capital gains of $165 million, before tax, supporting discontinued products.
- Non-controlling interests supporting our discontinued products of $71 million consisting of third party interests in our investment holdings. This amount does not represent future cash payments we will be required to make.
- Other payables of $45 million.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to Aetna as a holding company, since Aetna is not an HMO or an insurance company. The additional regulations applicable to our HMO and insurance company subsidiaries are not expected to affect our ability to service our debt, meet our other financing obligations or pay dividends, or the ability of any of our subsidiaries to service other financing obligations. Under applicable regulatory requirements, at December 31, 2016, the amount of dividends that may be paid by our insurance and HMO subsidiaries without prior approval by regulatory authorities was approximately $1.9 billion in the aggregate.

We maintain capital levels in our operating subsidiaries at or above targeted and/or required capital levels and dividend amounts in excess of these levels to meet our liquidity requirements, including the payment of interest on debt and shareholder dividends. In addition, at our discretion, we use these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes we consider advisable.

At December 31, 2016 and 2015, we held investments of $657 million and $690 million, respectively, that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of our business. Refer to

Note 4 “Investments” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Off-Balance Sheet Arrangements

We do not have any guarantees or other off-balance sheet arrangements that we believe, based on historical experience and current business plans, are reasonably likely to have a material impact on our current or future operating results, financial position or cash flows (other than the guarantees described in Note 17 “Commitments and Contingencies” included in Part II, Item 8 of this Annual Report on Form 10-K) at December 31, 2016. In addition, refer to Note 4 “Investments” included in Part II, Item 8 of this Annual Report on Form 10-K for additional detail of our variable interest entities at December 31, 2016.

Solvency Regulation

The National Association of Insurance Commissioners (the “NAIC”) utilizes risk-based capital (“RBC”) standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company’s adjusted surplus to its required surplus (the “RBC Ratio”). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2016, the RBC Ratio of each of our primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2016, at that date, each of our active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC’s RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company’s rating.

CRITICAL ACCOUNTING ESTIMATES

We prepare our consolidated financial statements in accordance with GAAP. The application of GAAP requires management to make estimates and assumptions that affect our consolidated financial statements and related notes. The accounting estimates described below are those we consider critical in preparing our consolidated financial statements. We use information available to us at the time the estimates are made; however, as described below, these estimates could change materially if different information or assumptions were used. Also, these estimates may not ultimately reflect the actual amounts that occur.

Health Care Costs Payable

At December 31, 2016 and 2015, 86% and 85%, respectively, of health care costs payable are estimates of the ultimate cost of claims that have been incurred but not yet reported to us and of those which have been reported to us but not yet paid (collectively “IBNR”). The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables and accruals for state assessments. We develop our estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Refer to Note 2 “Summary of Significant Accounting Policies - Health Care Costs Payable” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our reserving methodology.

During 2016 and 2015 we observed an increase in our completion factors relative to those assumed at the prior year end. After considering the claims paid in 2016 and 2015 with dates of service prior to the fourth quarter of the previous year, we observed the assumed incurred claims weighted average completion factors were 28 and 35 basis points higher, respectively, than previously estimated, resulting in a reduction of $230 million and $282 million in 2016 and in 2015, respectively, in health care costs payable that related to the prior year. We have considered the pattern of changes in our completion factors when determining the completion factors used in our estimates of IBNR at December 31, 2016. However, based on our historical claim experience, it is reasonably possible that our estimated weighted average completion factor may vary by plus or minus 18 basis points from our assumed rates, which could impact health care costs payable by approximately plus or minus $212 million pretax.

Also during 2016 and 2015, we observed that our health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2016 and 2015 with claim incurred dates for the fourth quarter of the previous year, we observed health care costs that were 6.5% lower for each fourth quarter than previously estimated, resulting in a reduction of $534 million in 2016 and $559 million in 2015 in health care costs payable that related to the prior year.

We consider historical health care cost trend rates together with our knowledge of recent events that may impact current trends when developing our estimates of current health care cost trend rates. When establishing our reserves at December 31, 2016, we increased our assumed health care cost trend rates for the most recent three months by 5% from health care cost trend rates

recently observed. However, based on our historical claim experience, it is reasonably possible that our estimated health care cost trend rates may vary by plus or minus 3.5% from our assumed rates, which could impact health care costs payable by plus or minus $304 million pretax.

Health care costs payable as of December 31, 2016 and 2015 consisted of the following products:

(Millions)	2016	2015
Commercial	$ 3,273	$ 3,252
Government	3,285	3,054
Total health care costs payable	$ 6,558	$ 6,306

Other Insurance Liabilities

We establish insurance liabilities other than health care costs payable for benefit claims primarily related to our Group Insurance segment. We refer to these liabilities as other insurance liabilities. These liabilities primarily relate to our life, disability and long-term care products.

Life and Disability

The liabilities for our life and disability products reflect estimates of the ultimate cost of benefit claims that have been reported to us but not yet paid, benefit claims that have been incurred but not yet reported to us, and future policy benefits earned under insurance contracts. We develop our estimate of these reserves and the related benefit expenses using actuarial principles and assumptions that consider, among other things, discount, resolution and mortality rates. Completion factors are also evaluated when estimating our reserves for claims incurred but not yet reported for life products. We also consider the benefit payments from the U.S. Social Security Administration for which our disability members may be eligible and which may offset our liability for disability claims (this is known as the Social Security offset). Each period, we estimate these factors, to the extent relevant, based primarily on historical data, and use these estimates to determine the assumptions underlying our reserve calculations. Given the extensive degree of judgment and uncertainty used in developing these estimates, it is possible that our estimates could develop either favorably or unfavorably.

The discount rate is the interest rate at which future benefit cash flows are discounted to determine the present value of those cash flows. The discount rate we select is a critical estimate, because higher discount rates result in lower reserves. We determine the discount rate based on the current and estimated future yield of the asset portfolio supporting our life and disability reserves. If the discount rate we select in estimating our reserves is lower (higher) than our actual future portfolio returns, our reserves may be higher (lower) than necessary. The discount rates we selected for life insurance waiver of premiums and long-term disability reserves at December 31, 2016 were 40 basis points lower than the rate selected at December 31, 2015, primarily due to the decrease in projected portfolio rates of return. The discount rates we selected for life insurance waiver of premiums and long-term disability reserves at December 31, 2015 were consistent with the rates used at 2014. Based on our historical experience, it is reasonably possible that the assumed discount rates for our life and disability reserves may vary by plus or minus 50 basis points from year to year. A 50 basis point decrease in the discount rates selected for both our life insurance waiver of premium and disability reserves would have increased current and future life and disability benefit costs by $38 million pretax for 2016.

For disability claims and a portion of our life claims, we must estimate the timing of benefit payments, which takes into consideration the maximum benefit period and the probabilities of recovery (i.e., recovery rate) or death (i.e., mortality rate) of the member. Benefit payments may also be affected by a change in employment status of a disabled member, for example, if the member returns to work on a part-time basis. Estimating the recovery and mortality rates of our members is complex. Our actuaries evaluate our current and historical claim patterns, the timing and amount of any Social Security offset (for disability only), as well as other factors including the relative ages of covered members and the duration of each member's disability when developing these assumptions. For disability reserves, if our actual recovery and mortality rates are lower (higher) than our estimates, our reserves will be lower (higher) than required to cover future disability benefit payments. For certain life insurance premium waiver reserves, if the actual recovery rates are lower (higher) than our estimates or the actual mortality rates are higher (lower) than our estimates, our reserves will be lower (higher) than required to cover future life benefit payments. We use standard industry tables and our historical claim experience to develop our estimated recovery and mortality rates. Claim reserves for our disability and life products are sensitive to these assumptions. Our historical experience has been that our recovery or mortality rates for our life and disability reserves vary by less than ten percent during the course of a year. A ten percent less (more) favorable assumption for our recovery or mortality rates would have increased (decreased) current and future life and disability benefit costs by $71 million pretax for 2016. When establishing our reserves at December 31, 2016, we set our estimates of recovery and mortality rates based on recent experience. Refer to Note 2 "Summary of

Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our reserving methodology.

Long-term Care
We established reserves for future policy benefits for the long-term care products we issued based on the present value of estimated future benefit payments less the present value of estimated future net premiums. In establishing this reserve, we evaluated assumptions about mortality, morbidity, lapse rates and the rate at which new claims would be submitted to us. We estimated the future policy benefits reserve for long-term care products using these assumptions and actuarial principles. For long-term care insurance contracts, we use our original assumptions throughout the life of the policy and do not subsequently modify them unless we deem the reserves to be inadequate. A portion of our reserves for long-term care products also reflect our estimates relating to future payments to members currently receiving benefits. These reserves are estimated primarily using recovery and mortality rates, as described above.

Premium Deficiency Reserves on our Health Care and Group Insurance products
We recognize a premium deficiency loss when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. Any such reserves established would normally cover expected losses until the next policy renewal dates for the related policies. In the second and third quarters of 2016, we recorded premium deficiency reserves totaling $85 million related to anticipated future losses for the 2016 coverage year in our individual Commercial products. We did not have any premium deficiency reserves for our Health Care or Group Insurance business at December 31, 2016 or 2015.

Large Case Pensions Discontinued Products Reserve
We discontinued certain Large Case Pensions products in 1993 and established a reserve to cover losses expected during the run-off period. Since 1993, we have made several adjustments resulting in a reduction to this reserve that have increased net income attributable to Aetna. These adjustments occurred primarily because our investment experience as well as our mortality and retirement experience have been better than the experience we projected at the time we discontinued the products. In 2016, we released $84 million ($128 million pre-tax) of this reserve primarily due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve. There was no adjustment of this reserve in 2015 or 2014. There can be no assurance that adjustments to the discontinued products reserve will occur in the future. Future adjustments could positively or negatively impact net income attributable to Aetna.

Recoverability of Goodwill and Other Acquired Intangible Assets
We have made acquisitions that included a significant amount of goodwill and other intangible assets. When we complete an acquisition, we apply the acquisition method of accounting, which among other things, requires the recognition of goodwill (which represents the excess cost of the acquisition over the fair value of net assets acquired and identified intangible assets). Goodwill is subject to an annual (or under certain circumstances more frequent) impairment test based on its estimated fair value. Other intangible assets that meet certain criteria are amortized over their useful lives, except for the valuation of business acquired which amortizes in proportion to estimated premiums over the expected life of the acquired contracts, and are also subject to a periodic impairment test. Historically, for these impairment evaluations, we have used an implied fair value approach, which used a discounted cash flow analysis and other valuation methodologies. Beginning in 2017, we adopted, on a prospective basis, the recently issued accounting standards update related to the methodology utilized to evaluate goodwill impairment. This update simplifies the methodology used to perform our annual, or interim, goodwill impairment evaluations. Our evaluation will be performed by comparing the estimated fair value of a reporting unit with its carrying amount. An impairment charge would be recognized when the carrying amount exceeds the estimated fair value of the reporting unit. These impairment evaluations use many assumptions and estimates in determining an impairment loss, including certain assumptions and estimates related to future earnings. If we do not achieve our earnings objectives, the assumptions and estimates underlying these impairment evaluations could be adversely affected, which could result in an asset impairment charge that would negatively impact our operating results. There were no impairment losses recognized in any of the three years ended December 31, 2016, 2015 or 2014.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans
We sponsor defined benefit pension plans ("pension plans") and OPEB plans for our employees and retirees. Effective December 31, 2010, our employees no longer earn future pension service credits in the Aetna Pension Plan, although the Aetna Pension Plan will continue to operate and account balances will continue to earn annual interest credits. Employees covered by our non-qualified supplemental pension plan stopped accruing benefits effective January 1, 2007, although interest credits continue to be credited on these cash balance accounts.

Major assumptions used in the accounting for our pension plans include the expected return on plan assets, if applicable, mortality rates and the discount rate. We select our assumptions based on our information and market indicators, and we evaluate our assumptions at each annual measurement date (December 31, for each year presented). A change in any of our assumptions would have an effect on our pension and OPEB plan costs. A discussion of our assumptions used to determine the expected return on plan assets and mortality rates can be found in Note 10 "Pension and Other Postretirement Plans" included in Part II, Item 8 of this Annual Report on Form 10-K.

The discount rates we used in accounting for our pension and OPEB plans were calculated using a yield curve as of our annual measurement date. Each yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds (that is, bonds with an average rating of AA based on ratings from Standard & Poor's, Fitch, and the equivalent ratings from Moody's). We project the benefits expected to be paid from each plan at each point in the future based on each participant's current service (but reflecting expected future pay increases). These projected benefit payments are then discounted to the measurement date using the corresponding rate from the yield curve. A lower discount rate increases the present value of benefit obligations. In 2016, we decreased our weighted average discount rate to 4.22% for our pension plans from the 4.50% used at the measurement date in 2015. In 2016, we decreased our weighted average discount rate on OPEB plans to 4.12% from the 4.39% used at the measurement date in 2015. A one-percentage point decrease in the assumed discount rate would decrease our annual pension costs by $10 million after-tax and would have a negligible effect on our annual OPEB costs.

Beginning in 2017, we changed the approach used to estimate the interest cost component of net periodic benefit cost for pension and OPEB for plans that utilize a yield curve approach. Historically, we estimated the interest cost using a single weighted-average discount rate derived from the yield curve used to measure the projected benefit obligation. With this refinement, we now measure interest costs by applying the specific spot rates along that yield curve to the relevant projected cash flows for each component. We believe the new approach provides a more precise measurement of interest cost. This refinement has no effect on the measurement of our plan obligations. We have accounted for this refinement as a change in accounting estimate and, accordingly, have accounted for it on a prospective basis beginning in 2017.

At December 31, 2016, our pension and OPEB plans had aggregate pretax accumulated actuarial losses of approximately $2.5 billion. Accumulated actuarial losses are primarily due to an increase in the present value of future plan obligations driven by lower interest rates and improving mortality trends as well as investment results below assumed returns in 2008. The accumulated actuarial loss is amortized over the weighted-average expected life of pension plan participants (estimated to be up to 28 years at December 31, 2016 for the pension plans) and the expected life of OPEB plan participants (estimated to be up to 16 years at December 31, 2016) to the extent the loss is outside of a corridor established in accordance with GAAP. The corridor is established based on the greater of 10% of the plan assets or 10% of the projected benefit obligation. At December 31, 2016, approximately $1.9 billion of the actuarial loss was outside of the corridor, which will result in amortization of $44 million after-tax in our 2017 pension and OPEB expense.

The expected return on plan assets and discount rate assumptions discussed above impacted the reported net periodic benefit costs and benefit obligations of our pension and OPEB plans, but did not impact the required contributions to these plans, if any. Refer to Note 10 "Pension and Other Postretirement Plans" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our defined benefit pension and other postretirement employee benefit plans, including our current funding strategy.

Other-Than-Temporary Impairment of Debt Securities

We regularly review our debt securities to determine whether a decline in fair value below the carrying value is other-than-temporary. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in our operating results, and the amount of the non-credit related component is included in other comprehensive income, unless we intend to sell the security or it is more likely than not that we will be required to sell the security prior to its anticipated recovery of its amortized cost basis. We analyze all facts and circumstances we believe are relevant for each investment when performing this analysis, in accordance with applicable accounting guidance promulgated by the Financial Accounting Standards Board and the U.S. Securities and Exchange Commission (the "SEC").

Among the factors we consider in evaluating whether a decline is other-than-temporary are whether the decline in fair value results from a change in the quality of the debt security itself, whether the decline results from a downward movement in the market as a whole, and the prospects for realizing the carrying value of the debt security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, we determine whether we intend to sell the debt security or if it is more likely than not that we will be required to sell the debt security before

recovery of its amortized cost basis. If either case is true, we recognize an other-than-temporary impairment ("OTTI"), and the cost basis/carrying amount of the debt security is written down to fair value.

Debt securities in an unrealized loss position for which we believe we will not recover the amortized cost due to the quality of the debt security or the creditworthiness of the issuer are categorized as credit-related OTTI.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from our projections and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Revenue Recognition and Allowance for Estimated Terminations and Uncollectible Accounts
Our revenue is principally derived from premiums and fees billed to customers in the Health Care and Group Insurance segments. In Health Care, revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in our records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. In Group Insurance, premium for group life and disability products is recognized as revenue, net of allowances for uncollectible accounts, over the term of coverage. Amounts received before the period of coverage begins are recorded as unearned premiums.

Health Care billings may be subsequently adjusted to reflect enrollment changes due to terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, we estimate the amount of future retroactivity and adjust the recorded revenue accordingly. In each period, we also estimate the amount of uncollectible receivables and establish an allowance for uncollectible amounts. We base such estimates on historical trends, premiums billed, the amount of contract renewal activity during the period and other relevant information. As information regarding actual retroactivity and uncollectible amounts becomes known, we refine our estimates and record any required adjustments to revenues in the period they arise. A significant difference in the actual level of retroactivity or uncollectible amounts compared to our estimated levels would have a significant effect on our operating results.

Additionally, premium revenue subject to the ACA's minimum MLR rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. We estimate the minimum MLR rebates by projecting MLRs for certain markets, as defined by the ACA, for each state in which each of our insurance entities operate. The claims and premiums used in estimating such rebates are modified for certain adjustments allowed by the ACA and include a statistical credibility adjustment for those states with a number of members that is not statistically credible.

Furthermore, premium revenue subject to the ACA's permanent risk adjustment program transfers funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of our qualified plan members relative to the average risk of members of other qualified plans in comparable markets, we estimate our ultimate risk adjustment receivable or payable for the current calendar year and reflect the pro-rata year-to-date impact as an adjustment to our premium revenue. In this analysis, we consider the estimate of the average risk of members of other qualified plans in comparable markets the most critical assumption. We estimate this assumption using management's best estimates, which are based on various data sources, including but not limited to market risk data compiled by third party sources as well as pricing and other regulatory inputs. Refer to Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on each of the ACA's risk adjustment, risk corridor and reinsurance programs.

NEW ACCOUNTING STANDARDS
Refer to Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for a discussion of recently issued accounting standards.

REGULATORY ENVIRONMENT

General
Our operations are subject to comprehensive United States federal, state and local and comparable multiple levels of international regulation in the jurisdictions in which we do business. The laws and rules governing our business and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The new U.S. presidential administration and the control of the U.S. Congress by a single political party increase the likelihood of significant changes in those laws and rules, including the ACA. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices.

We must obtain and maintain regulatory approvals to price, market and administer many of our products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight ("CCIIO") and the Department of Labor ("DOL"), as well as state health, insurance, managed care and Medicaid agencies and state boards of pharmacy have broad authority to take one or more of the following actions:

- Grant, suspend and revoke our licenses to transact business;
- Suspend or exclude us from participation in government programs;
- Suspend or limit our authority to market products;
- Regulate many aspects of the products and services we offer, including the pricing and underwriting of many of our products and services;
- Audit us and our performance of our contracts, which can, among other things, affect our Medicare Advantage plans' and Medicare Part D Prescription Drug plans' ("PDPs'") star ratings;
- Assess damages, fines and/or penalties;
- Terminate our contract with the government agency and/or withhold payments from the government agency to us;
- Impose retroactive adjustments to premiums and require us to pay refunds to the government, customers and/or members;
- Restrict our ability to conduct acquisitions or dispositions;
- Require us to maintain minimum capital levels in our companies and monitor our solvency and reserve adequacy;
- Regulate our investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude our plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by the U.S. Department of Health and Human Services ("HHS") or the applicable state.

Our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators. See "Audits and Investigations" below in this MD&A - Regulatory Environment for additional information on these matters.

The ACA made broad-based changes to the U.S. health care system. On January 20, 2017, the President signed an executive order that gives the regulatory agencies that enforce the ACA the authority to interpret regulations issued under the ACA in a way that limits fiscal burdens on states and financial or regulatory burdens on individuals, providers, health insurers and others. The practical implications of that order are unclear, and the future of the ACA is uncertain. While we anticipate efforts in 2017 and beyond to substantially modify, repeal or replace the ACA, we expect aspects of the ACA to continue to significantly impact our business operations and operating results, including our pricing, our MBRs and the geographies in which our products are available. The ACA has presented us with business opportunities, but also with financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, including Public Exchanges, required minimum MLRs in Commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's CMS quality performance ratings or "star ratings." The effects of these changes are reflected in our operating results. If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2020.

We have dedicated and expect to continue to be required to dedicate significant resources and incur significant expenses during 2017 to implement and comply with ACA-related requirements and changes to the ACA as well as state level health care reform. While most of the significant aspects of the ACA became effective during or prior to 2014, significant parts of the ACA, including aspects of nondiscrimination requirements, continue to evolve through the promulgation of executive orders, regulations and guidance. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing state and federal budgetary pressures make it more likely that any changes, including changes at the state level in response changes to, or repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, we cannot predict the impact on us of future changes to the ACA. It is reasonably possible that

repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on our business operations and operating results.

Potential repeal of the ACA, ongoing legislative and regulatory changes to the ACA, other pending efforts in the U.S. Congress to amend or restrict funding for various aspects of the ACA (including risk corridors and the ACA's Cost Sharing Subsidy program), the results of the 2016 presidential, congressional and state level elections, pending litigation challenging aspects of the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Examples of recent legislative and regulatory changes include: the January 20, 2017 executive order relating to the ACA; the November 2016 HHS announcement that risk corridor collections for the 2015 program year will be applied first to amounts owed to plans for the 2014 program year; the May 2016 final regulations relating to the ACA's non-discrimination requirements; the December 2015 suspension of the HIF for 2017 and two year delay of the "Cadillac" tax on high-cost employer-sponsored health coverage; the October 2015 PACE, which leaves groups with 51 to 100 employees within the large group category for each state unless the state exercises its option to include these groups within the small group category; and the October 2015 HHS announcement that the ACA's risk corridor receivables for the 2014 program year would only be funded at 12.6%. With respect to pending litigation, in May 2016, the U.S. District Court for the District of Columbia ruled that the U.S. Department of Health and Human Services does not have the authority to make payments under the ACA's Cost Sharing Subsidy program. Implementation of this decision has been stayed pending appeal. A final ruling that adversely impacts the Cost Sharing Subsidy program could cause significant adverse selection in individual Public Exchange products and instability in the individual Public Exchange marketplace and could have a material adverse effect on our business, cash flows, financial condition and operating results as well as hinder our ability to offer Public Exchange products.

As described above, the availability of funding for the ACA's temporary risk corridor program is an example of this uncertainty. We continue to believe that receipt of any risk corridor payment from HHS for the 2016 or 2015 program year and receipt of such payments in excess of the announced prorated amount for the 2014 program year are uncertain. At December 31, 2016, we had an immaterial receivable for the remaining 2014 program year prorated amount that had not been collected from HHS and no receivable for either of the 2015 or 2016 program years. In addition, these limited risk corridor payments created additional instability in the marketplace for individual Commercial products in 2016 and going forward by contributing to decisions by health plans to change or stop offering their Public Exchange products. 2016 was the last program year for the ACA's risk corridor program. On-going uncertainty regarding the funding of ACA-related programs and subsidies can be expected to create additional instability in the marketplace.

In addition to efforts to amend, repeal or replace the ACA and the related regulations, the federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and our business. We cannot predict whether pending or future federal or state legislation or court proceedings, including future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or the ACA or the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements we and other health plans are paid by the federal government for our Medicare members, among other sources. While not all-inclusive, the following are some of the key provisions of the ACA (assuming it continues to be implemented in its current form) that become effective on or after January 1, 2017. We continue to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on our business operations and operating results:

- States can open Public Exchanges to large group employers beginning January 1, 2017.
- The ACA's non-discrimination requirements for benefit plans beginning January 1, 2017.
- Closure of the gap in coverage for Medicare Part D prescription drug coverage (the so-called "donut hole") which began to close in 2010 and will incrementally close until the coverage gap is eliminated in 2020.
- Continuing reductions to Medicare Advantage payment rates for payments to us and other plans which are fully phased-in for 2017 and the linking of Medicare Advantage payments to a plan's CMS quality performance ratings or "star ratings." Any inability on our part to achieve and maintain acceptable star ratings could have a material adverse effect on our Medicare operating results and/or the geographies in which our Medicare products are available.
- The imposition on us and other health insurers, health plans and other market participants of significant fees, assessments and taxes, including the industry-wide reinsurance assessment of $5 billion in 2016 and an annual non-tax deductible industry-wide $11.3 billion HIF in 2016, which will be zero in 2017 and, as currently enacted, $14.3 billion in 2018 and increase annually thereafter. Our share of the 2016 ACA fees, assessments and taxes was $979 million, which includes our share of the HIF, which was $837 million. As a result of the 2017 suspension of the HIF and the

termination of the ACA's reinsurance and risk corridor provisions at the end of 2016, we do not expect our share of the applicable 2017 ACA fees, assessments and taxes to be significant.

- A non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold beginning in 2020.
- Reduced funding for Medicaid expansion beginning in 2017.

The ACA also specifies minimum MLRs for our Commercial and Medicare Insured products, specifies required Commercial benefit designs, limits Commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and significantly increases federal and state oversight of health plans, including regulations and processes that could delay or limit our ability to appropriately increase our health plan premium rates. This in turn could adversely affect our ability to continue to participate in certain product lines and/or geographies we serve today.

In addition, the ACA ties a portion of each Medicare Advantage plan's reimbursement to the achievement of favorable CMS quality performance measures ("star ratings"). Since 2015, only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, our Medicare Advantage plans' operating results in 2017 and going forward will be significantly affected by their star ratings. For additional information on CMS's stars program and our related performance, see "Medicare" below in this MD&A - Regulatory Environment.

In 2016, state legislatures focused on state budgets and taxes (including new assessments on health care premiums), provider network composition and provider directory accuracy requirements, pharmacy benefit and drug coverage requirements, Medicaid reforms and health care delivery system transformation. At the state level, all 50 U.S. states and the District of Columbia will hold regular legislative sessions in 2017. We expect additional state level legislation and regulatory activity that impacts our businesses to be enacted in 2017, including potentially significant changes in individual, small group and Medicaid products and/or programs in response to or in anticipation of reduced federal funding. In addition, independent of federal efforts, we expect many states to continue to consider legislation or regulations that affect privately-financed health insurance arrangements and/or public programs, including imposing requirements on the composition of our provider networks and the accuracy of our provider directories, requiring changes to health benefit product structure, mandating specific benefit coverages, and enhancing consumer transparency on provider network composition as well as cost and quality of care. For example, regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards or procedures for reviewing proposed premium rate changes, as well as imposing taxes on insurers and other health plans to finance Public Exchanges, Medicaid and other state programs. If any elements of the ACA are repealed at the federal level, we expect that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

We cannot predict what provisions legislation or regulation will contain in any state or what effect legislation or regulation will have on our business operations or operating results, but the effect could be materially adverse.

Health Care Regulation

General

Federal, state, local and foreign governments have adopted comprehensive laws and regulations that govern our business activities in various ways. Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. These laws and regulations, including the ACA, restrict how we conduct our business and result in additional burdens and costs to us.

In addition to the expanded regulation created by the ACA discussed above, significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, health care provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks, pharmacy and pharmacy benefit management operations and financial position (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of our regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In addition,

some of our business and related activities may be subject to preferred provider organization ("PPO"), managed care organization, utilization review or third-party administrator-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain health care provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for our delivery of services, payment of claims, fraud prevention, protection of consumer health information, payment for covered benefits and services and escheatment of funds to states. Our pharmacy benefit management ("PBM") services suppliers, including CaremarkPCS Health, L.L.C. (and its predecessors, collectively "CVS"), also are subject to extensive federal and state regulation, including many of the items described above.

Pricing and Underwriting Restrictions

Pricing and underwriting regulation by states limits our underwriting and rating practices and those of other health insurers, particularly for small employer groups and individuals. Since 2014, as a result of the ACA, health insurers cannot vary small group or individual premium rates based on individual members' characteristics except for geography and limited variation for age and tobacco use. Since 2016, as a result of the ACA, states have the ability to expand the small group rating category to cover groups of up to 100 employees. Pricing and underwriting laws and regulations vary by state. In general, they apply to certain customer segments and limit our ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict our ability to price for the risk we assume and/or reflect reasonable costs in our pricing.

The ACA expanded the premium rate review process by, among other things, requiring our rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding 10% (or a state specified threshold). HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect our ability to price for the risk we assume, which could adversely affect our medical benefit ratios and operating results, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds our projections.

The ACA also specifies minimum MLRs of 85% for large group commercial products, 80% for individual and small group commercial products and 85% for Medicare Advantage and Medicare Part D plans. Beginning in 2017, Medicaid managed care products, including those we offer, also are subject to a minimum MLR of 85% under a final rule issued by CMS in 2016. Because the ACA and the Medicaid minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing its various restrictions. For Medicaid managed care and commercial products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings for commercial products, require prior approval of premium rates for commercial products, or impose other requirements related to minimum MLR. For example, Texas has expanded from 50 to 100 the maximum size of "small groups" that are subject to its minimum MLR requirements, and New York, New Jersey and California all have established state-specific minimum MLR requirements. Minimum MLR requirements and similar actions further limit the level of margin we can earn in our Insured business while leaving us exposed to medical costs that are higher than those reflected in our pricing. We also may be subject to significant fines, penalties, premium refunds and litigation if we fail to comply with minimum MLR laws and regulations. In addition, if a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years (including on a retrospective basis), it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years (including on a retrospective basis), it will be terminated by CMS.

In addition, we requested significant increases in our premium rates in our individual and small group Health Care businesses for 2017 and expect to continue to request significant increases in those rates for 2018 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect adverse selection in our products, particularly in individual and small group products, which we expect to continue and potentially worsen in 2017 with the expiration of the ACA's risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of these laws and regulations also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups or individuals based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage. In addition, HHS' rules on rates impose additional public disclosure requirements on any rate filings that exceed the "reasonableness" threshold and require additional review of those rates.

In addition, a number of states provide for a voluntary reinsurance mechanism to spread small group risk among participating insurers and other carriers. In a small number of states, participation in this pooling mechanism is mandatory for all small group carriers. In general, we have elected not to participate in voluntary pools. However, even in the voluntary pool states, we may be subject to certain supplemental assessments related to the state's small group experience. Core elements of the ACA were designed to reduce or eliminate reliance on these state pooling mechanisms. If those elements of the ACA are modified or repealed, states may reinstate or expand their pooling requirements, including mandatory participation.

HIPAA Administrative Simplification, GLBA and Other Privacy, Security and Confidentiality Requirements
Federal, state and international privacy and security requirements change periodically because of legislation, regulations and judicial or administrative interpretation. The regulations under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") and the ACA, also impose a number of additional obligations on issuers of health insurance coverage and health benefit plan sponsors.

HIPAA's administrative simplification requirements apply to self-funded group health plans, health insurers and HMOs, health care clearinghouses and health care providers who transmit health information electronically ("Covered Entities"). Regulations adopted to implement administrative simplification also require that "business associates" acting for or on behalf of these Covered Entities be contractually obligated to meet HIPAA standards. The administrative simplification regulations establish significant criminal penalties and civil sanctions for noncompliance.

The HIPAA privacy regulations adopted by HHS establish limits on the use and disclosure of medical records and other individually identifiable health information (protected health information or "PHI") by Covered Entities. Further, ARRA requires us and other Covered Entities to report any breaches of PHI to impacted individuals and to HHS and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Business associates (e.g., entities that provide services to health plans, such as electronic claims clearinghouses, print and fulfillment vendors, consultants, and us for the administrative services we provide to our ASC customers) must also comply with certain HIPAA provisions. In addition, ARRA establishes greater civil and criminal penalties for Covered Entities and business associates who fail to comply with HIPAA's provisions and gives new enforcement rights to state attorneys general. Additional regulations under HIPAA remain pending. We will continue to assess the impact of these regulations on our business as they are issued.

The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may apply to us and other Covered Entities, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. Complying with additional state requirements requires us to make additional investments beyond those we have made to comply with the HIPAA regulations. HHS also has adopted security regulations designed to protect member health information from unauthorized use or disclosure. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

The HIPAA privacy regulations provide patients with rights to understand and control how their health information is used. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. The GLBA regulations apply to health, life and disability insurance. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection.

The Cybersecurity Information Sharing Act of 2015 ("CISA") encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency. States are also starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with possibly conflicting cybersecurity regulations, which may differ from state to state, would require significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. Widely-reported large scale U.S. commercial data breaches increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of

our businesses, including the consumer business we are creating, our privacy and security strategy and our web-based and mobile assets.

Other Legislative Initiatives and Regulatory Initiatives

In addition to the ACA, HIPAA and ARRA measures discussed above, the U.S. federal and state governments, as well as governments in other countries where we do business, continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system. For example:

- Under the Budget Control Act of 2011 (the "BCA") and the American Taxpayer Relief Act of 2012 (the "ATRA") significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. CMS's April 2016 final notice for 2017 Medicare Advantage benchmark payment rates (the "Final Notice") provides for rate cuts to the employer group waiver program that will begin in 2017 and be fully phased in for 2018 as well as adverse changes to the risk adjustment mechanism for dual eligible beneficiaries and the Medicare Advantage star rating program. Overall, we project the benchmark payment rates for 2017 in the Final Notice will decrease funding for our Medicare Advantage businesses by less than 1 percent in 2017 compared to 2016. This 2017 rate decrease adds to the challenge we face from the impact of the increasing cost of medical care, the HIF beginning in 2018 (as currently enacted) and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids. Significant uncertainty remains as to whether and how the U.S. Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. We cannot predict future Medicare or Medicaid funding levels or the impact that future federal budget actions or entitlement program reform, if it occurs, will have on our business, operations or operating results, but the effects could be materially adverse, particularly on our Medicare and/or Medicaid revenues, medical benefit ratios and operating results.
- A number of states have enacted or introduced legislation or regulations requiring life insurers to take additional steps to identify unreported deceased policyholders and make other changes to their claim payment and related escheat practices. For additional information on these life insurance matters, refer to "Life and Disability Insurance" below in this MD&A - Regulatory Environment.
- The Department of Labor has issued final rules that will increase the administrative expense of and our related liability for processing claims for disability benefits. These rules are scheduled to become effective January 1, 2018.

Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:

- Restricting our ability to limit providers' participation in our networks and/or remove providers from our networks by imposing network adequacy requirements or otherwise (including in our Medicare, Public Exchange and other Commercial products).
- Stabilizing the marketplace for individual Commercial insurance products.
- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
- Reducing federal and/or state government funding of government-sponsored health programs in which we participate, including Medicare and Medicaid programs.
- Restricting or mandating health plan or life insurer claim processing, review, payment and/or related procedures.
- Mandating coverage for additional conditions and/or specified procedures, drugs or devices (for example, high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
- Imposing requirements and restrictions on the administration of pharmacy benefits, including restricting or eliminating the use of formularies for prescription drugs; restricting our ability to require members to obtain drugs through a mail order or specialty pharmacy; restricting our ability to place certain specialty or other drugs in the higher cost tiers of our pharmacy formularies; restricting our ability to make changes to drug formularies and/or our clinical programs; limiting or eliminating rebates on pharmaceuticals; restricting our ability to configure our pharmacy networks; and restricting or eliminating the use of certain drug pricing methodologies.
- Regulating electronic connectivity.
- Mandating or regulating the disclosure of health care provider fee schedules and other data about our payments to providers.

- Mandating or regulating disclosure of health care provider outcome and/or efficiency information.
- Prescribing or limiting members' financial responsibility for health care or other covered services they utilize.
- Assessing the medical device status of health information technology ("HIT") products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with U.S. Food and Drug Administration ("FDA") requirements in relation to some of these products, solutions and/or tools.
- Imposing payment levels for services rendered to our members by health care providers who do not have contracts with us.
- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
- Imposing additional requirements on the processing of claims for disability benefits.
- Amending or supplementing the Employee Retirement Income Security Act of 1974 ("ERISA") to impose greater requirements on the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

Some of the changes, if enacted, could provide us with business opportunities. However, it is uncertain whether we can counter the potential adverse effects of such potential legislation or regulation, including whether we can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying our systems to implement any enacted legislation or regulations.

Our business also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs, reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA") and creates a Federal Insurance Office ("FIO") within the U.S. Department of the Treasury (the "Treasury") with powers that include information-gathering and subpoena authority. Although the FIO does not have authority over health insurance, it may have authority over other parts of our business, primarily life insurance.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA are also regulated by the Treasury and the Internal Revenue Service (the "IRS").

We also may be adversely impacted by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing group and individual life insurance payment practices, bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Medicare

Our Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. Our Medicare PDP and Medicare Supplement products are complementary products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

We continue to expand the Medicare markets we serve and Medicare products we offer. We expect to further expand our Medicare service area and products in 2017 and are seeking to substantially grow our Medicare membership, revenue and operating results over the next several years, including through growth in our Medicare Supplement products, which products are regulated at the state level. The organic expansion of the Medicare markets we serve and Medicare products we offer and the Medicare-related provisions of the ACA significantly increase our exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which we participate, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, sequestration began in 2013 and resulted in an automatic reduction in Medicare reimbursements to health plans of not more than 2% of total program costs per year through 2024. In addition, the ACA as currently enacted contains further significant reductions in the reimbursements we receive for our Medicare Advantage members which were fully phased-in for 2017. Since the 2014 contract year, the ACA also has required minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years (including on a retrospective basis), it will become ineligible to participate in open enrollment. If a Medicare Advantage contracts pays rebates for five consecutive years (including on a retrospective basis), it will be terminated by CMS.

CMS's Final Notice provides for rate cuts to the employer group waiver program that will begin in 2017 and be fully phased in for 2018 as well as adverse changes to the risk adjustment mechanism for dual eligible beneficiaries and the Medicare Advantage star rating program. Overall, we project the benchmark payment rates for 2017 in the Final Notice will decrease funding for our Medicare Advantage businesses by less than 1 percent in 2017 compared to 2016. This 2017 rate decrease adds to the challenge we face from the impact of the increasing cost of medical care, the HIF beginning in 2018 (as currently enacted) and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids.

Our Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to us and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. We have invested significant resources to comply with Medicare standards, and our Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit us from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of our Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare or dual eligible programs and/or institute other sanctions against us if we fail to comply with CMS regulations or our Medicare contractual requirements.

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare Advantage and PDP beneficiaries. For example, CMS currently conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. In December 2015, CMS released a request for information ("RFI") for a significant expansion of the RADV audit program. As described in the RFI, CMS would use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. Refer to "CMS Actions" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K for information on certain pending CMS audits.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Our star ratings and past performance scores are adversely affected by compliance issues that arise in our Medicare operations, such as our distribution of inaccurate information regarding which pharmacies were part of our Medicare network and related $1 million civil monetary penalty in 2015 and notices of non-compliance and warning letters in 2016.

Since 2015, Medicare Advantage plans must have an overall star rating of four stars or higher (out of five stars) to qualify for a quality bonus in their basic premium rates. CMS released our 2017 star ratings in October 2016. Our 2017 star ratings will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2018. Based on our membership at December 31, 2016, 92% of our Medicare Advantage members were in plans with 2017 star ratings of at least 4.0 stars. CMS will release updated stars ratings in October 2017 that will be used to determine the portion of our Medicare Advantage membership that will reside in plans with ratings of four stars or higher and qualify for bonus payments in 2019. In 2017 and going forward, our Medicare Advantage plans' operating results will continue to be significantly affected by their star ratings. CMS continues to revise the star ratings system to make it harder to achieve four stars or more. Despite our success in improving our star ratings and other quality measures for 2017 and the continuation of our improvement efforts, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

We cannot predict future Medicare funding levels or the impact that future federal budget actions or entitlement program reform, if it occurs, will have on our business, operations or operating results, but the effects could be materially adverse, particularly on our Medicare and/or Medicaid revenues, medical benefit ratios and operating results. For example, the Federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. We currently believe that the payments we receive and will receive in the near term are adequate to justify our continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

Going forward, we expect CMS, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDP, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' role. It is not possible to predict the outcome of this Congressional or regulatory activity, either of which could adversely affect us.

Medicaid

We are seeking to substantially grow our Medicaid and dual eligible businesses over the next several years. As a result, we also are increasing our exposure to changes in government policy with respect to and/or regulation of the various Medicaid and dual eligible programs in which we participate, including changes in the amounts payable to us under those programs.

In April 2016, CMS issued a final rule that overhauls the entire Medicaid managed care delivery system. The final rule represents the first update to Medicaid managed care regulations since 2002. Among other things the final rule requires Medicaid products to have a minimum MLR of 85%; establishes a Medicaid managed care quality rating system; and establishes provider network adequacy requirements. The minimum MLR requirements are effective beginning in 2017.

The impact of Medicaid expansion under the ACA is uncertain. The future of the ACA is uncertain, and states may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, thirty-one states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Starting in 2017, federal funding for expanded Medicaid coverage is decreasing and proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2017 and beyond, including the possibility of converting federal Medicaid support to block grants and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation may adversely affect Medicaid payment rates, our revenues and our Medicaid membership in those states.

The economic aspects of the Medicaid and dual eligible business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states are also considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in our networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for us to continue program participation due to state and federal budgetary constraints and continuing efforts to reduce health care costs. In addition, our Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (for example, when a state discontinues a managed care program) or in the event of insufficient state funding.

Our Medicaid and dual eligible products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit our performance to determine compliance with CMS contracts and regulations. Our Medicaid products, dual eligible products and Children's Health Insurance Program ("CHIP") contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services we provide to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to us and other participants in Medicaid and dual eligible programs, including requirements that we submit encounter data to the applicable state agency, are extensive, complex and subject to change. We have invested significant resources to comply with these standards, and our Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine us, withhold payments to us, seek premium and other refunds, terminate our existing contracts, elect not to award us new contracts or renew our existing contracts, prohibit us from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of our Medicaid or dual eligible products, exclude us from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions against us if we fail to comply with CMS or state regulations or our contractual requirements.

We cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can we predict the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

Federal Employees Health Benefits Program

Our subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. We also manage certain FEHB plans on a "cost-plus" basis. The OPM conducts periodic audits of its contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under its insured contracts and costs allocated pursuant to its cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against us if we fail to comply with the FEHB program requirements.

The Employee Retirement Income Security Act of 1974

The provision of services to certain employee benefit plans, including certain Health Care, Group Insurance and Large Case Pensions benefit plans, is subject to ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the IRS and the U.S. Department of Labor (the "DOL"). ERISA regulates certain aspects of the relationships between us and employers who maintain employee benefit plans subject to ERISA. Some of our administrative services and other activities also are subject to regulation and/or review by the DOL under ERISA. ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts.

Some of our Health Care, Group Insurance and Large Case Pensions products and services and related fees we charge are also subject to potential issues raised by certain judicial interpretations relating to ERISA. Under those interpretations, together with DOL regulations, we may have ERISA fiduciary duties with respect to certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those assets are subject to conflict of interest and other restrictions, and we must provide certain disclosures to policyholders annually. We must comply with these restrictions or face substantial penalties.

HMO, Insurance Holding Company and Other State Laws

A number of states, including Pennsylvania and Connecticut, regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require us and our subsidiaries to maintain certain levels of equity and require prior regulatory approval of material intercompany transfers of assets as well as transactions between the regulated companies and their affiliates, including their parent holding companies. We expect the states in which our insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of our insurance companies and HMOs.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or "RBC", requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2016, the RBC level of each of our insurance and HMO subsidiaries was above the level that would require regulatory action.

In addition, changes to regulations or the interpretation of those regulations due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to recent and expected payor insolvencies, could negatively impact our business in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

For information regarding restrictions on certain payments of dividends or other distributions by our HMO and insurance company subsidiaries, refer to Note 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K.

The holding company laws for the states of domicile of Aetna and certain of its subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as our parent company, Aetna Inc.) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Our workers' compensation business includes the comparison of medical claims data against the applicable state's fee schedule pricing, including applicable regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. Our workers' compensation business also includes PBM and care management services, both of which are regulated at the state level. Our workers' compensation customers include insurance carriers and TPA's who also are regulated at the state level. The laws and regulations applicable to us and other participants in the workers' compensation business are extensive, complex and subject to change. We have invested significant resources to comply with these standards, and our workers' compensation compliance efforts will continue to require significant resources. We may be subject to significant fines, penalties and litigation if we fail to comply with those laws and regulations.

Audits and Investigations

We and our vendors and other downstream entities typically have been, are currently and may in the future be involved in various governmental investigations, audits, examinations, reviews, subpoenas and other requests for information, the intensity and scope of which continue to increase. These include routine, regular and special investigations, audits, examinations and reviews by, as well as subpoenas and other requests for information from, CMS, HHS (including the Office of Civil Rights), various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the CCIIO, the Office of the Inspector General (the "OIG"), the OPM, the DOL, the Treasury, the FDA, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice (the "DOJ"), the U.S. Federal Trade Commission (the "FTC"), the Office of Foreign Assets Control ("OFAC") of the Treasury, U.S. attorneys and other state, federal and international governmental authorities.

For example, certain of our Medicare Advantage plans are currently under audit for, among other things, compliance with coding and other requirements under the Medicare risk adjustment model; federal and state auditors are challenging our Commercial business compliance with the ACA's minimum MLR requirements; federal auditors are challenging our FEHB plans' compliance with the OPM's FEHB program specific minimum MLR requirements; and our Commercial business is subject to audits related to the ACA's risk adjustment and reinsurance data since those programs were implemented in 2014. HHS also has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security. Such government actions may, among other things, prevent or delay us from implementing planned premium rate increases and have resulted and may result in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds to members or the government, withholding of premium payments to us by government agencies, payments under insurance policies prior to those payments being due under the terms of the policy, assessments of damages, civil or criminal fines or penalties (including under the federal false claims act (the "False Claims Act")), or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

A significant number of states are investigating life insurers' and health insurers' claims payment and related escheat practices. For additional information on these life insurance matters, refer to "Life and Disability Insurance" below in this MD&A - Regulatory Environment.

Refer to "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K for more information regarding pending audits and investigations.

Federal and State Reporting

We are subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the state and federal level. Our ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. We are and will continue to be required to modify our information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, we cannot eliminate the risks of unavailability of or errors in our reports.

Fraud, Waste and Abuse Laws

Federal and state governments have made investigating and prosecuting health care fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a health care provider, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to us and other participants in these public-sector programs are complex and subject to change. Although our compliance program is designed to meet all statutory and regulatory requirements, our policies and procedures are frequently under review and subject to updates, and our training and education programs continue to evolve. We have

invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

Federal and State Laws and Regulations Governing Submission of Information and Claims to Agencies
We are subject to federal and state laws and regulations that apply to the submission of information and claims to various government agencies. For example, the False Claims Act provides, in part, that the federal government may bring a lawsuit against any person or entity who the government believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. There also is False Claims Act liability for knowingly or improperly avoiding repayment of an overpayment received from the government and/or failing to promptly report and return any such overpayment. The federal government, whistleblowers and some courts have taken the position that claims presented in violation of other statutes, such as the federal anti-kickback statute, may be considered a violation of the False Claims Act. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products sold on Public Exchanges. Violations of the False Claims Act are punishable by treble damages and penalties of up to a specified dollar amount per false claim. In addition, a special provision under the False Claims Act allows a private person (for example, a "whistleblower" such as a disgruntled current or former competitor, member or employee) to bring an action under the False Claims Act on behalf of the government alleging that a company has defrauded the federal government and permits the private person to share in any settlement of, or judgment entered in, the lawsuit.

A number of states, including states in which we operate, have adopted their own false claims acts and whistleblower provisions that are similar to the False Claims Act. From time to time, companies in the health and related benefits industry, including ours, may be subject to actions under the False Claims Act or similar state laws.

Product Design and Administration and Sales Practices
State and/or federal regulatory scrutiny of health care benefit and life insurance product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. Refer to "Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K for more information on the expected liquidation of Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") and certain assessments to which our HMOs are subject. If Penn Treaty is placed in liquidation in the first half of 2017, we expect to record an estimated liability and expense of approximately $230 million pretax at the time of such event. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

Regulation of Pharmacy Operations
CVS has provided certain PBM services to us and certain of our customers and members since January 1, 2011. As amended, our PBM agreement with CVS has a term ending in December 2022, although we have certain termination rights beginning in January 2020. Express Scripts also provides certain PBM services to certain of our customers and members under an agreement with a term ending in 2017 for a portion of our Commercial and Medicaid members. Express Scripts also provided PBM services to a portion of our Medicare members in 2015.

Notwithstanding our contracting with our PBM services suppliers, we remain responsible to regulators and members for the delivery of PBM services. In addition, we continue to operate two mail order pharmacy facilities and one specialty pharmacy facility (our "Pharmacies") and utilize certain pharmacies of our PBM services suppliers. Our Pharmacies dispense pharmaceuticals throughout the U.S. and are participating providers in Medicare, Medicare Part D and various Medicaid programs. The pharmacy practice is generally regulated at the state level by state boards of pharmacy. Our Pharmacies are

required to be licensed in the state where they are located, as well as the states that require registration or licensure of mail order pharmacies with the state's board of pharmacy or similar regulatory body. Our Pharmacies also must register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances and must comply with applicable Medicare, Medicaid and other provider rules and regulations, including the False Claims Act, state false claims acts and federal and state anti-kickback laws. Our PBM services suppliers' owned and contracted pharmacies are subject to these same licensing requirements and other laws and regulations. The loss or suspension of any such licenses or registrations could have a material adverse effect on our ability to meet our contractual obligations to our customers, which could, in turn, have a material adverse effect on our pharmacy business and/or operating results.

Regulation of Pharmacy Benefit Management Operations

Our PBM services are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and federal and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of, and/or changes to drug formularies, maximum allowable cost list pricing, average wholesale prices and/or clinical programs; disclosure of data to third parties; drug utilization management practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of our Pharmacies (including audits of our Pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by us or one of our PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on our operating results.

Life and Disability Insurance

Our life and disability insurance operations are subject to extensive regulation. Changes in these regulations, such as expanding the definition of disability or mandating changes to claim payment, determination and/or settlement practices, could have a material adverse impact on our life insurance and/or disability insurance operations and/or operating results. Legislation has been enacted or introduced in a number of states requiring life insurers to take additional steps to identify unreported deceased policy holders, and make other changes to their claim payment and related escheat practices, including consultation of certain databases. A significant number of states are investigating life insurers' claims payment and related escheat practices, and these investigations have resulted in significant charges to earnings by other life insurers in connection with related settlement agreements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

Consumer Protection Laws

Our consumer business which began serving members on January 1, 2016 and certain of our other businesses participate in direct-to-consumer activities, and we increasingly offer mobile and web-based solutions to our members and to other consumers. We are therefore subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. In particular, the FTC is aggressively exercising its enforcement authority in the areas of consumer privacy and data security with a focus on web-based, mobile products and "big data." As a result of the widely-reported large scale U.S. commercial data breaches during 2016 and prior years, the FTC and state regulators have increased their enforcement activity in these regimes. These enforcement developments will impact the design, management and operation of our businesses, including our consumer business, our privacy and security strategy and our web-based and mobile assets.

International Regulation

We expect to continue to expand our Health Care operations in foreign countries through both organic growth and acquisitions. We currently have insurance licenses in several foreign jurisdictions and do business directly or through local affiliations in numerous countries around the world. The impact on our international operations and results of the United Kingdom's pending exit from the European Union ("EU") is uncertain.

Our international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which will apply across the EU effective May 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and

repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of our operations into foreign countries increases our exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. We also are subject to applicable anti-corruption laws of the jurisdictions in which we operate. In many countries outside the U.S., health care professionals are employed by the government. Therefore, our dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the SEC and the DOJ have increased their enforcement activities with respect to the FCPA. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. We have internal control policies and procedures and conduct training and compliance programs for our employees to deter prohibited practices. However, if our employees or agents fail to comply with applicable laws governing our international operations, we may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions. See *"As we expand our international operations, we will increasingly face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations. Our exposure to these risks is expected to increase"* in "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K for a discussion of the risks related to operating globally.

Anti-Money Laundering Regulations

Certain of our lines of business are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their compliance with the regulations. We also may be subject to anti-money laundering laws in non-U.S. jurisdictions where we operate.

Office of Foreign Assets Control

We also are subject to regulation by OFAC. OFAC administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, we may be subject to similar regulations in the non-U.S. jurisdictions in which we operate.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Our earnings and financial position are exposed to interest rate risk, credit quality risk and market valuation risk.

Evaluation of Interest Rate and Credit Quality Risk

We manage interest rate risk by seeking to maintain a tight match between the durations of our assets and liabilities when appropriate. We manage credit risk by seeking to maintain high average credit quality ratings and diversified sector exposure within our debt securities portfolio. In connection with our investment and risk management objectives, we also use derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. Our use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject us to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, we expect these instruments to reduce overall risk.

Investments

Our investment portfolio supported the following products at December 31, 2016 and 2015:

(Millions)	**2016**	**2015**
Experience-rated products	**$ 1,154**	$ 1,157
Discontinued products	**2,929**	3,059
Remaining products	**20,796**	20,464
Total investments	**$ 24,879**	$ 24,680

Investment risks associated with our experience-rated and discontinued products generally do not impact our operating results. The risks associated with investments supporting experience-rated pension and annuity products in our Large Case Pensions business are assumed by the contract holders and not by us (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals. The distributions on our experience-rated products consisted of scheduled contract maturities and benefit payments and contract holder withdrawals of $90 million, $285 million and $153 million, respectively, in the years ended December 31, 2016, 2015 and 2014. Participant-directed withdrawals were not material in the years ended December 31, 2016, 2015 or 2014. Refer to Note 19 "Discontinued Products" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information related to our discontinued products.

Debt and Equity Securities

The debt securities in our investment portfolio had an average credit quality rating of A at both December 31, 2016 and 2015, with approximately $5.2 billion and $5.0 billion rated AAA at December 31, 2016 and 2015, respectively. The debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) were $1.6 billion and $1.4 billion at December 31, 2016 and 2015, respectively (of which 12% and 13% at December 31, 2016 and 2015, respectively, supported our experience-rated and discontinued products).

At December 31, 2016 and 2015, we held $812 million and $956 million, respectively, of municipal debt securities that were guaranteed by third parties, representing 3% and 4%, respectively, of our total investments. These securities had an average credit quality rating of AA at both December 31, 2016 and 2015 with the guarantee. These securities had an average credit quality rating of A at both December 31, 2016 and 2015 without the guarantee. We do not have any significant concentration of investments with third party guarantors (either direct or indirect).

At both December 31, 2016 and 2015, less than 1% of our investment portfolio was comprised of investments that were either European sovereign, agency, or local government debt of countries which, in our judgment based on an analysis of market-yields, are experiencing economic, fiscal or political strains such that the likelihood of default may be higher than if those factors did not exist.

We generally classify our debt and equity securities as available for sale, and carry them at fair value on our balance sheets. At both December 31, 2016 and 2015, 1% of our debt and equity securities were valued using inputs that reflect our own assumptions (categorized as Level 3 inputs in accordance with GAAP). Refer to Note 5 "Fair Value" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the methodologies and key assumptions we use to determine the fair value of investments.

For additional information related to our investments, see Note 4 "Investments" included in Part II, Item 8 of this Annual Report on Form 10-K.

We regularly review our debt securities to determine if a decline in fair value below the carrying value is other-than temporary. If we determine a decline in fair value is other-than-temporary, we will write down the carrying value of the debt security. The amount of the credit-related impairment is included in our operating results, and the non-credit related component is included in other comprehensive income unless we intend to sell the debt security or it is more likely than not that we will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. Accounting for other-than-temporary impairment ("OTTI") of our debt securities is considered a critical accounting estimate. Refer to "Critical Accounting Estimates - Other-Than-Temporary Impairment of Debt Securities" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K for additional information.

Evaluation of Market Risks

We regularly evaluate our risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. We also regularly evaluate the appropriateness of investments relative to our management-approved investment guidelines (and operate within those guidelines) and the business objectives of our portfolios.

On a quarterly basis, we review the impact of hypothetical net losses in our investment portfolio on our consolidated near-term financial position, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for us. We have estimated the impact on the fair value of our market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which we believe represents a moderately adverse scenario and is approximately equal to the historical annual volatility of interest rate

movements for our intermediate-term available-for-sale debt securities) and an immediate decrease of 15% in prices for domestic equity securities.

Assuming an immediate 100 basis point increase in interest rates and immediate decrease of 15% in the prices for domestic equity securities, the theoretical decline in the fair values of our market sensitive instruments at December 31, 2016 is as follows:

- The fair value of our long-term debt would decline by $1.1 billion ($1.6 billion pretax). Changes in the fair value of our long-term debt do not impact our financial position or operating results.
- The theoretical reduction in the fair value of our investment securities partially offset by the theoretical reduction in the fair value of our interest rate sensitive liabilities would result in a net decline in fair value of $322 million ($495 million pretax) related to our non-experience-rated products. Reductions in the fair value of our investment securities would be reflected as an unrealized loss in equity, as we classify these securities as available for sale. We do not record our liabilities at fair value.

Based on our overall exposure to interest rate risk and equity price risk, we believe that these changes in market rates and prices would not materially affect our consolidated near-term financial position, operating results or cash flows as of December 31, 2016.

Evaluation of Operational Risks

We also face certain operational risks, including risks related to information security, including cybersecurity. We and our vendors have experienced a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted virus infections, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, malware or injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. We are dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis our systems and processes that are designed to mitigate the information security risks we face and protect the security of our computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, destroy data, disrupt or degrade service, sabotage systems or cause other damage. The impact of the cyber attacks we have experienced through December 31, 2016 has not been material to our operations or operating results. Our Board and Audit Committee are regularly informed regarding our information security policies, practices and status.

Item 8. Financial Statements and Supplementary Data

Index to Consolidated Financial Statements

Consolidated Balance Sheets

(Millions)	At December 31, 2016	2015
Assets:		
Current assets:		
Cash and cash equivalents	**$ 17,996**	$ 2,524
Investments	**3,046**	3,015
Premiums receivable, net	**2,356**	1,880
Other receivables, net	**2,224**	2,307
Accrued investment income	**232**	228
Income taxes receivable	**44**	261
Other current assets	**2,551**	2,510
Total current assets	**28,449**	12,725
Long-term investments	**21,833**	21,665
Reinsurance recoverables	**727**	724
Goodwill	**10,637**	10,637
Other acquired intangible assets, net	**1,442**	1,688
Property and equipment, net	**587**	630
Other long-term assets	**1,480**	1,405
Separate Accounts assets	**3,991**	4,035
Total assets	**$ 69,146**	$ 53,509
Liabilities and shareholders' equity:		
Current liabilities:		
Health care costs payable	**$ 6,558**	$ 6,306
Future policy benefits	**645**	672
Unpaid claims	**801**	772
Unearned premiums	**556**	676
Policyholders' funds	**2,772**	2,263
Current portion of long-term debt	**1,634**	—
Accrued expenses and other current liabilities	**5,728**	4,920
Total current liabilities	**18,694**	15,609
Future policy benefits	**5,929**	6,268
Unpaid claims	**1,703**	1,656
Policyholders' funds	**812**	886
Long-term debt, less current portion	**19,027**	7,785
Deferred income taxes	**4**	177
Other long-term liabilities	**1,043**	914
Separate Accounts liabilities	**3,991**	4,035
Total liabilities	**51,203**	37,330
Commitments and contingencies (Note 17)		
Shareholders' equity:		
Common stock ($.01 par value; 2.5 billion shares authorized and 351.7 million shares issued and outstanding in 2016; 2.5 billion shares authorized and 349.5 million shares issued and outstanding in 2015) and additional paid-in capital	**4,716**	4,647
Retained earnings	**14,717**	12,797
Accumulated other comprehensive loss	**(1,552)**	(1,330)
Total Aetna shareholders' equity	**17,881**	16,114
Non-controlling interests	**62**	65
Total equity	**17,943**	16,179
Total liabilities and equity	**$ 69,146**	$ 53,509

Refer to accompanying Notes to Consolidated Financial Statements.

Consolidated Statements of Income

(Millions, except per common share data)	For the Years Ended December 31, 2016	2015	2014
Revenue:			
Health care premiums	**$ 54,116**	$ 51,618	$ 49,562
Other premiums	**2,182**	2,171	2,186
Fees and other revenue [1]	**5,861**	5,696	5,229
Net investment income	**910**	917	946
Net realized capital gains (losses)	**86**	(65)	80
Total revenue	**63,155**	60,337	58,003
Benefits and expenses:			
Health care costs [2]	**44,255**	41,712	40,747
Current and future benefits	**2,101**	2,121	2,165
Operating expenses:			
Selling expenses	**1,678**	1,611	1,653
General and administrative expenses	**10,407**	10,033	9,180
Total operating expenses	**12,085**	11,644	10,833
Interest expense	**604**	369	334
Amortization of other acquired intangible assets	**247**	255	243
Loss on early extinguishment of long-term debt	**—**	—	181
Reduction of reserve for anticipated future losses on discontinued products	**(128)**	—	—
Total benefits and expenses	**59,164**	56,101	54,503
Income before income taxes	**3,991**	4,236	3,500
Income tax expense	**1,735**	1,841	1,455
Net income including non-controlling interests	**2,256**	2,395	2,045
Less: Net (loss) income attributable to non-controlling interests	**(15)**	5	4
Net income attributable to Aetna	**$ 2,271**	$ 2,390	$ 2,041
Earnings per common share:			
Basic	**$ 6.46**	$ 6.84	$ 5.74
Diluted	**$ 6.41**	$ 6.78	$ 5.68

(1) Fees and other revenue include administrative services contract member co-payments and plan sponsor reimbursements related to our mail order and specialty pharmacy operations of $128 million, $112 million and $102 million for 2016, 2015 and 2014, respectively (net of pharmaceutical and processing costs of $1.3 billion for each of 2016, 2015 and 2014).

(2) Health care costs have been reduced by Insured member co-payments related to our mail order and specialty pharmacy operations of $115 million, $117 million and $107 million for 2016, 2015 and 2014, respectively.

Refer to accompanying Notes to Consolidated Financial Statements.

Consolidated Statements of Comprehensive Income

	For the Years Ended December 31,		
(Millions)	**2016**	**2015**	**2014**
Net income including non-controlling interests	**$ 2,256**	$ 2,395	$ 2,045
Other comprehensive (loss) income, net of tax:			
Previously impaired debt securities	**(3)**	(16)	1
All other securities	**(15)**	(256)	241
Derivatives and foreign currency	**(161)**	(13)	(61)
Pension and OPEB plans	**(43)**	66	(380)
Other comprehensive loss	**(222)**	(219)	(199)
Comprehensive income including non-controlling interests	**2,034**	2,176	1,846
Less: Comprehensive (loss) income attributable to non-controlling interests	**(15)**	5	4
Comprehensive income attributable to Aetna	**$ 2,049**	$ 2,171	$ 1,842

Refer to accompanying Notes to Consolidated Financial Statements, including Note 14 for further information about other comprehensive (loss) income.

Consolidated Statements of Shareholders' Equity

(Millions)	Number of Common Shares Outstanding	Attributable to Aetna: Common Stock and Additional Paid-in Capital	Attributable to Aetna: Retained Earnings	Attributable to Aetna: Accumulated Other Comprehensive Loss	Attributable to Aetna: Total Aetna Shareholders' Equity	Non-Controlling Interests	Total Equity
Balance at December 31, 2013	362.2	$ 4,382	$ 10,555	$ (912)	$ 14,025	$ 53	$ 14,078
Net income	—	—	2,041	—	2,041	4	2,045
Other increases in non-controlling interest	—	—	—	—	—	12	12
Other comprehensive loss (Note 14)	—	—	—	(199)	(199)	—	(199)
Common shares issued for benefit plans, including tax benefits, net of employee tax withholdings	3.5	160	—	—	160	—	160
Repurchases of common shares	(15.9)	—	(1,218)	—	(1,218)	—	(1,218)
Dividends declared	—	—	(326)	—	(326)	—	(326)
Balance at December 31, 2014	349.8	4,542	11,052	(1,111)	14,483	69	14,552
Net income	—	—	2,390	—	2,390	5	2,395
Other decreases in non-controlling interest	—	—	—	—	—	(9)	(9)
Other comprehensive loss (Note 14)	—	—	—	(219)	(219)	—	(219)
Common shares issued for benefit plans, including tax benefits, net of employee tax withholdings	2.7	105	—	—	105	—	105
Repurchases of common shares	(3.0)	—	(296)	—	(296)	—	(296)
Dividends declared	—	—	(349)	—	(349)	—	(349)
Balance at December 31, 2015	**349.5**	**4,647**	**12,797**	**(1,330)**	**16,114**	**65**	**16,179**
Net income (loss)	**—**	**—**	**2,271**	**—**	**2,271**	**(15)**	**2,256**
Other increases in non-controlling interest	**—**	**—**	**—**	**—**	**—**	**12**	**12**
Other comprehensive loss (Note 14)	**—**	**—**	**—**	**(222)**	**(222)**	**—**	**(222)**
Common shares issued for benefit plans, net of employee tax withholdings	**2.2**	**69**	**—**	**—**	**69**	**—**	**69**
Dividends declared	**—**	**—**	**(351)**	**—**	**(351)**	**—**	**(351)**
Balance at December 31, 2016	**351.7**	**$ 4,716**	**$ 14,717**	**$ (1,552)**	**$ 17,881**	**$ 62**	**$ 17,943**

Refer to accompanying Notes to Consolidated Financial Statements.

Consolidated Statements of Cash Flows

(Millions)	For the Years Ended December 31, 2016	2015	2014
Cash flows from operating activities:			
Net income including non-controlling interests	**$ 2,256**	$ 2,395	$ 2,045
Adjustments to reconcile net income to net cash provided by operating activities:			
Net realized capital (gains) losses	**(86)**	65	(80)
Depreciation and amortization	**681**	671	629
Debt fair value amortization	**(30)**	(30)	(53)
Amortization of interest rate hedges	**20**	6	6
Equity in earnings of affiliates, net	**(6)**	(31)	(40)
Stock-based compensation expense	**191**	181	163
Reduction of reserve for anticipated future losses on discontinued products	**(128)**	—	—
Amortization of net investment premium	**79**	84	72
Loss on early extinguishment of long-term debt	**—**	—	181
Pension settlement charge	**—**	—	112
Changes in assets and liabilities:			
Accrued investment income	**(4)**	(4)	(13)
Premiums due and other receivables	**(153)**	(616)	(784)
Income taxes	**155**	31	(154)
Other assets and other liabilities	**653**	644	363
Health care and insurance liabilities	**91**	470	926
Net cash provided by operating activities	**3,719**	3,866	3,373
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	**14,741**	12,299	9,484
Cost of investments	**(14,852)**	(12,943)	(10,804)
Additions to property, equipment and software	**(270)**	(363)	(370)
Cash used for acquisitions, net of cash acquired	**—**	(20)	(440)
Net cash used for investing activities	**(381)**	(1,027)	(2,130)
Cash flows from financing activities:			
Issuance of long-term debt	**12,886**	—	1,482
Repayment of long-term debt	**—**	(229)	(1,798)
Net (repayment) issuance of short-term debt	**—**	(500)	500
Deposits and interest credited to investment contracts net of (withdrawals)	**1**	(35)	2
Common shares issued under benefit plans, net	**(139)**	(143)	(60)
Stock-based compensation tax benefits	**—**	53	41
(Settlements) proceeds from repurchase agreements	**—**	(202)	202
Common shares repurchased	**—**	(296)	(1,218)
Dividends paid to shareholders	**(351)**	(349)	(321)
Net payment on interest rate derivatives	**(274)**	(25)	(77)
Contributions (distributions), non-controlling interests	**11**	(9)	12
Net cash provided by (used for) financing activities	**12,134**	(1,735)	(1,235)
Net increase in cash and cash equivalents	**15,472**	1,104	8
Cash and cash equivalents, beginning of period	**2,524**	1,420	1,412
Cash and cash equivalents, end of period	**$ 17,996**	$ 2,524	$ 1,420
Supplemental cash flow information:			
Interest paid	**$ 541**	$ 338	$ 379
Income taxes paid	**1,580**	1,755	1,573

Refer to accompanying Notes to Consolidated Financial Statements.

Notes to Consolidated Financial Statements

1. Organization

We conduct our operations in three business segments:

- **Health Care** consists of medical, pharmacy benefit management services, dental, behavioral health and vision plans offered on both an Insured basis (where we assume all or a majority of the risk for medical and dental care costs) and an employer-funded basis (where the plan sponsor under an administrative services contract ("ASC") assumes all or a majority of this risk) and emerging business products and services that complement and enhance our medical products. We also offer Medicare and Medicaid products and services and other medical products, such as medical management and data analytics services, medical stop loss insurance, workers' compensation administrative services and products that provide access to our provider networks in select geographies.
- **Group Insurance** primarily includes group life insurance and group disability products. Group life insurance products are offered on an Insured basis. Group disability products are offered to employers on both an Insured and an ASC basis. Group Insurance also includes long-term care products that were offered primarily on an Insured basis. We no longer solicit or accept new long-term care customers.
- **Large Case Pensions** manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. These products provide a variety of funding and benefit payment distribution options and other services. Large Case Pensions also includes certain discontinued products (refer to Note 19 for additional information).

Our three business segments are distinct businesses that offer different products and services. Our Chief Executive Officer evaluates financial performance and makes resource allocation decisions at these segment levels. The accounting policies of the segments are the same as those described in the summary of significant accounting policies in Note 2. We evaluate the performance of these business segments based on operating earnings (net income or loss attributable to Aetna, excluding net realized capital gains or losses and other items, if any). Refer to Note 18 for segment financial information.

2. Summary of Significant Accounting Policies

Basis of Presentation
The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP") and include the accounts of Aetna and the subsidiaries that we control. All significant intercompany balances have been eliminated in consolidation. The Company has evaluated subsequent events from the balance sheet date through the date the financial statements were issued and determined there were no subsequent events to disclose other than as disclosed in Notes 3, 9, 13, 16 and 17.

Reclassifications
Certain prior year amounts have been reclassified to conform to the current year presentation.

Use of Estimates
The preparation of the accompanying consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the amounts reported in these consolidated financial statements and notes. We consider the following accounting estimates critical in the preparation of the accompanying consolidated financial statements: health care costs payable, other insurance liabilities, recoverability of goodwill and other acquired intangible assets, measurement of defined benefit pension and other postretirement employee benefit plans, other-than-temporary impairment of debt securities, revenue recognition, allowance for estimated terminations and uncollectible accounts and accounting for certain provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA"). We use information available to us at the time estimates are made; however, these estimates could change materially if different information or assumptions were used. Additionally, these estimates may not ultimately reflect the actual amounts of the final transactions that occur.

Cash and Cash Equivalents
Cash and cash equivalents include cash on-hand and debt securities with an original maturity of three months or less when purchased. The carrying value of cash equivalents approximates fair value due to the short-term nature of these investments. Cash and cash equivalents at December 31, 2016 include approximately $13 billion of highly-rated money market fund investments related to the net proceeds received from the 2016 senior notes we issued in June 2016 to partially fund our then pending acquisition of Humana Inc. (the "Humana Acquisition"). These money market funds have average maturities of 60 days or less and are redeemable daily at par value plus accrued dividends with specified yield rates.

Investments
Debt and Equity Securities
Debt and equity securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt and equity securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless we intend to sell an investment within the next twelve months, in which case it is classified as current on our balance sheets. We have classified our debt and equity securities as available for sale and carry them at fair value. Refer to Note 5 for additional information on how we estimate the fair value of these investments.

The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments.

We regularly review our debt and equity securities to determine whether a decline in fair value below the carrying value is other-than-temporary. When a debt or equity security is in an unrealized capital loss position, we monitor the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in the fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in our operating results, and the amount of the non-credit related component is included in other comprehensive income, unless we intend to sell the debt security or it is more likely than not that we will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. We do not accrue interest on debt securities when management believes the collection of interest is unlikely. If we intend to sell an equity security, we will recognize the unrealized capital gain or loss in our operating results.

Mortgage Loans
We value our mortgage loan investments on our balance sheet at the unpaid principal balance, net of impairment reserves. A mortgage loan may be impaired when it is a problem loan (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure), a potential problem loan (i.e., high probability of default) or a restructured loan. For impaired loans, a specific impairment reserve is established for the difference between the recorded investment in the loan and the estimated fair value of the collateral. We apply our loan impairment policy individually to all loans in our portfolio.

The impairment evaluation described above also considers characteristics and risk factors attributable to the aggregate portfolio. We establish an additional allowance for loan losses if it is probable that there will be a credit loss on a group of similar mortgage loans. We consider the following characteristics and risk factors when evaluating if a credit loss is probable on a group of similar mortgage loans: loan to value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition. As a result of that evaluation, we determined that a credit loss was not probable and did not record any additional allowance for groups of similar mortgage loans in 2016, 2015 or 2014.

We record full or partial impairments of loans at the time an event occurs affecting the legal status of the loan, typically at the time of foreclosure or upon a loan modification giving rise to forgiveness of debt. Interest income on a potential problem loan or restructured loan is accrued to the extent we deem it collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on our balance sheets.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships, which are carried at fair value on our balance sheets. The fair values of private equity limited partnerships are estimated based on the fair value of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. We typically do not have a controlling ownership in our private equity limited partnership investments, and therefore we apply the equity method of accounting for these investments. Hedge fund limited partnerships are carried at fair

value which is estimated using the net asset value ("NAV") per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. We review our investments for impairment at least quarterly and monitor their performance throughout the year through discussions with the administrators, managers and/or general partners. If we become aware of an impairment of a limited partnership's investments through our review or prior to receiving the limited partnership's financial statements at the balance sheet date, we will recognize an impairment by recording a reduction in the carrying value of the limited partnership with a corresponding charge to realized capital losses.

- Investment real estate, which is carried on our balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any of our real estate investments is considered held-for-sale, we carry it at the lower of its carrying value or fair value less estimated selling costs. We generally estimate fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, we record the difference between the sales price and the carrying value as a realized capital gain or loss.
- Privately-placed equity securities, which are carried at cost on our balance sheets. We do not estimate the fair value of these securities if there are no identified events or changes in circumstances that may have a significant adverse effect on the fair value of the investment. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), we are required to purchase and hold shares of the FHLBB. These shares are restricted and also carried at cost.
- Bank loans, which are carried on our balance sheets at amortized cost, net of any allowance for impairments. If any of our bank loans are considered held-for-sale, we carry those loans at the lower of cost or fair value.
- Derivatives, which we make limited use of in order to manage interest rate, foreign exchange and price risk and credit exposure. The derivatives we use consist primarily of interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options, and credit default swaps. Derivative assets are recorded in investments and derivative liabilities are recorded in accrued expenses and other current liabilities on our balance sheets and reflected at fair value. When we enter into a derivative contract, if certain criteria are met, we may designate it as one of the following: a hedge of the fair value of a recognized asset or liability or of an unrecognized firm commitment; a hedge of a forecasted transaction or of the variability of cash flows to be received or paid related to a recognized asset or liability; or a foreign currency fair value or cash flow hedge.

Net Investment Income

Net investment income on investments supporting Health Care and Group Insurance liabilities and Large Case Pensions products (other than experience-rated and discontinued products) is reflected in our operating results.

Experience-rated products are products in the Large Case Pensions business where the contract holder, not us, assumes investment and other risks, subject to, among other things, minimum guarantees provided by us. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact our operating results (as long as our minimum guarantees are not triggered).

When we discontinued the sale of our fully-guaranteed Large Case Pensions products, we established a reserve for anticipated future losses from these discontinued products and segregated the related investments. Investment performance on this separate portfolio is ultimately credited/charged to the reserve and, generally, does not impact our operating results.

Net investment income supporting Large Case Pensions' experience-rated and discontinued products is included in net investment income in our statements of income and is credited to contract holders' accounts or the reserve for anticipated future losses through a charge to current and future benefits.

Realized/Unrealized Capital Gains and Losses

Realized capital gains and losses on investments supporting Health Care and Group Insurance liabilities and Large Case Pensions products (other than experience-rated and discontinued products) are reflected in our operating results. Realized capital gains and losses are determined on a specific identification basis. We reflect purchases and sales of debt and equity securities and alternative investments on the trade date. We reflect purchases and sales of mortgage loans and investment real estate on the closing date.

Realized capital gains and losses on investments supporting Large Case Pensions' experience-rated and discontinued products are not included in realized capital gains and losses in our statements of income and instead are credited directly to contract holders' accounts, in the case of experience-rated products, or allocated to the reserve for anticipated future losses, in the case of discontinued products. The contract holders' accounts are reflected in policyholders' funds, and the reserve for anticipated future losses is reflected in future policy benefits on our balance sheets.

Unrealized capital gains and losses on investments supporting Health Care and Group Insurance liabilities and Large Case Pensions products (other than experience-rated and discontinued products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive loss.

Unrealized capital gains and losses on investments supporting Large Case Pensions' experience-rated products are credited directly to contract holders' accounts, which are reflected in policyholders' funds on our balance sheets. Unrealized capital gains and losses on discontinued products are reflected in other long-term liabilities on our balance sheets.

Refer to Note 19 for additional information on our discontinued products.

Premium Receivables
Premium receivables include the uncollected amounts from fully-insured groups, individuals and government programs and are reported net of an allowance for estimated terminations and uncollectible accounts of $139 million and $146 million at December 31, 2016 and 2015, respectively. We estimate the allowance for estimated terminations and uncollectible accounts using management's best estimate of collectability, taking into consideration the age of the outstanding amount, historical collection patterns and other economic factors.

Other Receivables
Other receivables include uncollected amounts from self-funded groups, pharmacy rebates, other government receivables, proceeds due from brokers on investment trades, provider advances and other miscellaneous amounts due to us. These receivables are reported net of an allowance for uncollectible accounts of $37 million and $20 million at December 31, 2016 and 2015, respectively. We estimate the allowance for uncollectible accounts using management's best estimate of collectability, taking into consideration the age of the outstanding amount, historical collection patterns and other economic factors.

Reinsurance Recoverables
We utilize reinsurance agreements primarily to reduce our required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit us to recover a portion of our losses from reinsurers, although they do not discharge our primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify us could result in losses; however, we do not expect charges for unrecoverable reinsurance to have a material effect on our operating results or financial position. We evaluate the financial condition of our reinsurers and monitor concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of our reinsurers. At December 31, 2016, our reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations.

Health Care Contract Acquisition Costs
Health care benefits products included in our Health Care segment are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to our prepaid health care and health indemnity contracts are generally expensed as incurred. At December 31, 2016 and 2015, the balance of our deferred acquisition costs was $412 million and $305 million, respectively, comprised primarily of commissions paid on our Medicare Supplement products. Deferred acquisition costs are recorded as other current assets or other long-term assets on our balance sheets and are amortized over the estimated life of the contracts.

Goodwill and Other Acquired Intangible Assets
When we complete an acquisition, we apply the acquisition method of accounting, which requires the recognition of goodwill (the excess cost of the acquisition over the fair value of net assets acquired and identified intangible assets). We evaluate goodwill for impairment (at the reporting unit level) annually, or more frequently if circumstances indicate a possible impairment, by comparing an estimate of the fair value of the applicable reporting unit to its carrying value, including goodwill. If the carrying value exceeds fair value, we have historically compared the implied fair value of the applicable goodwill to its carrying amount to measure the amount of goodwill impairment, if any. Beginning in 2017, we adopted, on a prospective basis, the recently issued accounting standards update related to the methodology utilized to evaluate goodwill impairment. This update simplifies the methodology used to perform our annual, or interim, goodwill impairment evaluations. Our evaluation will be performed by comparing the estimated fair value of a reporting unit with its carrying amount. An impairment charge would be recognized when the carrying amount exceeds the estimated fair value of the reporting unit. Impairments, if any, would be classified as an operating expense. The fair value of each reporting unit substantially exceeded its carrying value in each of the years in the three-year period ended December 31, 2016, and therefore there were no goodwill impairment losses recognized in any of those years.

Our annual impairment tests were based on an evaluation of future discounted cash flows. These evaluations utilized the best information available to us at the time, including supportable assumptions and projections we believe are reasonable. Collectively, these evaluations were our best estimates of projected future cash flows. Our discounted cash flow evaluations used discount rates that correspond to a weighted-average cost of capital consistent with a market-participant view. The discount rates are consistent with those used for investment decisions and take into account the operating plans and strategies of the Health Care and Group Insurance segments. Certain other key assumptions utilized, including changes in membership, revenue, health care costs, operating expenses, impacts of health care reform fees, assessments and taxes, and effective tax rates, are based on estimates consistent with those utilized in our annual planning process that we believe are reasonable. If we do not achieve our earnings objectives, the assumptions and estimates underlying these goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment.

We report other acquired intangible assets at historical cost, net of accumulated amortization. Other acquired intangible assets primarily relate to provider networks, customer lists, value of business acquired ("VOBA"), technology and trademarks and are amortized over the useful-life based upon the pattern of future cash flows attributable to the asset. Other than VOBA and indefinite lived trademarks, other acquired intangible assets generally are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. Other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually.

We regularly evaluate whether events or changes in circumstances indicate that the carrying value of other acquired intangible assets may not be recoverable. If we determine that the carrying value of an asset may not be recoverable, we group the asset with other assets and liabilities at the lowest level for which independent identifiable cash flows are available and estimate the future undiscounted cash flows expected to result from future use of the asset group and its eventual disposition. If the sum of the expected undiscounted future cash flows is less than the carrying value of the asset group, we recognize an impairment loss for the amount by which the carrying value of the asset group exceeds its fair value. There were no material impairment losses on other acquired intangible assets recognized in any of the three years ended December 31, 2016, 2015 or 2014.

Property and Equipment

We report property and equipment at historical cost, net of accumulated depreciation. At December 31, 2016 and 2015, the historical cost of property and equipment was each approximately $1.4 billion, and the related accumulated depreciation was $851 million and $774 million, respectively. We calculate depreciation primarily using the straight-line method over the estimated useful lives of the respective assets, which range from 10 to 40 years for buildings and 3 to 15 years for equipment. Depreciation expense was $125 million, $131 million and $137 million for the years ended December 31, 2016, 2015 and 2014, respectively. If we determine the carrying value of our property and equipment is not recoverable, an impairment charge is recorded. There were no material impairment losses on property and equipment recognized in any of the three years ended December 31, 2016, 2015 or 2014.

Separate Accounts

Separate Accounts assets and liabilities in the Large Case Pensions segment represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income and net realized capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from our other businesses. Deposits, withdrawals, net investment income and net realized and net unrealized capital gains and losses on Separate Accounts assets are not reflected in our statements of income or cash flows. Management fees charged to contract holders are included in fees and other revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs and other amounts due to health care providers pursuant to risk-sharing arrangements related to the Health Care segment's Insured Commercial, Medicare and Medicaid products. Unpaid health care claims include our estimate of payments we will make on claims reported to us but not yet paid and for services rendered to members but not yet reported to us as of the balance sheet date (collectively, "IBNR") in our Health Care segment. Also included in these estimates is the cost of services that will continue to be rendered after the balance sheet date if we are obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors. We reflect changes in these estimates in health care costs in our operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the member. Approximately 4%, 4% and 5% of our

health care costs related to capitated arrangements in 2016, 2015 and 2014, respectively. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the balance sheet date.

We develop our estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, we consider the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing our estimate of IBNR, we consistently apply these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to calculate IBNR in 2016.

We analyze historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." We estimate completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents our estimate of claims remaining to be paid as of the financial statement date and is included in our health care costs payable. We use completion factors predominantly to estimate reserves for claims with claim incurred dates greater than three months prior to the financial statement date. The completion factors we use reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months prior to the financial statement date are less mature, we use a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. We place a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

Our health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including our ability to manage health care costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of our business. The health status of our members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and our health care cost trend rate.

For each reporting period, we use an extensive degree of judgment in the process of estimating our health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period we recognize the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. We believe our estimate of health care costs payable is reasonable and adequate to cover our obligations at December 31, 2016; however, actual claim payments may differ from our estimates. A worsening (or improvement) of our health care cost trend rates or changes in completion factors from those that we assumed in estimating health care costs payable at December 31, 2016 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, we re-examine previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that our estimates of health care costs payable could develop either favorably (that is, our actual health care costs for the period were less than we estimated) or unfavorably. The changes in our estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For our roll forward of our health care costs payable, refer to Note 7. Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for health care costs payable.

Unpaid claims
Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts in the Group Insurance segment, including an estimate for IBNR in our Group Insurance segment as of the balance sheet date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon our estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. We develop our estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. We discount certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect our expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. Our estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in our statements of income in the period they are determined. Refer to Note 7 for additional information related to our long-term disability unpaid claim liabilities.

We estimate our reserve for claims IBNR for life products largely based on completion factors. The completion factors we use are based on our historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. At December 31, 2016, we held $246 million in reserves for life claims incurred but not yet reported to us.

There have been no significant changes to the methodologies or assumptions used to calculate IBNR in 2016.

Future policy benefits
Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts in the Large Case Pensions segment and long-duration group life and long-term care insurance contracts in the Group Insurance segment. Reserves for limited payment contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from .8% to 11.3% in both 2016 and 2015. We periodically review mortality assumptions against both industry standards and our experience. Reserves for long-duration group life and long-term care contracts represent our estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. Assumed interest rates on such contracts ranged from 2.5% to 8.8% in both 2016 and 2015. Our estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions.

Policyholders' funds
Policyholders' funds consist primarily of reserves for pension and annuity investment contracts in the Large Case Pensions segment and customer funds associated with group life and health contracts in the Health Care and Group Insurance segments. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus credited interest thereon, net of experience-rated adjustments. In 2016, interest rates for pension and annuity investment contracts ranged from 3.5% to 15.9%, and interest rates for group life and health contracts ranged from 0% to 2.4%. In 2015, interest rates for pension and annuity investment contracts ranged from 3.5% to 14.7%, and interest rates for group life and health contracts ranged from 0% to 2.7%. Reserves for contracts subject to experience rating reflect our rights as well as the rights of policyholders and plan participants.

We also hold funds for health savings accounts ("HSAs") on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $1.7 billion and $1.5 billion at December 31, 2016 and 2015, respectively, and are reflected in other current assets with a corresponding liability in policyholder funds.

We review health care and other insurance liabilities periodically. We reflect any necessary adjustments during the current period in operating results. While the ultimate amount of claims and related expenses are dependent on future developments, it is management's opinion that the liabilities that have been established are adequate to cover such costs. The health care and other insurance liabilities that are expected to be paid within twelve months are classified as current on our balance sheets.

Premium Deficiency Reserves

We evaluate our insurance contracts to determine if it is probable that a loss will be incurred. We recognize a premium deficiency loss when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with our method of acquiring, servicing and measuring the profitability of such contracts. In the second and third quarters of 2016, we recorded premium deficiency reserves totaling $85 million related to anticipated future losses for the 2016 coverage year in our individual Commercial products. We did not have any premium deficiency reserves at December 31, 2016 or 2015.

Revenue Recognition

Premium Revenue

Health care premiums are recognized as income in the month in which the enrollee is entitled to receive health care services. Health care premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the ACA's minimum Medical Loss Ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. Other premium revenue for group life, long-term care and disability products is recognized as income, net of allowances for termination and uncollectible accounts, over the term of the coverage. Other premium revenue for Large Case Pensions' limited payment pension and annuity contracts is recognized as revenue in the period received. Premiums related to unexpired contractual coverage periods are reported as unearned premiums in our balance sheets and recognized as revenue when earned.

Some of our contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Administrative Service Contract ("ASC") Fees

Fees and other revenue consists primarily of ASC fees which are received in exchange for performing certain claim processing and member services for health and disability members and are recognized as revenue over the period the service is provided. Fees and other revenue also includes fees related to our pharmacy benefit management and workers' compensation administrative services products and services. Some of our contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, we are financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to us by the customer involved. Each period we estimate our obligations under the terms of these guarantees and record it as an offset to our ASC fees.

In addition, fees and other revenue also include charges assessed against contract holders' funds for contract fees, participant fees and asset charges related to pension and annuity products in the Large Case Pensions segment. Other amounts received on pension and annuity investment-type contracts are reflected as deposits and are not recorded as revenue. Some of our Large Case Pensions contract holders have the contractual right to purchase annuities with life contingencies using the funds they maintain on deposit with us. Since these products are considered an insurance contract, when the contract holder makes this election, we treat the accumulated investment balance as a single premium and reflect it as both premiums and current and future benefits in our statements of income.

Accounting for the Medicare Part D Prescription Drug Program Plans ("PDPs")

We were selected by the Centers for Medicare & Medicaid Services ("CMS") to be a national provider of PDPs in all 50 states to both individuals and employer groups in 2016, 2015 and 2014. Under these annual contracts, CMS pays us a portion of the premium, a portion of, or a capitated fee for, catastrophic drug costs and a portion of the health care costs for low-income Medicare beneficiaries and provides a risk-sharing arrangement to limit our exposure to unexpected expenses.

We recognize premiums received from, or on behalf of, members or CMS and capitated fees as premium revenue ratably over the contract period. We expense the cost of covered prescription drugs as incurred. Costs associated with low-income Medicare beneficiaries (deductible, coinsurance, etc.) and the catastrophic drug costs paid in advance by CMS are recorded as a liability and offset health care costs when incurred. For individual PDP coverage, the risk-sharing arrangement provides a risk corridor whereby the amount we received in premiums from members and CMS based on our annual bid is compared to our actual drug costs incurred during the contract year. Based on the risk corridor provision and PDP activity-to-date, we record an estimated risk-sharing receivable or payable on a quarterly basis as an adjustment to premium revenue. We perform a reconciliation of the final risk-sharing, low-income subsidy and catastrophic amounts after the end of each contract year.

Health Care Reform

Health Insurer Fee

Since January 1, 2014, the ACA imposes an annual premium-based health insurer fee ("HIF") for each calendar year payable in September which is not deductible for tax purposes. We are required to estimate a liability for the HIF at the beginning of the calendar year in which the fee is payable with a corresponding deferred asset that is amortized ratably to general and administrative expense over the calendar year. We record the liability for the health insurer fee in accrued expenses and other current liabilities and record the deferred asset in other current assets in our consolidated financial statements. In 2016, 2015 and 2014, general and administrative expense includes $837 million, $857 million and $605 million, respectively, related to our share of the HIF. In December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the HIF.

Public Exchanges

We are participating in certain public health insurance exchanges established pursuant to the ACA ("Public Exchanges"). Under regulations established by the U.S. Department of Health and Human Services ("HHS"), HHS pays us a portion of the premium ("Premium Subsidy") and a portion of the health care costs ("Cost Sharing Subsidy") for low-income individual Public Exchange members. In addition, HHS administers the ACA's Reinsurance, Risk Adjustment and Risk Corridor (the "3Rs") risk management programs.

We recognize monthly premiums received from Public Exchange members and the Premium Subsidy as premium revenue ratably over the contract period. The Cost Sharing Subsidy offsets health care costs based on our estimate of the portion of claim costs incurred by our low income individual Public Exchange members that qualify for reimbursement by HHS. We record a liability or a receivable depending on whether qualifying health care costs incurred are less than or greater than the Cost Sharing Subsidy received to date.

Reinsurance

The ACA established a temporary reinsurance program that expired at the end of 2016. Under this program, all issuers of major medical commercial insurance products and self-insured plan sponsors are required to contribute funding in amounts set by HHS. Funds collected will be utilized to reimburse issuers' high claims costs incurred for qualified individual members. The expense related to this required funding is reflected in general and administrative expenses for all of our insurance products with the exception of products associated with qualified individual members; this expense for qualified individual members is reflected as a reduction of premium revenue.

In 2016, 2015 and 2014, our estimated contribution to the funding of the ACA's reinsurance program was $118 million, $210 million and $336 million, respectively, which was recorded in general and administrative expenses. When annual claim costs incurred by our qualified individual members exceed a specified attachment point, we are entitled to certain reimbursements from this program. We record a receivable and offset health care costs to reflect our estimate of these recoveries.

Risk Adjustment

The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of our qualified plan members relative to the average risk of members of other qualified plans in comparable markets, we estimate our ultimate risk adjustment receivable or payable for the current calendar year and reflect the pro-rata year-to-date impact as an adjustment to our premium revenue.

Risk Corridor

The ACA established a temporary risk sharing program, which expired at the end of 2016, for qualified individual and small group insurance plans. Under this program we make (or receive) a payment to (or from) HHS based on the ratio of allowable costs to target costs (as defined by the ACA). We record a risk corridor receivable or payable as an adjustment to premium revenue on a pro-rata year-to-date basis based on our estimate of the ultimate risk sharing amount for the current calendar year. At December 31, 2016, we did not record any ACA risk corridor receivables related to the 2016 or 2015 program years or any amount in excess of HHS's announced pro-rated funding amount for the 2014 program year because payments from HHS are uncertain.

We expect to perform an annual final reconciliation and settlement with HHS of the Cost Sharing Subsidy and 3Rs in each subsequent year, except for the final reconciliation and settlement of the 2014 Cost Sharing Subsidy which occurred in 2016.

Refer to Note 8 for additional information related to the 3Rs.

Voluntary Early Retirement Program
In September 2016, we announced a voluntary early retirement program (the "Program"). Under the terms of the Program, eligible employees elected early retirement during the fourth quarter of 2016. We recorded a liability associated with the Program in accrued expenses and other current liabilities and an expense in general and administrative expenses of $330 million pretax at and for the year ended December 31, 2016, respectively.

Selling Expenses
Selling expenses include broker commissions, the variable component of our internal sales force compensation and premium taxes.

Stock-Based Compensation
We record compensation expense for stock-based awards over their vesting periods primarily based on the estimated fair value at the grant date. For stock appreciation rights ("SARs"), the fair value is estimated using the Black-Scholes option-pricing model. For restricted stock units ("RSUs") and performance stock units ("PSUs"), the fair value is equal to the market price of the Company's common stock on the date of grant. For market stock units ("MSUs") and performance stock appreciation rights ("PSARs"), the fair value is estimated using Monte Carlo simulations. Refer to Note 12 for additional information related to our stock-based employee incentive plans.

Income Taxes
We are taxed at the statutory corporate income tax rates after adjusting income reported for financial statement purposes for certain items. We recognize deferred income tax assets and liabilities for the differences between the financial and income tax reporting basis of assets and liabilities based on enacted tax rates and laws. Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. Deferred income tax expense or benefit primarily reflects the net change in deferred income tax assets and liabilities during the year.

Our current income tax provision reflects the tax results of revenues and expenses currently taxable or deductible. Penalties and interest on our tax positions are classified as a component of our income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit ("OPEB") Plans
We sponsor defined benefit pension plans ("pension plans") and OPEB plans for our employees and retirees. We recognize the funded status of our pension plans and OPEB plans on the consolidated balance sheets based on our year-end measurements of plan assets and benefit obligations. Prepaid pension and OPEB benefits represent prepaid costs related to our pension plans and are reported with other current and long-term assets. Liabilities associated with pension plans and OPEB plans are reported within current and other long-term liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets.

Earnings Per Share
We calculate basic earnings per share based on the weighted average number of common shares outstanding for the period. Diluted earnings per common share is calculated based on the weighted average number of common shares outstanding plus the dilutive effect of outstanding SARs, MSUs, PSUs, RSUs and PSARs using the treasury stock method. Refer to Notes 12 and 15 for additional information.

New Accounting Standards
Amendments to the Consolidation Analysis
Effective January 1, 2016, we adopted new accounting guidance related to the evaluation of consolidation for certain legal entities. The new guidance changes how a reporting entity assesses consolidation, including whether an entity is considered a variable interest entity, determination of the primary beneficiary and how related parties are considered in the analysis. The adoption of this new guidance required more of our other investments to be considered variable interest entities; however, it did not require additional investments to be consolidated or de-consolidated or have a material impact on our financial position or operating results. Our variable interest entity disclosures as of December 31, 2015 were retrospectively adjusted to conform with the new accounting guidance. Refer to Note 4 for further discussion.

Simplifying the Presentation of Debt Issuance Costs
Effective January 1, 2016, we adopted new accounting guidance related to the financial statement presentation of all debt issuance costs, including those related to line-of-credit arrangements. The new guidance requires debt issuance costs to be presented as a direct deduction from the carrying amount of our debt liability, consistent with the approach used for debt premiums or discounts. We also elected to report debt issuance costs associated with any line-of-credit arrangements as a direct deduction from the carrying amount of our debt liability. Amortization of debt issuance costs also will be reported in our statements of income in interest expense, as opposed to general and administrative expenses. We are applying this new

guidance on a full retrospective basis, with all prior periods restated for the new presentation. As a result of adopting this guidance, we reclassified $43 million of other current and long-term assets as a reduction of long-term debt on our balance sheet at December 31, 2015. Additionally, we reclassified an immaterial amount of general and administrative expenses into interest expense for the year ended December 31, 2015.

Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)
Effective January 1, 2016, we adopted new accounting guidance related to the presentation of investments in certain entities that calculate net asset value per share (or its equivalent). The new guidance removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. This new guidance is applicable to certain of our investments that reside in our general accounts, separate accounts and employee benefit plans. The adoption of this new guidance did not have a material impact on our financial position or operating results.

Improvements to Employee Share-Based Payment Accounting
Effective April 1, 2016, we elected to early adopt new accounting guidance related to the accounting for and financial statement presentation of employee share-based payments. As a result of adopting this new guidance, we recognized $29 million of excess tax benefits in our statements of income that previously would have been recorded in additional paid-in capital for the year ended December 31, 2016, and correspondingly reclassified the excess tax benefits for the year ended December 31, 2016 from financing activities to operating activities in our statements of cash flows. We applied each of these provisions on a prospective basis, with adjustments reflected as of January 1, 2016, and prior periods were not retrospectively adjusted. Our ability under the new guidance to withhold more shares to satisfy our statutory income tax obligations had no impact on our financial statements and was adopted on a modified retrospective basis. We continue to estimate expected forfeitures of share-based payment awards in each period.

Disclosures about Short-Duration Insurance Contracts
Effective December 31, 2016, we adopted new accounting guidance related to the disclosure of short-duration insurance contracts. The new guidance requires insurance companies that issue short-duration contracts to include additional disclosures about those insurance liabilities, including disaggregation of certain disclosures, as appropriate. The adoption of this new guidance did not have an impact on our financial position or operating results; however, the new guidance required additional disclosure for our health care cost payable and unpaid claims short-duration insurance liabilities that reside in our Health Care and Group Insurance segments.

Future Application of Accounting Standards
Simplifying the Test for Goodwill Impairment
Effective January 1, 2017, we adopted, on a prospective basis, new accounting guidance which simplifies the accounting for goodwill impairment. The new guidance eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. A goodwill impairment charge would be recognized if the carrying amount of a reporting unit exceeds the estimated fair value of the reporting unit. The adoption of this new guidance is not expected to have a material impact on our financial position or operating results.

Revenue from Contracts with Customers
Effective January 1, 2018, we will adopt new accounting guidance related to revenue recognition from contracts with customers. While industry-specific guidance related to contracts with customers within the scope of *Accounting Standards Codification ("ASC") 944 Financial Services - Insurance* remains unchanged, most other industry-specific revenue recognition requirements have been removed. The new guidance requires that an entity recognize revenue for the transfer of goods or services to a customer at an amount that reflects the consideration to which an entity expects to be entitled in exchange for those goods or services. The new guidance also requires additional disclosures regarding the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts. We currently anticipate adopting the new guidance using the modified retrospective approach with a cumulative effect adjustment to retained earnings. While we are still evaluating the impact of this new guidance to our financial statements, we anticipate that any impact will only relate to contracts with customers outside the scope of ASC Topic 944. Adoption of this new guidance could result in reclassifications within our consolidated statements of income; however, we do not anticipate any material changes in the timing of our recognition of revenue or net income.

Recognition and Measurement of Financial Assets and Financial Liabilities
Effective January 1, 2018, we will adopt new accounting guidance related to the recognition and measurement of financial assets and financial liabilities. Under the new guidance, all equity investments in unconsolidated entities will be measured at fair value with changes in fair value recognized in net income. A reporting entity may elect to report equity investments without a readily determinable fair value at cost. The new guidance also revises certain disclosures regarding financial assets and

liabilities. The adoption of this new guidance is not expected to have a material impact on our financial position or operating results.

Leases
Effective January 1, 2019, we will adopt new accounting guidance related to the recognition, measurement and disclosure requirements for leases. Under the new guidance, lessees will be required to recognize a right-of-use asset and corresponding lease liability on their balance sheets for all leases other than those that meet the definition of a short-term lease. The new guidance also revises certain disclosure requirements regarding leases. While we are still evaluating the impact of adoption of this new guidance, we anticipate that obligations related to our operating leases (as described in Note 17) will be required to be recorded on our balance sheet.

Measurement of Credit Losses on Financial Instruments
Effective January 1, 2020, we will adopt new accounting guidance related to the measurement of credit losses on financial assets and certain other instruments. The new guidance requires the use of a new forward-looking expected loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments; requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account; and revises certain disclosure requirements. We are still assessing the impact of this new guidance on our financial position and operating results.

3. Acquisitions, Terminated Acquisition and Terminated Divestiture

Terminated Acquisition of Humana and Terminated Divestiture to Molina
On July 2, 2015, we entered into a definitive agreement (the "Merger Agreement") to acquire Humana Inc. ("Humana") in a transaction valued at approximately $37.0 billion, based on the closing price of Aetna common shares on July 2, 2015, including the assumption of Humana debt and Humana cash and cash equivalents.

On July 21, 2016, the U.S. Department of Justice (the "DOJ") and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that the Humana Acquisition would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Acquisition. On February 14, 2017, Aetna and Humana entered into a mutual termination agreement (the "Termination Agreement") pursuant to which the parties thereto (collectively the "Parties") agreed to terminate the Merger Agreement, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby, entered pursuant thereto or entered in connection therewith (other than certain confidentiality agreements) (collectively with the Merger Agreement, the "Transaction Documents"), effective immediately as of February 14, 2017 (the "Termination Date"). Under the Termination Agreement, Aetna agreed to pay Humana the Regulatory Termination Fee (as defined in the Merger Agreement) of $1.0 billion in cash in full satisfaction of any amounts required to be paid by Aetna under the Merger Agreement. The Parties also agreed to release each other from any and all liability, claims, rights, actions, causes of action, suits, liens, obligations, accounts, debts, demands, agreements, promises, liabilities, controversies, costs, charges, damages, expenses and fees, however arising, in connection with, arising out of or related to the Transaction Documents, the transactions contemplated therein or thereby or certain related matters. We paid Humana the Regulatory Termination Fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes (as defined below).

In June 2016, we issued $13.0 billion of senior notes to partially fund the Humana Acquisition (collectively, the "2016 senior notes"). In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for $10.2 billion aggregate principal amount of certain of the 2016 senior notes (collectively, the "Special Mandatory Redemption Notes") at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem the Special Mandatory Redemption Notes on or about March 16, 2017. As a result of the redemption of the Special Mandatory Redemption Notes, in the first quarter of 2017, we will recognize on a pretax basis in our net income the entire approximately $420 million unamortized portion of the related cash flow hedge losses, debt issuance costs and debt issuance discounts and the entire approximately $100 million redemption premium paid on the Special Mandatory Redemption Notes upon such redemption.

In order to address the DOJ's perceived competitive concerns regarding Medicare Advantage relating to the Humana Acquisition, on August 2, 2016, we entered into a definitive agreement (the "Aetna APA") to sell for cash to Molina Healthcare, Inc. ("Molina") certain of our Medicare Advantage assets. On February 14, 2017, Aetna and Molina entered into a Termination Agreement (the "APA Termination Agreement") pursuant to which Aetna terminated the Molina APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, Aetna agreed to pay Molina in cash (a) a termination fee of $53 million and (b) approximately 70% of

Molina's transaction costs. We paid Molina the termination fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes. We expect to pay Molina the applicable transaction costs during the first quarter of 2017.

Acquisition of bswift LLC

In November 2014, we acquired bswift LLC ("bswift") for approximately $400 million. bswift provides a technology platform that offers a retail shopping experience for health insurance exchanges and employees nationwide, and provides benefit administration technology and services to employers. We recorded goodwill related to this transaction of $329 million, none of which will be tax deductible. All of the goodwill related to this acquisition was assigned to our Health Care segment.

Acquisition of the InterGlobal Group

In April 2014, we acquired the InterGlobal group ("InterGlobal"), a company that specializes in international private medical insurance for groups and individuals in the Middle East, Asia, Africa and Europe. The purchase price was not material, and the goodwill related to this acquisition was assigned to our Health Care segment.

4. Investments

Total investments at December 31, 2016 and 2015 were as follows:

	2016			2015		
(Millions)	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt and equity securities available for sale	**$ 2,876**	**$ 18,866**	**$ 21,742**	$ 2,877	$ 18,446	$ 21,323
Mortgage loans	**170**	**1,341**	**1,511**	127	1,427	1,554
Other investments	**—**	**1,626**	**1,626**	11	1,792	1,803
Total investments	**$ 3,046**	**$ 21,833**	**$ 24,879**	$ 3,015	$ 21,665	$ 24,680

At December 31, 2016 and 2015, we held investments of $657 million and $690 million, respectively, related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. These investments are included in the total investments of our Large Case Pensions segment supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of our business and only support our future policy benefits obligations under that group annuity contract. Refer to Note 2 for additional information.

Debt and Equity Securities

Debt and equity securities available for sale at December 31, 2016 and 2015 were as follows:

(Millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2016				
Debt securities:				
U.S. government securities	**$ 1,643**	**$ 51**	**$ —**	**$ 1,694**
States, municipalities and political subdivisions	**5,047**	**152**	**(61)**	**5,138**
U.S. corporate securities	**8,145**	**385**	**(55)**	**8,475**
Foreign securities	**2,958**	**163**	**(33)**	**3,088**
Residential mortgage-backed securities	**793**	**11**	**(9)**	**795**
Commercial mortgage-backed securities	**1,382**	**5**	**(39)** [1]	**1,348**
Other asset-backed securities	**1,077**	**7**	**(9)** [1]	**1,075**
Redeemable preferred securities	**22**	**5**	**—**	**27**
Total debt securities	**21,067**	**779**	**(206)**	**21,640**
Equity securities	**84**	**20**	**(2)**	**102**
Total debt and equity securities [2]	**$ 21,151**	**$ 799**	**$ (208)**	**$ 21,742**
December 31, 2015				
Debt securities:				
U.S. government securities	$ 1,804	$ 69	$ (1)	$ 1,872
States, municipalities and political subdivisions	4,890	244	(9)	5,125
U.S. corporate securities	7,982	340	(147)	8,175
Foreign securities	2,910	148	(61)	2,997
Residential mortgage-backed securities	914	17	(6)	925
Commercial mortgage-backed securities	1,262	17	(9) [1]	1,270
Other asset-backed securities	910	3	(19) [1]	894
Redeemable preferred securities	33	11	—	44
Total debt securities	20,705	849	(252)	21,302
Equity securities	23	4	(6)	21
Total debt and equity securities [2]	$ 20,728	$ 853	$ (258)	$ 21,323

[1] At both December 31, 2016 and 2015, we held securities for which we previously recognized an immaterial amount of non-credit related impairments in accumulated other comprehensive loss. These securities each had an immaterial amount of net unrealized capital gains at December 31, 2016 and 2015, respectively.

[2] Investment risks associated with our experience-rated and discontinued products generally do not impact our operating results (refer to Note 19 for additional information on our accounting for discontinued products). At December 31, 2016, debt and equity securities with a fair value of approximately $2.9 billion, gross unrealized capital gains of $195 million and gross unrealized capital losses of $35 million and, at December 31, 2015, debt and equity securities with a fair value of approximately $3.0 billion, gross unrealized capital gains of $209 million and gross unrealized capital losses of $68 million were included in total debt and equity securities, but support our experience-rated and discontinued products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income.

The fair value of debt securities at December 31, 2016 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or we intend to sell a security prior to maturity.

(Millions)	Amortized Cost	Fair Value
Due to mature:		
Less than one year	$ 1,380	$ 1,394
One year through five years	6,604	6,758
After five years through ten years	5,059	5,162
Greater than ten years	4,772	5,108
Residential mortgage-backed securities	793	795
Commercial mortgage-backed securities	1,382	1,348
Other asset-backed securities	1,077	1,075
Total	$ 21,067	$ 21,640

Mortgage-Backed and Other Asset-Backed Securities
All of our residential mortgage-backed securities at December 31, 2016 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2016, our residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 4.9 years.

Our commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2016, these securities had an average credit quality rating of AAA and a weighted average duration of 6.8 years.

Our other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2016, these securities had an average credit quality rating of AA- and a weighted average duration of 1.2 years.

Summarized below are the debt and equity securities we held at December 31, 2016 and 2015 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total [1]		
(Millions, except number of securities)	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses
December 31, 2016									
Debt securities:									
U.S. government securities	**26**	**$ 39**	**$ —**	**1**	**$ 1**	**$ —**	**27**	**$ 40**	**$ —**
States, municipalities and political subdivisions	**865**	**2,228**	**58**	**37**	**75**	**3**	**902**	**2,303**	**61**
U.S. corporate securities	**1,428**	**2,277**	**44**	**114**	**101**	**11**	**1,542**	**2,378**	**55**
Foreign securities	**649**	**970**	**27**	**62**	**76**	**6**	**711**	**1,046**	**33**
Residential mortgage-backed securities	**188**	**455**	**8**	**104**	**17**	**1**	**292**	**472**	**9**
Commercial mortgage-backed securities	**285**	**1,038**	**39**	**3**	**3**	**—**	**288**	**1,041**	**39**
Other asset-backed securities	**226**	**403**	**4**	**208**	**177**	**5**	**434**	**580**	**9**
Total debt securities	**3,667**	**7,410**	**180**	**529**	**450**	**26**	**4,196**	**7,860**	**206**
Equity securities	**2**	**3**	**—**	**8**	**3**	**2**	**10**	**6**	**2**
Total debt and equity securities [1]	**3,669**	**$ 7,413**	**$ 180**	**537**	**$ 453**	**$ 28**	**4,206**	**$ 7,866**	**$ 208**
December 31, 2015									
Debt securities:									
U.S. government securities	48	$ 67	$ —	6	$ 13	$ —	54	$ 80	$ —
States, municipalities and political subdivisions	286	714	6	42	92	3	328	806	9
U.S. corporate securities	2,751	3,169	131	215	144	16	2,966	3,313	147
Foreign securities	793	1,102	50	82	89	11	875	1,191	61
Residential mortgage-backed securities	212	329	3	177	89	3	389	418	6
Commercial mortgage-backed securities	226	562	9	30	24	—	256	586	9
Other asset-backed securities	626	653	16	69	67	4	695	720	20
Total debt securities	4,942	6,596	215	621	518	37	5,563	7,114	252
Equity securities	11	—	5	5	2	1	16	2	6
Total debt and equity securities [1]	4,953	$ 6,596	$ 220	626	$ 520	$ 38	5,579	$ 7,116	$ 258

[1] At December 31, 2016 and 2015, debt and equity securities in an unrealized capital loss position of $35 million and $68 million, respectively, and with related fair value of $890 million and $966 million, respectively, related to experience-rated and discontinued products.

We reviewed the securities in the tables above and concluded that they are performing assets generating investment income to support the needs of our business. In performing this review, we considered factors such as the quality of the investment security based on research performed by our internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. At December 31, 2016, we did not intend to sell these securities, and we did not believe it was more likely than not that we would be required to sell these securities prior to anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2016 were as follows:

	Supporting discontinued and experience-rated products		Supporting remaining products		Total	
(Millions)	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Due to mature:						
Less than one year	$ 5	$ —	$ 201	$ —	$ 206	$ —
One year through five years	70	1	2,083	28	2,153	29
After five years through ten years	288	9	1,559	43	1,847	52
Greater than ten years	317	17	1,244	51	1,561	68
Residential mortgage-backed securities	16	1	456	8	472	9
Commercial mortgage-backed securities	174	6	867	33	1,041	39
Other asset-backed securities	20	1	560	8	580	9
Total	$ 890	$ 35	$ 6,970	$ 171	$ 7,860	$ 206

Mortgage Loans

Our mortgage loans are collateralized by commercial real estate. During 2016 and 2015 we had the following activity in our mortgage loan portfolio:

(Millions)	2016	2015
New mortgage loans	$ 190	$ 213
Mortgage loans fully-repaid	173	163
Mortgage loans foreclosed	8	9

We assess our mortgage loans on a regular basis for credit impairments, and annually assign a credit quality indicator to each loan. Our credit quality indicator is internally developed and categorizes our portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan to value ratios, property condition, market trends, creditworthiness of the borrower and deal structure. The vast majority of our mortgage loans fall into categories 2 to 4.

- *Category 1* - Represents loans of superior quality
- *Category 2 to 4* - Represents loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represents loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk and if necessary, an impairment is recorded.

Based upon our most recent assessments at December 31, 2016 and 2015, our mortgage loans were given the following credit quality indicators:

(In Millions, except credit ratings indicator)	2016	2015
1	$ 45	$ 66
2 to 4	1,449	1,467
5 and 6	17	21
7	—	—
Total	$ 1,511	$ 1,554

At December 31, 2016 scheduled mortgage loan principal repayments were as follows:

(Millions)	
2017	**$ 171**
2018	**216**
2019	**123**
2020	**166**
2021	**253**
Thereafter	**582**

Net Investment Income

Sources of net investment income for 2016, 2015 and 2014 were as follows:

(Millions)	2016	2015	2014
Debt securities	**$ 772**	$ 794	$ 801
Mortgage loans	**95**	91	108
Other investments	**82**	78	76
Gross investment income	**949**	963	985
Investment expenses	**(39)**	(46)	(39)
Net investment income [1]	**$ 910**	$ 917	$ 946

[1] Net investment income includes $208 million, $248 million and $289 million for 2016, 2015 and 2014, respectively, related to investments supporting our experience-rated and discontinued products.

Realized Capital Gains/Losses

Net realized capital (losses) gains for the three years ended December 31, 2016, 2015 and 2014, excluding amounts related to experience-rated contract holders and discontinued products, were as follows:

(Millions)	2016	2015	2014
Other-than-temporary impairment ("OTTI") losses on debt securities recognized in earnings	**$ (30)**	$ (64)	$ (5)
Other net realized capital gains (losses)	**116**	(1)	85
Net realized capital gains (losses)	**$ 86**	$ (65)	$ 80

The net realized capital gains in 2016 were primarily attributable to gains from the sales of debt securities and other investments, partially offset by yield-related OTTI on debt securities. The net realized capital losses in 2015 were primarily attributable to yield-related OTTI on U.S. corporate debt securities. The net realized capital gains in 2014 were primarily attributable to gains from the sales of debt and equity securities.

Yield-related impairments are recognized in other comprehensive income unless we have the intention to sell the security in an unrealized capital loss position, in which case the yield-related OTTI is recognized in earnings. In 2016 and 2015, we recognized yield-related OTTI losses of $24 million and $63 million, respectively, related to our debt securities. Yield-related OTTI losses were not significant in 2014. We had no other individually material realized capital losses on debt or equity securities that impacted our operating results during 2016, 2015 or 2014.

Excluding amounts related to experience-rated and discontinued products, proceeds from the sale of available for sale debt and equity securities and the related gross realized capital gains and losses for 2016, 2015 and 2014 were as follows [1]:

(Millions)	2016	2015	2014
Proceeds on sales	**$ 6,725**	$ 4,987	$ 4,615
Gross realized capital gains	**155**	83	109
Gross realized capital losses	**61**	76	36

[1] The proceeds on sales and gross realized capital gains and losses exclude the impact of the sales of short-term debt securities which primarily relate to our investments in mutual funds. These investments were excluded from the disclosed amounts because they represent an immaterial amount of aggregate gross realized capital gains or losses and have a high volume of sales activity.

Variable Interest Entities

As discussed in Note 2, we adopted the guidance of Accounting Standards Update (ASU) *No. 2015-02, Amendments to the Consolidation Analysis (Topic 810)* effective January 1, 2016. As a result of adopting the new guidance, we have investments in certain hedge fund and private equity investments and real estate partnerships that are considered Variable Interest Entities ("VIE's"). We do not have a future obligation to fund losses or debts on behalf of these investments; however, we may voluntarily contribute funds.

In evaluating whether we are the primary beneficiary of a VIE, we considered several factors, including whether we (a) have the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary

Upon adoption of the new guidance, we identified one hedge fund investment previously consolidated as a Voting Interest Entity in our balance sheets and operating results that is determined to be a VIE under the new guidance. The investment represents a majority-owned hedge fund where we are the investment manager and have the power to direct the activities that most significantly impact the VIE's economic performance, including determining the hedge fund's investment strategy. Accordingly, we are the primary beneficiary and will continue to consolidate the investment in our operating results. The fund invests in additional hedge funds that are VIEs; however, we are not the primary beneficiary of these underlying funds as discussed in further detail below.

Substantially all of the assets of the VIE hedge fund are comprised of hedge fund investments reported as long-term investments on our balance sheets. The VIE hedge fund had no material liabilities at December 31, 2016 or 2015. The total amount of the VIE hedge fund's assets included in long term investments on our balance sheets at December 31, 2016 and 2015 was $472 million and $477 million, respectively.

Variable Interest Entities - Other Variable Interest Holder

Our involvement with VIEs where we are not determined to be the primary beneficiary consists of the following:

- *Hedge fund and private equity investments* - We invest in hedge fund and private equity investments in order to generate investment returns for our investment portfolio supporting our businesses.
- *Real estate partnerships* - We invest in various real estate partnerships including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to us are from tax credits and other tax benefits.

We are not the primary beneficiary of these investments because the nature of our involvement with the activities of these VIEs does not give us the power to direct the activities that most significantly impact their economic performance. We record the amount of our investment in these VIEs as long-term investments on our balance sheets and recognize our share of each VIE's income or losses in earnings. Our maximum exposure to loss from these VIEs is limited to our investment balances as disclosed below and the risk of recapture of tax credits related to the real estate partnerships previously recognized, which we do not consider significant.

The total amount of other variable interest holder VIE assets included in long term investments on our balance sheets at December 31, 2016 and 2015 were as follows:

(Millions)	**December 31, 2016**	**December 31, 2015**
Hedge fund investments	**$ 384**	$ 418
Private equity investments	**454**	443
Real estate partnerships	**278**	254
Total	**$ 1,116**	$ 1,115

The carrying value of the total assets and liabilities of our other variable interest holder VIE investments at December 31, 2016 and 2015 were as follows:

(Millions)	December 31, 2016	December 31, 2015
Assets:		
Hedge fund investments	**$ 32,926**	$ 33,066
Private equity investments	**25,368**	28,552
Real estate partnerships	**6,743**	6,809
Total	**$ 65,037**	$ 68,427
Liabilities:		
Hedge fund investments	**$ 2,819**	$ 3,535
Private equity investments	**2,354**	3,236
Real estate partnerships	**4,938**	5,045
Total	**$ 10,111**	$ 11,816

Non-controlling (Minority) Interests
At December 31, 2016 and 2015, continuing business non-controlling interests were $62 million and $65 million, respectively, primarily related to third party interests in our investment holdings as well as third party interests in certain of our operating entities. The non-controlling entities' share was included in total equity. Net loss attributable to non-controlling interests was $15 million during 2016. Net income attributable to non-controlling interests was $5 million and $4 million during 2015 and 2014, respectively. These non-controlling interests did not have a material impact on our financial position or operating results.

5. Fair Value

The preparation of our consolidated financial statements in accordance with GAAP requires certain of our assets and liabilities to be reflected at their fair value, and others on another basis, such as an adjusted historical cost basis. In this note, we provide details on the fair value of financial assets and liabilities and how we determine those fair values. We present this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income attributable to Aetna or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value in our Balance Sheets
Certain of our financial instruments are measured at fair value in our balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified in Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for our financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Debt Securities – Where quoted prices are available in an active market, our debt securities are classified in Level 1 of the fair value hierarchy. Our Level 1 debt securities are comprised primarily of U.S. Treasury securities.

The fair values of our Level 2 debt securities are obtained using models such as matrix pricing, which use quoted market prices of debt securities with similar characteristics, or discounted cash flows to estimate fair value. We review these prices to ensure they are based on observable market inputs that include, but are not limited to, quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable but not prices (for example, interest rates and credit risks). We also review the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, we select a sample of our Level 2 debt securities' prices and compare them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, our internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. We obtained one price for each of our Level 2 debt securities and did not adjust any of these prices at December 31, 2016 or 2015.

We also value certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. We obtained one non-binding broker quote for each of these Level 3 debt securities and did not adjust any of these quotes at December 31, 2016 or 2015. The total fair value of our broker quoted debt securities was $80 million and $78 million at December 31, 2016 and 2015, respectively. Examples of these broker quoted Level 3 debt securities include certain U.S. and foreign corporate securities and certain of our commercial mortgage-backed securities as well as other asset-backed securities. For some of our private placement securities, our internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

Equity Securities – We currently have two classifications of equity securities: those that are publicly traded and those that are privately placed. Our publicly-traded securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, we classify these securities in Level 3 because we price these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would result in a change in the fair value measurement, which may be significant.

Derivatives – Where quoted prices are available in an active market, our derivatives are classified in Level 1. Certain of our derivative instruments are valued using models that primarily use market observable inputs and therefore are classified in Level 2 because they are traded in markets where quoted market prices are not readily available.

Financial assets and liabilities measured at fair value on a recurring basis in our balance sheets at December 31, 2016 and 2015 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total
December 31, 2016				
Assets:				
Debt securities:				
U.S. government securities	**$ 1,514**	**$ 180**	**$ —**	**$ 1,694**
States, municipalities and political subdivisions	**—**	**5,137**	**1**	**5,138**
U.S. corporate securities	**—**	**8,395**	**80**	**8,475**
Foreign securities	**—**	**3,067**	**21**	**3,088**
Residential mortgage-backed securities	**—**	**795**	**—**	**795**
Commercial mortgage-backed securities	**—**	**1,348**	**—**	**1,348**
Other asset-backed securities	**—**	**1,075**	**—**	**1,075**
Redeemable preferred securities	**—**	**26**	**1**	**27**
Total debt securities	**1,514**	**20,023**	**103**	**21,640**
Equity securities	**59**	**—**	**43**	**102**
Derivatives	**—**	**—**	**—**	**—**
Total	**$ 1,573**	**$ 20,023**	**$ 146**	**$ 21,742**
Liabilities:				
Derivatives	**$ —**	**$ —**	**$ —**	**$ —**
December 31, 2015				
Assets:				
Debt securities:				
U.S. government securities	$ 1,671	$ 201	$ —	$ 1,872
States, municipalities and political subdivisions	—	5,124	1	5,125
U.S. corporate securities	—	8,111	64	8,175
Foreign securities	—	2,972	25	2,997
Residential mortgage-backed securities	—	925	—	925
Commercial mortgage-backed securities	—	1,270	—	1,270
Other asset-backed securities	—	894	—	894
Redeemable preferred securities	—	39	5	44
Total debt securities	1,671	19,536	95	21,302
Equity securities	2	—	19	21
Derivatives	—	20	—	20
Total	$ 1,673	$ 19,556	$ 114	$ 21,343
Liabilities:				
Derivatives	$ —	$ 88	$ —	$ 88

There were no transfers between Levels 1 and 2 during the years ended December 31, 2016 and 2015.

The changes in the balances of Level 3 financial assets during 2016 were as follows:

(Millions)	Foreign securities	U.S. corporate securities	Equity securities	Other	Total
Beginning balance	**$ 25**	**$ 64**	**$ 19**	**$ 6**	**$ 114**
Net realized and unrealized capital (losses) gains:					
Included in earnings	**—**	**(15)**	**—**	**—**	**(15)**
Included in other comprehensive income	**—**	**(4)**	**11**	**(3)**	**4**
Other [1]	**—**	**—**	**3**	**—**	**3**
Purchases	**16**	**41**	**10**	**33**	**100**
Sales	**(8)**	**(3)**	**—**	**(5)**	**(16)**
Settlements	**(2)**	**(3)**	**—**	**—**	**(5)**
Transfers out of Level 3, net	**(10)**	**—**	**—**	**(29)**	**(39)**
Ending balance	**$ 21**	**$ 80**	**$ 43**	**$ 2**	**$ 146**

(1) Reflects realized and unrealized capital gains and losses on investments supporting our experience-rated and discontinued products, which do not impact our operating results.

The changes in the balances of Level 3 financial assets during 2015 were as follows:

(Millions)	Foreign securities	U.S. corporate securities	Equity securities	Other	Total
Beginning balance	$ 32	$ 58	$ 18	$ 54	$ 162
Net realized and unrealized capital gains (losses):					
Included in earnings	—	(6)	—	—	(6)
Included in other comprehensive income	—	2	2	—	4
Other [1]	(1)	—	(3)	—	(4)
Purchases	—	11	2	24	37
Sales	(5)	(1)	—	—	(6)
Settlements	(1)	—	—	(9)	(10)
Transfers out of Level 3, net	—	—	—	(63)	(63)
Ending balance	$ 25	$ 64	$ 19	$ 6	$ 114

(1) Reflects realized and unrealized capital gains and losses on investments supporting our experience-rated and discontinued products, which do not impact our operating results.

The total gross transfers into (out of) Level 3 during the years ended December 31, 2016 and 2015 were as follows:

(Millions)	2016	2015
Gross transfers into Level 3	**$ —**	$ 1
Gross transfers out of Level 3	**(39)**	(64)
Net transfers out of Level 3	**$ (39)**	$ (63)

Gross transfers out of Level 3 during 2016 primarily related to commercial mortgage-backed securities. Gross transfers out of Level 3 during 2015 primarily related to other asset-backed securities.

Financial Instruments Not Measured at Fair Value in our Balance Sheets

The following is a description of the valuation methodologies used for estimating the fair value of our financial assets and liabilities that are carried on our balance sheets at adjusted cost or contract value.

Mortgage loans: Fair values are estimated by discounting expected mortgage loan cash flows at market rates that reflect the rates at which similar loans would be made to similar borrowers. These rates reflect our assessment of the creditworthiness of the borrower and the remaining duration of the loans. The fair value estimates of mortgage loans of lower credit quality, including problem and restructured loans, are based on the estimated fair value of the underlying collateral.

Bank loans: Where fair value is determined by quoted market prices of bank loans with similar characteristics, our bank loans are classified in Level 2. For bank loans classified in Level 3, fair value is determined by outside brokers using their internal analyses through a combination of their knowledge of the current pricing environment and market flows.

Equity securities: Certain of our equity securities are carried at cost. The fair values of our cost-method investments are not estimated if there are no identified events or changes in circumstances that may have a significant adverse effect on the fair value of the investment.

Investment contract liabilities:

- *With a fixed maturity*: Fair value is estimated by discounting cash flows at interest rates currently being offered by, or available to, us for similar contracts.
- *Without a fixed maturity*: Fair value is estimated as the amount payable to the contract holder upon demand. However, we have the right under such contracts to delay payment of withdrawals that may ultimately result in paying an amount different than that determined to be payable on demand.

Long-term debt: Fair values are based on quoted market prices for the same or similar issued debt or, if no quoted market prices are available, on the current rates estimated to be available to us for debt of similar terms and remaining maturities.

The carrying value and estimated fair value classified by level of fair value hierarchy for our financial instruments carried on our balance sheets at adjusted cost or contract value at December 31, 2016 and 2015 were as follows:

(Millions)	Carrying Value	Estimated Fair Value			
		Level 1	Level 2	Level 3	Total
December 31, 2016					
Assets:					
Mortgage loans	**$ 1,511**	**$ —**	**$ —**	**$ 1,540**	**$ 1,540**
Bank loans	**8**	**—**	**—**	**8**	**8**
Equity securities [1]	**35**	**N/A**	**N/A**	**N/A**	**N/A**
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	**8**	**—**	**—**	**8**	**8**
Without a fixed maturity	**378**	**—**	**—**	**364**	**364**
Long-term debt	**20,661**	**—**	**21,468**	**—**	**21,468**

(Millions)	Carrying Value	Estimated Fair Value			
		Level 1	Level 2	Level 3	Total
December 31, 2015					
Assets:					
Mortgage loans	$ 1,554	$ —	$ —	$ 1,599	$ 1,599
Bank loans	193	—	180	8	188
Equity securities [1]	35	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	9	—	—	9	9
Without a fixed maturity	371	—	—	351	351
Long-term debt	7,785	—	8,227	—	8,227

[1] It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies.

Separate Accounts Measured at Fair Value in our Balance Sheets

Separate Accounts assets in our Large Case Pensions segment represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from our other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in our statements of income, shareholders' equity or cash flows.

Separate Accounts assets include debt and equity securities and derivative instruments. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 5. Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts' interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value per share/unit on the valuation date.

Separate Accounts financial assets at December 31, 2016 and 2015 were as follows:

	2016				2015			
(Millions)	**Level 1**	**Level 2**	**Level 3**	**Total**	**Level 1**	**Level 2**	**Level 3**	**Total**
Debt securities	**$ 766**	**$ 2,378**	**$ —**	**$ 3,144**	$ 751	$ 2,382	$ 4	$ 3,137
Equity securities	**166**	**6**	**—**	**172**	170	5	—	175
Common/collective trusts	**—**	**582**	**—**	**582**	—	540	—	540
Total [1]	**$ 932**	**$ 2,966**	**$ —**	**$ 3,898**	$ 921	$ 2,927	$ 4	$ 3,852

[1] Excludes $93 million and $183 million of cash and cash equivalents and other receivables at December 31, 2016 and 2015, respectively.

During 2016 and 2015, we had an immaterial amount of Level 3 Separate Accounts financial assets and an immaterial amount of gross transfers of Separate Accounts financial assets into or out of Level 3. During 2016 and 2015, there were no transfers of Separate Accounts financial assets between Levels 1 and 2.

Offsetting Financial Assets and Liabilities

Certain financial assets and liabilities are offset in our balance sheets or are subject to master netting arrangements or similar agreements with the applicable counterparty. Financial assets, including derivative assets, subject to offsetting and enforceable master netting arrangements as of December 31, 2016 and December 31, 2015 were as follows:

		Gross Amounts Not Offset In the Balance Sheets		
(Millions)	**Gross Amounts of Recognized Assets [1]**	**Financial Instruments**	**Cash Collateral Received**	**Net Amount**
December 31, 2016				
Derivatives	**$ —**	**$ 17**	**$ —**	**$ 17**
Total	**$ —**	**$ 17**	**$ —**	**$ 17**
December 31, 2015				
Derivatives	$ 20	$ 12	$ (17)	$ 15
Total	$ 20	$ 12	$ (17)	$ 15

[1] There were no amounts offset in our balance sheets at December 31, 2016 or December 31, 2015.

Financial liabilities, including derivative liabilities, subject to offsetting and enforceable master netting arrangements as of December 31, 2016 and December 31, 2015 were as follows:

		Gross Amounts Not Offset In the Balance Sheets		
(Millions)	**Gross Amounts of Recognized Liabilities [1]**	**Financial Instruments**	**Cash Collateral Paid**	**Net Amount**
December 31, 2016				
Derivatives	**$ —**	**$ —**	**$ —**	**$ —**
Total	**$ —**	**$ —**	**$ —**	**$ —**
December 31, 2015				
Derivatives	$ 88	$ —	$ (90)	$ (2)
Total	$ 88	$ —	$ (90)	$ (2)

[1] There were no amounts offset in our balance sheets at December 31, 2016 or December 31, 2015.

6. Goodwill and Other Acquired Intangible Assets

The change in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2016 and 2015 was as follows:

(Millions)	Health Care	Group Insurance	Total Company
Balance at January 1, 2015	$ 10,500	$ 113	$ 10,613
Acquisitions	12	—	12
Dispositions	—	—	—
Subsequent adjustments	12	—	12
Balance at December 31, 2015	**10,524**	**113**	**10,637**
Acquisitions	—	—	—
Dispositions	—	—	—
Subsequent adjustments	—	—	—
Balance at December 31, 2016	**$ 10,524**	**$ 113**	**$ 10,637**

No goodwill is allocated to the Large Case Pensions segment. The increase in goodwill during 2015 was due to purchase accounting adjustments related to the bswift acquisition and goodwill associated with an immaterial acquisition.

Other acquired intangible assets at December 31, 2016 and 2015 were comprised of the following:

(Millions)	Cost	Accumulated Amortization	Net Balance	Amortization Period (Years)	
2016					
Provider networks	**$ 1,254**	**$ 694**	**$ 560**	**12-25**	(1)
Customer lists	**1,166**	**485**	**681**	**3-14**	(1)
Value of business acquired	**149**	**92**	**57**	**20**	
Technology	**176**	**123**	**53**	**4-10**	
Other	**10**	**4**	**6**	**10-15**	
Definite-lived trademarks	**170**	**107**	**63**	**5-20**	
Indefinite-lived trademarks	**22**	**—**	**22**		
Total other acquired intangible assets	**$ 2,947**	**$ 1,505**	**$ 1,442**		
2015					
Provider networks	$ 1,254	$ 632	$ 622	12-25	(1)
Customer lists	1,165	374	791	5-14	(1)
Value of business acquired	149	80	69	20	
Technology	176	93	83	4-10	
Other	10	3	7	2-15	
Definite-lived trademarks	170	76	94	5-20	
Indefinite-lived trademarks	22	—	22		
Total other acquired intangible assets	$ 2,946	$ 1,258	$ 1,688		

(1) The amortization period for our provider networks and customer lists includes an assumption of renewal or extension of these arrangements. At both December 31, 2016 and 2015, the periods prior to the next renewal or extension for our provider networks primarily ranged from 1 to 3 years, and the period prior to the next renewal or extension for our customer lists was 1 year. Any costs related to the renewal or extension of these contracts are expensed as incurred.

We estimate annual pre-tax amortization for other acquired intangible assets over the next five years to be as follows:

(Millions)	
2017	**$ 234**
2018	**198**
2019	**192**
2020	**180**
2021	**156**

7. Health Care and Other Insurance Liabilities

Health Care Costs Payable

The following is information about incurred and cumulative paid Health Care claims development as of December 31, 2016, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. Refer to Note 2 for information on how we estimate our IBNR reserve and health care costs payable as well as changes to those methodologies, if any. Our estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of our liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to our inability to gather consistent claim frequency information across our multiple claims processing systems. Any claim frequency count disclosure would not be comparable across our different claim processing systems and would not be consistent from period to period based on the volume of claims processed through each system. As a result, we have not included health care claim count frequency in the disclosures included below.

The information about incurred and paid Health Care claims development for the year ended December 31, 2015 is presented as required unaudited supplemental information.

(Millions)	**Incurred Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2015**	**2016**
	(Unaudited)	
2015	$ 41,825	**$ 41,114**
2016		**44,110**
	Total	**$ 85,224**

(Millions)	**Cumulative Paid Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2015**	**2016**
	(Unaudited)	
2015	$ 35,735	**$ 40,947**
2016		**37,888**
	Total	**$ 78,835**
All outstanding liabilities for health care costs payable prior to 2015, net of reinsurance		**66**
Total outstanding liabilities for health care costs payable, net of reinsurance		**$ 6,455**

At December 31, 2016, total Health Care IBNR liabilities plus expected development on reported claims totaled approximately $5.6 billion. Substantially all of the total Health Care IBNR liabilities plus expected development on reported claims at December 31, 2016 related to the current year.

The reconciliation of the December 31, 2016 Health Care net incurred and paid claims development tables to the health care costs payable liability in the consolidated balance sheet is as follows:

(Millions)	December 31, 2016
Short-duration health care costs payable, net of reinsurance	**$ 6,455**
Reinsurance recoverables	**5**
Insurance lines other than short duration	**98**
Total health care costs payable	**$ 6,558**

The following table shows the components of the change in health care costs payable during 2016, 2015 and 2014:

(Millions)	2016	2015	2014
Health care costs payable, beginning of the period	**$ 6,306**	$ 5,621	$ 4,547
Less: Reinsurance recoverables	**4**	6	8
Health care costs payable, beginning of the period, net	**6,302**	5,615	4,539
Acquisition of businesses	**—**	—	29
Add: Components of incurred health care costs			
Current year	**45,019**	42,553	41,328
Prior years	**(764)**	(841)	(581)
Total incurred health care costs	**44,255**	41,712	40,747
Less: Claims paid			
Current year	**38,700**	36,389	35,851
Prior years	**5,304**	4,636	3,849
Total claims paid	**44,004**	41,025	39,700
Health care costs payable, end of period, net	**6,553**	6,302	5,615
Add: Reinsurance recoverables	**5**	4	6
Health care costs payable, end of period	**$ 6,558**	$ 6,306	$ 5,621

Our estimates of prior years' health care costs payable decreased in each of 2016, 2015 and 2014, respectively, because claims settled for amounts less than originally estimated, primarily due to lower health care cost trends as well as the actual claim submission time being faster than we assumed in establishing our health care costs payable in the prior year. This development does not directly correspond to an increase in our current year operating results as these reductions were offset by estimated current period health care costs when we established our estimate of the current year health care costs payable.

Long-Term Disability Unpaid Claims

The following is information about incurred and cumulative paid long-term disability claims development as of December 31, 2016, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. Refer to Note 2 for information on how we estimate our IBNR reserve and unpaid long-term disability claims liability as well as changes to those methodologies. We define a unique claim in our long-term disability Insured products based on the date an individual is placed on disability. There have been no significant changes to the methodologies or assumptions used to determine claim frequency in 2016.

The information about incurred and paid long-term disability claims development for the years ended December 31, 2011 through 2015 is presented as required unaudited supplemental information. At December 31, 2016, we have disclosed six years of claims development and will add one year going forward in each subsequent year until we reach ten years of disclosure.

Incurred Long-Term Disability Claims, Net of Reinsurance

(Millions)	For the Years Ended December 31, (Unaudited)						As of December 31, 2016	
Date of Service	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**Total IBNR liabilities plus expected development on reported claims**	**Cumulative number of reported claims** *(Actual)*
2011	$ 360	$ 346	$ 335	$ 338	$ 342	**$ 340**	**$ 2**	**6,988**
2012		413	394	385	381	**384**	**1**	**8,171**
2013			473	482	463	**478**	**2**	**10,104**
2014				512	490	**481**	**8**	**11,622**
2015					533	**504**	**18**	**12,924**
2016						**573**	**270**	**11,464**
					Total	**$ 2,760**		

Cumulative Paid Long-Term Disability Claims, Net of Reinsurance

(Millions)	For the Years Ended December 31, (Unaudited)					
Date of Service	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
2011	$ 20	$ 96	$ 144	$ 173	$ 199	**$ 219**
2012		24	119	177	208	**236**
2013			32	151	224	**264**
2014				35	161	**242**
2015					40	**181**
2016						**48**
					Total	**1,190**
					All outstanding unpaid long-term disability claims prior to 2011, net of reinsurance	**754**
					Total outstanding unpaid long-term disability claims, net of reinsurance	**$ 2,324**

The reconciliation of the December 31, 2016 short-duration long-term disability net incurred and paid claims development tables to the short-duration long-term disability unpaid claims liability is as follows:

	December 31, 2016
Short-duration long-term disability unpaid claims, net of reinsurance	**$ 2,324**
Reinsurance recoverables	**26**
Impact of discounting	**(446)**
Total short-duration long-term disability unpaid claims	**$ 1,904**

The following is information on long-term disability unpaid claims liabilities presented at present value:

Unpaid Long-Term Disability Claims Liabilities Presented at Present Value

	Carrying amount of unpaid claims liabilities		**Discount rate**		**Aggregate amount of discount**	
	As of December 31,		**As of December 31,**		**As of December 31,**	
(Millions)	**2016**	**2015**	**2016**	**2015**	**2016**	**2015**
Long-term disability	**$ 1,878**	$ 1,793	**5.0%**	5.4%	**$ 446**	$ 473

Interest accretion in the amounts of $97 million, $97 million and $93 million were recognized for the years ended December 31, 2016, 2015 and 2014, respectively, within current and future benefits in our statements of income.

The following is required unaudited supplementary information about average historical long-term disability claims duration as of December 31, 2016:

Average Annual Percentage Payout of Incurred Claims by Age, Net of Reinsurance (Unaudited)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Long-term disability	7.3%	25.3%	15.0%	8.2%	6.9%	5.8%

The following table shows the components of the change in unpaid long-term disability claims during 2016, 2015 and 2014:

(Millions)	2016	2015	2014
Long-term disability unpaid claims beginning of the period	**$ 1,819**	$ 1,772	$ 1,685
Less: Reinsurance recoverables	**27**	27	28
Long-term disability unpaid claims, beginning of the period, net	**1,792**	1,745	1,657
Add: Components of incurred claims			
Current year	**529**	488	465
Prior years	**41**	(4)	22
Total incurred claims	**570**	484	487
Less: Claims paid			
Current year	**48**	40	35
Prior years	**436**	397	364
Total claims paid	**484**	437	399
Long-term disability unpaid claims, end of period, net	**1,878**	1,792	1,745
Add: Reinsurance recoverables	**26**	27	27
Long-term disability unpaid claims, end of period	**$ 1,904**	$ 1,819	$ 1,772

Our estimates of prior years' long-term disability unpaid claims liability were relatively consistent with actual results in each of 2016, 2015 and 2014, respectively.

The reconciliation of the short-duration long-term disability unpaid claims liability to the total unpaid claims liability in the consolidated balance sheet is as follows for 2016, 2015 and 2014:

(Millions)	2016	2015	2014
Short duration long-term disability unpaid claims	**$ 1,904**	$ 1,819	$ 1,772
Term life unpaid claims	**481**	493	518
Other unpaid claims	**119**	116	106
Total unpaid claims	**$ 2,504**	$ 2,428	$ 2,396

8. The ACA's Reinsurance, Risk Adjustment and Risk Corridor

We participate in certain Public Exchanges established pursuant to the ACA. Under regulations established by HHS, HHS pays us a portion of the Premium Subsidy and the Cost Sharing Subsidy for low-income individual Public Exchange members. In addition, HHS administers the 3Rs risk management programs.

Our current net receivable (payable) related to the 3Rs risk management programs at December 31, 2016 and 2015 was as follows:

	At December 31, 2016			At December 31, 2015		
(Millions)	Reinsurance	Risk Adjustment	Risk Corridor	Reinsurance	Risk Adjustment	Risk Corridor
Total current net receivable (payable)	**$ 202**	**$ (690)**	**$ (10)**	$ 395	$ (710)	$ (8)

At December 31, 2016, we estimate that we are entitled to receive a total of $465 million from HHS under the three-year ACA risk corridor program for the 2014 through 2016 program years. In November 2016, HHS announced that all 2015 ACA risk corridor collections will be used to pay a portion of the balances on the 2014 ACA risk corridor payments. At December 31, 2016, we did not record any ACA risk corridor receivables related to the 2016 or 2015 program years or any amount in excess of HHS's announced pro-rated funding amount for the 2014 program year because payments from HHS are uncertain.

We expect to perform an annual final reconciliation and settlement with HHS of the Cost Sharing Subsidy and 3Rs in each subsequent year, except for the final reconciliation and settlement of the 2014 Cost Sharing Subsidy which occurred in 2016.

Refer to Note 2 for additional information.

9. Debt

Long-term debt

The carrying value of our long-term debt at December 31, 2016 and 2015 was as follows:

(Millions)	2016	2015
Senior notes, 5.95% due March 2017 [1]	**$ 386**	$ 402
Senior notes, 1.75% due May 2017 [1]	**250**	249
Senior notes, 1.5% due November 2017 [1]	**499**	498
Senior notes, floating rate due December 2017 [1]	**499**	—
Senior notes, 1.7% due June 2018	**997**	—
Senior notes, 2.2% due March 2019	**374**	373
Senior notes, 1.9% due June 2019	**1,642**	—
Senior notes, 3.95% due September 2020	**745**	743
Senior notes, 2.4% due June 2021	**1,839**	—
Senior notes, 5.45% due June 2021	**661**	675
Senior notes, 4.125% due June 2021	**495**	494
Senior notes, 2.75% due November 2022	**986**	983
Senior notes, 2.8% due June 2023	**1,290**	—
Senior notes, 3.5% due November 2024	**742**	741
Senior notes, 3.2% due June 2026	**2,771**	—
Senior notes, 4.25% due June 2036	**1,480**	—
Senior notes, 6.625% due June 2036	**765**	765
Senior notes, 6.75% due December 2037	**527**	527
Senior notes, 4.5% due May 2042	**478**	477
Senior notes, 4.125% due November 2042	**489**	489
Senior notes, 4.75% due March 2044	**371**	371
Senior notes, 4.375% due June 2046	**2,375**	—
Total long-term debt	**20,661**	7,787
Less current portion of long-term debt	**1,634**	—
Less credit facility issuance costs	**—**	2
Total long-term debt, less current portion and credit facility issuance costs	**$ 19,027**	$ 7,785

[1] At December 31, 2016, our 5.95% senior notes due March 2017, 1.75% senior notes due May 2017, 1.5% senior notes due November 2017 and floating rate senior notes due December 2017 are each classified as current in our consolidated balance sheet.

At December 31, 2016 the amount of future maturities of our long-term debt are as follows:

(Millions)		
2017	**$**	**1,634**
2018		**997**
2019		**2,016**
2020		**745**
2021		**2,995**
Thereafter		**12,274**

2016 Senior Notes; Long-Term Debt and Bridge Credit Agreement
In June 2016, in connection with the Humana Acquisition, we issued the 2016 senior notes, which are comprised of: $500 million of floating rate senior notes due December 2017, $1.0 billion of 1.7% senior notes due June 2018, approximately $1.7 billion of 1.9% senior notes due June 2019, approximately $1.9 billion of 2.4% senior notes due June 2021, $1.3 billion of 2.8% senior notes due June 2023, $2.8 billion of 3.2% senior notes due June 2026, $1.5 billion of 4.25% senior notes due June 2036 and $2.4 billion of 4.375% senior notes due June 2046. As a result of the termination of the Merger Agreement, we will redeem all of the $10.2 billion aggregate principal amount of the 2016 senior notes that are due in 2019, 2021, 2026, 2036 and 2046 at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem those notes on or about March 16, 2017, and we expect to fund the redemption with the proceeds of the 2016 senior notes.

On July 30, 2015, we entered into a $13.0 billion 364-day senior unsecured bridge credit agreement (the "Bridge Credit Agreement") with a group of fifteen lenders. In connection with the closing of the 2016 senior notes, we terminated the Bridge Credit Agreement effective June 9, 2016. There were no amounts outstanding under the Bridge Credit Agreement at any time during the year ended December 31, 2016.

Early Extinguishment of Long-Term Debt
November 2014
On November 3, 2014, we announced the redemption for cash of the entire $496 million aggregate principal amount outstanding of our 6.50% senior notes due 2018. The redemption of these notes occurred on December 3, 2014 (the "December Redemption Date") at a redemption price that included a make-whole premium, plus interest accrued and unpaid at the December Redemption Date. We financed the redemption by issuing $750 million of 3.5% senior notes due 2024 (the "November 2014 Senior Notes"). As a result of the redemption, in the fourth quarter of 2014, we recorded a loss on the early extinguishment of long-term debt of $58 million ($89 million pretax).

In April 2014, we entered into an interest rate swap with a notional value of $250 million. We designated this swap as a cash flow hedge against interest rate exposure related to the forecasted future issuance of fixed-rate debt to be primarily used to refinance long-term debt maturing in 2018. In November 2014, prior to issuing the November 2014 Senior Notes used to refinance our 6.50% senior notes due 2018 and for general corporate purposes, we terminated this swap and paid an aggregate of $15 million to the swap counterparty upon termination. We performed a final effectiveness test upon termination of this swap and determined there was $3 million pretax of ineffectiveness that arose due to the actual debt issuance date being earlier than forecasted. The ineffectiveness was recorded as a realized capital loss in the fourth quarter of 2014. The effective portion of the hedge loss of $12 million pretax was recorded in accumulated other comprehensive loss, net of tax, and is being amortized as an increase to interest expense over the first 20 semi-annual interest payments of the November 2014 Senior Notes.

March 2014
On February 7, 2014, we announced the redemption for cash of the entire $750 million aggregate principal amount outstanding of our 6.0% senior notes due 2016. The redemption of these notes occurred on March 14, 2014 (the "March Redemption Date") at a redemption price that included a make-whole premium, plus interest accrued and unpaid at the March Redemption Date. We financed the redemption by issuing $375 million of 2.2% senior notes due 2019 and $375 million of 4.75% senior notes due 2044 (collectively, the "March 2014 Senior Notes"), together with other available resources. As a result of the redemption, in the first quarter of 2014, we recorded a loss on the early extinguishment of long-term debt of $60 million ($92 million pretax).

During June and July 2012, we entered into two interest rate swaps with an aggregate notional value of $375 million. We designated these swaps as cash flow hedges against interest rate exposure related to the forecasted future issuance of fixed-rate debt to refinance our 6.0% senior notes due 2016. In March 2014, prior to issuing the March 2014 Senior Notes used to

refinance our 6.0% senior notes due 2016, we terminated these swaps and received an aggregate of $34 million from the swap counterparties upon termination. We performed a final effectiveness test upon termination of these swaps and determined there was $12 million pretax of ineffectiveness that arose due to the actual debt issuance date being earlier than forecasted. The ineffectiveness was recorded as a realized capital gain in the first quarter of 2014. The effective portion of the hedge gain of $22 million pretax was recorded in accumulated other comprehensive loss, net of tax, and is being amortized as a reduction to interest expense over the first 20 semi-annual interest payments associated with the $375 million of 4.75% senior notes due 2044.

Cash Flow Hedges

In 2015 and 2016, we entered into various interest rate swaps and treasury rate locks with an aggregate notional value of $3.5 billion. We designated these interest rate swaps and treasury rate locks as cash flow hedges against interest rate exposure related to the forecasted future issuance of fixed-rate debt to be primarily used to finance a portion of the purchase price of the Humana Acquisition.

During the second quarter of 2016, prior to issuing the 2016 senior notes, we terminated interest rate swaps with an aggregate notional value of $2.3 billion and paid an aggregate of $193 million to the swap counterparties upon termination. We performed a final effectiveness test upon the termination of each swap, and the effective portion of the hedge loss of $193 million was recorded in accumulated other comprehensive loss, net of tax, as the forecasted future issuance of fixed-rate debt associated with the Humana Acquisition remained probable of occurring at the time of termination. Upon termination of the interest rate swaps in the second quarter of 2016, we concurrently entered into treasury rate locks with an aggregate notional value of $2.3 billion to replace the vacated hedged positions. The treasury rate locks were designated as cash flow hedges against interest rate exposure related to the forecasted future issuance of fixed-rate debt to be primarily used to finance a portion of the purchase price of the Humana Acquisition. In June 2016, in conjunction with the issuance of the 2016 senior notes, we terminated outstanding interest rate swaps and treasury rate locks with an aggregate notional value of $3.5 billion and paid an aggregate of $51 million to the hedge counterparties upon termination. We performed a final effectiveness test upon termination of each interest rate swap and treasury rate lock, and the effective portion of the hedge loss of $51 million was recorded in accumulated other comprehensive loss, net of tax. Upon the redemption of certain of the 2016 senior notes as described above, the remaining unamortized effective portion of the hedge loss recorded in accumulated other comprehensive income will be recognized in net income upon such redemption for each of the cash flow hedges discussed above.

In March 2014, we entered into two interest rate swaps with an aggregate notional value of $500 million. We designated these swaps as cash flow hedges against interest rate exposure related to the forecasted future issuance of fixed-rate debt to be primarily used to refinance long-term debt maturing in 2017. On September 30, 2015, we modified the timing of the forecasted future issuance of fixed-rate debt in conjunction with the expected timing of the financing of the Humana Acquisition and, as a result, we de-designated these swaps and re-designated them as cash flow hedges against interest rate exposure related to the forecasted future issuance of fixed-rate debt. The effective portion of the hedge loss of $73 million pretax remains in accumulated other comprehensive loss, net of tax, and will be amortized as an increase to interest expense over the first 20 semi-annual interest payments related to the fixed-rate debt. At March 31, 2016, we performed a quarterly effectiveness test of these swaps and determined there was $4 million pretax of ineffectiveness. That ineffectiveness was recorded as a realized capital loss in the first quarter of 2016. In June 2016, we terminated the hedges in conjunction with the issuance of the 2016 senior notes and paid an aggregate of $103 million to the hedge counterparties upon termination. We performed a final effectiveness test upon termination of each interest rate swap and determined there was $2 million pretax of ineffectiveness. That ineffectiveness was recorded as a realized capital loss in the second quarter of 2016. The effective portion of the hedge loss of $25 million pretax was recorded in accumulated other comprehensive loss, net of tax. Upon the redemption of certain of the 2016 senior notes as described above, the remaining unamortized effective portion of the hedge loss recorded in accumulated other comprehensive income will be recognized in net income upon such redemption.

Refer to Note 14 for additional information regarding hedge losses reclassified from accumulated other comprehensive loss to net income during the year ended December 31, 2016. Upon the redemption of certain of the 2016 senior notes in the first quarter of 2017, the remaining unamortized effective portion of the hedge loss as discussed above of approximately $330 million pretax recorded in accumulated other comprehensive income will be recognized in net income as a realized capital loss.

Revolving Credit Facility
On March 27, 2012, we entered into an unsecured $1.5 billion five-year revolving credit agreement (the "Credit Agreement") with several financial institutions. On September 24, 2012, in connection with the acquisition of Coventry, we entered into a First Amendment (the "First Amendment") to the Credit Agreement and also entered into an Incremental Commitment Agreement (the "Incremental Commitment Agreement"). On March 2, 2015, we entered into a Second Amendment to the Credit Agreement (the "Second Amendment"). On July 30, 2015, in connection with the Humana Acquisition, we entered into a Third Amendment (the "Third Amendment," and together with the First Amendment, the Incremental Commitment Agreement, the Second Amendment and the Credit Agreement, resulting in the "Facility"). The Facility is an unsecured $2.0 billion revolving credit agreement. The Third Amendment modified the calculation of total debt for the purposes of determining compliance prior to the Closing Date (as defined below) with certain covenants to exclude debt incurred by us to finance the Humana Acquisition, the other financing transactions related to the Humana Acquisition and/or the payment of fees and expenses incurred in connection therewith so long as either (A) the net proceeds of such debt are set aside to finance the Humana Acquisition, the other financing transactions related to the Humana Acquisition and/or the payment of fees and expenses incurred in connection therewith or (B) such debt is subject to mandatory redemption in the event that the Merger Agreement is terminated or expires.

In addition, upon our agreement with one or more financial institutions, we may expand the commitments under the Facility by an additional $500 million. The Facility also provides for the issuance of up to $200 million of letters of credit at our request, which count as usage of the available commitments under the Facility. In each of 2013, 2014 and 2015, we extended the maturity date of the Facility by one year. The maturity date of the Facility is March 27, 2020.

Various interest rate options are available under the Facility. Any revolving borrowings mature on the termination date of the Facility. We pay facility fees on the Facility ranging from .050% to .150% per annum, depending upon our long-term senior unsecured debt rating. The facility fee was .100% at December 31, 2016. The Facility contains a financial covenant that requires us to maintain a ratio of total debt to consolidated capitalization as of the end of each fiscal quarter at or below 50%. For this purpose, consolidated capitalization equals the sum of total shareholders' equity, excluding any overfunded or underfunded status of our pension and OPEB plans and any net unrealized capital gains and losses, and total debt (as defined in the Facility). We met this requirement at December 31, 2016. There were no amounts outstanding under the Facility at any time during the year ended December 31, 2016 or 2015.

Term Loan Agreement
On July 30, 2015, in connection with the Humana Acquisition, we entered into a senior three-year $3.2 billion term loan credit agreement (the "Term Loan Agreement") with a group of seventeen lenders. The lenders' commitments under the Term Loan Agreement terminated on February 14, 2017, as a result of the termination of the Merger Agreement.

Commercial Paper
At December 31, 2016 and 2015, we did not have any commercial paper outstanding.

Federal Home Loan Bank of Boston
We are a member of the Federal Home Loan Bank of Boston (the "FHLBB"), and as a member we have the ability to obtain cash advances, subject to certain minimum collateral requirements. Our maximum borrowing capacity available from the FHLBB at December 31, 2016 was $854 million. At both December 31, 2016 and 2015, we did not have any outstanding borrowings from the FHLBB.

10. Pension and Other Postretirement Plans

Defined Benefit Retirement Plans
We sponsor various defined benefit plans, including two pension plans, and OPEB plans that provide certain health care and life insurance benefits for retired employees, including those of our former parent company.

During 2016, 2015 and 2014 we did not make any contribution to the Aetna Pension Plan. Effective December 31, 2010, our employees no longer earn future pension service credits in the Aetna Pension Plan (i.e., the Plan was "frozen" effective December 31, 2010), although the Aetna Pension Plan will continue to operate and account balances will continue to earn annual interest credits.

In July 2014, we enhanced the Aetna Pension Plan. Effective December 1, 2014, we permitted certain current and future former employees with deferred vested Aetna Pension Plan balances to elect to receive a 100% lump-sum distribution. This election is a permanent addition to the Aetna Pension Plan. In addition, in July 2014, we announced a limited-time offer permitting certain former employees with deferred vested Aetna Pension Plan balances to elect a 100% lump-sum distribution. These distributions

in 2014 were funded from existing Aetna Pension Plan assets and exceeded the total 2014 service and interest cost. As a result, we performed a remeasurement of the Aetna Pension Plan, and we recorded a pretax non-cash settlement charge of $112 million in 2014 in general and administrative expenses.

We also sponsor a non-qualified supplemental pension plan (the "Non-qualified Pension Plan") that, prior to January 1, 2007, had been used to provide benefits for wages above the Internal Revenue Code wage limits applicable to tax qualified pension plans (such as the Aetna Pension Plan). Effective January 1, 2007, no new benefits accrue under the Non-qualified Pension Plan, but interest will continue to be credited on outstanding supplemental cash balance accounts; and the plan may continue to be used to credit special pension arrangements.

In addition, we currently provide certain medical and life insurance benefits for retired employees, including those of our former parent company. We provide subsidized health care benefits to certain eligible employees who terminated employment prior to December 31, 2006. There is a cap on our portion of the cost of providing medical and dental benefits to our retirees. Through December 31, 2015, all current and future retirees and employees who terminated employment at age 45 or later with at least five years of service were eligible to participate in our group health plans at their own cost. Effective January 1, 2016, only current and future retirees and employees who terminate employment at age 55 or later are eligible for such participation.

The information set forth in the following tables is based upon current actuarial reports using the annual measurement dates (December 31, for each year presented) for our pension and OPEB plans.

The following table shows the changes in the benefit obligations during 2016 and 2015 for our pension and OPEB plans:

	Pension Plans		OPEB Plans	
(Millions)	**2016**	**2015**	**2016**	**2015**
Benefit obligation, beginning of year	**$ 5,946**	$ 6,505	**$ 257**	$ 277
Interest cost	**260**	261	**11**	11
Actuarial loss (gain)	**161**	(453)	**—**	(10)
Benefits paid	**(335)**	(367)	**(20)**	(21)
Benefit obligation, end of year	**$ 6,032**	$ 5,946	**$ 248**	$ 257

The pension plans' benefit obligation remained relatively consistent in 2016 driven by interest cost recognized in 2016 and an increase in actuarial losses arising as a result of a lower discount rate as further described below; substantially offset by benefits paid in 2016.

The Aetna Pension Plan comprises 96% of the pension plans' total benefit obligation at December 31, 2016. The discount rates used to determine the benefit obligation of our pension and OPEB plans were calculated using a yield curve as of our annual measurement date. Each yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve. The weighted average discount rate for our pension plans was 4.22% and 4.50% for 2016 and 2015, respectively. The discount rate for our OPEB plans was 4.12% and 4.39% for 2016 and 2015, respectively. The discount rates differ for our pension and OPEB plans due to the duration of the projected benefit payments for each plan.

Beginning in 2017, we changed the approach used to estimate the interest cost component of net periodic benefit cost for pension and OPEB for plans that utilize a yield curve approach. Historically, we estimated the interest cost using a single weighted-average discount rate derived from the yield curve used to measure the projected benefit obligation. With this refinement, we will measure interest cost by applying the specific spot rates along that yield curve to the relevant projected cash flows for each component. We believe the new approach provides a more precise measurement of interest cost. This refinement has no effect on the measurement of our plan obligations. We have accounted for this as a change in accounting estimate and accordingly, have accounted for it on a prospective basis beginning in 2017.

Additionally, based on the mortality experience of our pension and OPEB plans, in 2016 we utilized the RP-2014 Mortality Table with a generation projection of future mortality improvements using Scale MP-2016. In 2015 we utilized the RP-2014 Mortality Table with a generational projection of future mortality improvements using Scale MP-2015. In 2014 we utilized the RP-2014 Mortality Table with a generational projection of future mortality improvements using Scale MP-2014.

The following table reconciles the beginning and ending balances of the fair value of plan assets during 2016 and 2015 for our pension and OPEB plans:

	Pension Plans		OPEB Plans	
(Millions)	**2016**	**2015**	**2016**	**2015**
Fair value of plan assets, beginning of year	**$ 5,802**	$ 6,147	**$ 55**	$ 58
Actual return on plan assets	**426**	—	**1**	1
Employer contributions	**21**	22	**16**	17
Benefits paid	**(335)**	(367)	**(20)**	(21)
Fair value of plan assets, end of year	**$ 5,914**	$ 5,802	**$ 52**	$ 55

The difference between the fair value of plan assets and the plan's benefit obligation is referred to as the plan's funded status. This funded status is an accounting-based calculation and is not indicative of our mandatory funding requirements.

The funded status of our pension and OPEB plans at the measurement date for 2016 and 2015 was as follows:

	Pension Plans		OPEB Plans	
(Millions)	**2016**	**2015**	**2016**	**2015**
Benefit obligation	**$ (6,032)**	$ (5,946)	**$ (248)**	$ (257)
Fair value of plan assets	**5,914**	5,802	**52**	55
Funded status	**$ (118)**	$ (144)	**$ (196)**	$ (202)

At December 31, 2016, the fair value of plan assets of the Aetna Pension Plan was in excess of the benefit obligations, while the Non-qualified Pension Plan had benefit obligations in excess of the fair value of plan assets. Below is the funded status of each of our Pension Plans:

	Aetna Pension Plan		Non-qualified Pension Plan	
(Millions)	**2016**	**2015**	**2016**	**2015**
Benefit obligation	**$ (5,807)**	$ (5,714)	**$ (225)**	$ (232)
Fair value of plan assets	**5,914**	5,802	**—**	—
Funded status	**$ 107**	$ 88	**$ (225)**	$ (232)

The amounts in accumulated other comprehensive loss that have not yet been recognized in net periodic benefit cost as of December 31, 2016 and 2015 were as follows:

	Pension Plans		OPEB Plans	
(Millions)	**2016**	**2015**	**2016**	**2015**
Unrecognized prior service credit	**$ —**	$ (1)	**$ (19)**	$ (22)
Unrecognized net actuarial losses	**2,460**	2,398	**66**	67
Amount recognized in accumulated other comprehensive loss	**$ (2,460)**	$ (2,397)	**$ (47)**	$ (45)

The (liabilities) assets recognized on our balance sheets at December 31, 2016 and 2015 for our pension and OPEB plans were comprised of the following:

	Pension Plans		OPEB Plans	
(Millions)	**2016**	**2015**	**2016**	**2015**
Accrued benefit assets reflected in other long-term assets	**$ 107**	$ 88	**$ —**	$ —
Accrued benefit liabilities reflected in other current liabilities	**(20)**	(19)	**(13)**	(14)
Accrued benefit liabilities reflected in other long-term liabilities	**(205)**	(213)	**(183)**	(188)
Net amount of (liabilities) assets recognized at December 31,	**$ (118)**	$ (144)	**$ (196)**	$ (202)

At December 31, 2016, we had approximately $2.5 billion and $66 million of net actuarial losses for our pension and OPEB plans, respectively, and $19 million of prior service credits for our OPEB plans and an immaterial amount of prior service credits

for our pension plan, that have not been recognized as components of net periodic benefit costs. We expect to recognize $65 million and $2 million in amortization of net actuarial losses for our pension and OPEB plans, respectively, and $4 million in amortization of prior service credits for our OPEB plans in 2017. Our amortization of prior service credits for our pension plans in 2017 is not expected to be material.

Components of the net periodic benefit (income) cost of our defined benefit pension plans and OPEB plans for the years ended December 31, 2016, 2015 and 2014 were as follows:

	Pension Plans			OPEB Plans		
(Millions)	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**
Amortization of prior service credit	**$ —**	$ (1)	$ (1)	**$ (4)**	$ (4)	$ (4)
Interest cost	**260**	261	288	**11**	11	12
Expected return on plan assets	**(389)**	(419)	(422)	**(3)**	(3)	(3)
Recognized net actuarial losses	**61**	62	47	**3**	3	1
Settlement charge	**—**	—	112	**—**	—	—
Net periodic benefit (income) cost	**$ (68)**	$ (97)	$ 24	**$ 7**	$ 7	$ 6

The weighted average assumptions used to determine net periodic benefit (income) cost in 2016, 2015 and 2014 for the pension and OPEB plans were as follows:

	Pension Plans			OPEB Plans		
	2016	**2015**	**2014**	**2016**	**2015**	**2014**
Discount rate	**4.50%**	4.12%	4.96%	**4.39%**	4.02%	4.73%
Expected long-term return on plan assets	**6.90%**	7.00%	7.00%	**4.75%**	5.30%	5.30%

We assume different health care cost trend rates for medical costs and prescription drug costs in estimating the expected costs of our OPEB plans. The assumed medical cost trend rate for 2017 is 5.5%, decreasing gradually to 4.5% by 2024. The assumed prescription drug cost trend rate for 2017 is 10.2%, decreasing gradually to 4.5% by 2024. These assumptions reflect our historical as well as expected future trends for retirees. In addition, the trend assumptions reflect factors specific to our retiree medical plan, such as plan design, cost-sharing provisions, benefits covered and the presence of subsidy caps. A one-percentage point increase in both the assumed medical cost and assumed prescription drug cost trend rates would result in a $.3 million pretax increase in the aggregate of the service and interest cost components of OPEB costs and a $8 million increase in the OPEB benefit obligation. A one-percentage point decrease in both the assumed medical cost and assumed prescription drug cost trend rates would result in a $.2 million pretax decrease in the aggregate of the service and interest cost components of OPEB costs and an $7 million decrease in the OPEB benefit obligation.

Our current funding strategy for the Aetna Pension Plan is to fund an amount at least equal to the minimum funding requirement as determined under applicable regulatory requirements with consideration of factors such as the maximum tax deductibility of such amounts. Minimum funding requirements for the Aetna Pension Plan were met in 2016 and 2015, and we were not required to make cash contributions for either of those years. We do not have any required contribution to the Aetna Pension Plan in 2017, although we may voluntarily contribute $60 million in 2017. Employer contributions related to the supplemental pension and OPEB plans represent payments to retirees for current benefits. We have no plans to return any pension or OPEB plan assets to the Company in 2017. Our non-qualified supplemental pension plan and OPEB plans do not have minimum funding requirements.

Expected benefit payments, which reflect future employee service, as appropriate, of the pension and OPEB plans to be paid for each of the next five years and in the aggregate for the next five years thereafter at December 31, 2016 were as follows:

(Millions)	Pension Plans	OPEB Plans
2017	$ 495	$ 18
2018	360	18
2019	360	18
2020	362	18
2021	366	17
2022-2026	1,844	82

Assets of the Aetna Pension Plan

The assets of the Aetna Pension Plan ("Pension Assets") primarily include debt and equity securities held in separate accounts, as well as common/collective trusts and real estate investments. The valuation methodologies used to price these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 5. Pension Assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodology used to price real estate investments and these additional investments, including the general classification pursuant to the valuation hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which includes, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity limited partnerships - Private equity limited partnerships are carried at fair value which is estimated based on the fair value of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. We typically do not have a controlling ownership in our private equity limited partnership investments, and therefore we apply the equity method of accounting for these investments. Accordingly, these investments have been excluded from the fair value table below.

Hedge fund limited partnerships - Hedge fund limited partnerships are carried at fair value which is estimated using the net asset value ("NAV") per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Pension Assets with changes in fair value measured on a recurring basis at December 31, 2016 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total
Debt securities:				
U.S. government securities	$ 460	$ 122	$ —	$ 582
States, municipalities and political subdivisions	—	128	—	128
U.S. corporate securities	—	1,291	—	1,291
Foreign securities	—	103	—	103
Residential mortgage-backed securities	—	163	—	163
Commercial mortgage-backed securities	—	57	—	57
Other asset-backed securities	—	60	—	60
Redeemable preferred securities	—	6	—	6
Total debt securities	460	1,930	—	2,390
Equity securities:				
U.S. Domestic	1,305	5	—	1,310
International	611	—	—	611
Domestic real estate	34	—	—	34
Total equity securities	1,950	5	—	1,955
Other investments:				
Real estate	—	—	478	478
Common/collective trusts [1]	—	465	—	465
Total other investments	—	465	478	943
Total pension investments [2]	$ 2,410	$ 2,400	$ 478	$ 5,288

(1) The assets in the underlying funds of common/collective trusts are comprised of $307 million of equity securities and $158 million of debt securities.

(2) Excludes $180 million of cash and cash equivalents and other payables.

Pension Assets with changes in fair value measured on a recurring basis at December 31, 2015 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total
Debt securities:				
U.S. government securities	$ 428	$ 135	$ —	$ 563
States, municipalities and political subdivisions	—	126	—	126
U.S. corporate securities	—	1,229	2	1,231
Foreign securities	—	136	—	136
Residential mortgage-backed securities	—	196	—	196
Commercial mortgage-backed securities	—	51	1	52
Other asset-backed securities	—	40	—	40
Redeemable preferred securities	—	7	—	7
Total debt securities	428	1,920	3	2,351
Equity securities:				
U.S. Domestic	1,222	5	—	1,227
International	547	—	—	547
Domestic real estate	28	—	—	28
Total equity securities	1,797	5	—	1,802
Other investments:				
Real estate	—	—	497	497
Common/collective trusts [1]	—	556	—	556
Total other investments	—	556	497	1,053
Total pension investments [2]	$ 2,225	$ 2,481	$ 500	$ 5,206

[1] The assets in the underlying funds of common/collective trusts are comprised of $302 million of equity securities and $254 million of debt securities.

[2] Excludes $133 million of cash and cash equivalents and other payables.

The changes in the balances of Level 3 Pension Assets during 2016 and 2015 were as follows:

	2016		
(Millions)	Real Estate	Other	Total
Beginning balance	**$ 497**	**$ 3**	**$ 500**
Actual return on plan assets	**42**	**—**	**42**
Purchases, sales and settlements	**(61)**	**(1)**	**(62)**
Transfers out of Level 3	**—**	**(2)**	**(2)**
Ending balance	**$ 478**	**$ —**	**$ 478**

	2015		
(Millions)	Real Estate	Other	Total
Beginning balance	$ 470	$ 2	$ 472
Actual return on plan assets	46	—	46
Purchases, sales and settlements	(19)	—	(19)
Transfers into Level 3	—	1	1
Ending balance	$ 497	$ 3	$ 500

The Aetna Pension Plan invests in a diversified mix of assets intended to maximize long-term returns while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons, and by assessing the Aetna Pension Plan's liability characteristics, our financial position and our future potential obligations from both the pension and general corporate perspectives. Complementary investment styles and techniques are utilized by multiple professional investment firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed

favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2016, target investment allocations for the Aetna Pension Plan were: 38% in equity securities, 48% in debt securities, 7% in real estate, 4% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the plan's Benefit Finance Committee. Forecasting of asset and liability growth is performed at least annually.

We have several benefit plans for retired employees currently supported by the OPEB plan assets. OPEB plan assets are directly and indirectly invested in a diversified mix of traditional asset classes, primarily high-quality fixed income securities.

The actual and target asset allocations of the OPEB plans used at December 31, 2016 and 2015 presented as a percentage of total plan assets, were as follows:

(Millions)	**2016**	**Target Allocation**	**2015**	**Target Allocation**
Equity securities	**11%**	**5-15%**	10%	5-15%
Debt securities	**82%**	**80-90%**	83%	80-90%
Real estate/other	**7%**	**0-10%**	7%	0-10%

Our expected return on plan assets assumption is based on many factors, including forecasted capital market real returns over a long-term horizon, forecasted inflation rates, historical compounded asset returns and patterns and correlations on those returns. Expectations for modest increases in interest rates, normal inflation trends and average capital market real returns led us to an expected return on the pension plan assets assumption of 6.90% for 2016 and 7.00% for each of 2015 and 2014, and an expected return on OPEB plan assets assumption of 4.75% for 2016 and 5.30% for 2015 and 2014. We regularly review actual asset allocations and periodically rebalance our investments to the mid-point of our targeted allocation ranges when we consider it appropriate.

401(k) Plan

Our employees are eligible to participate in a defined contribution retirement savings plan under which designated contributions may be invested in our common stock or certain other investments (the "Aetna 401(k) Plan"). Our 401(k) contribution to the Aetna 401(k) Plan provides for a match of 100% of up to 6% of the eligible pay contributed by the employee. During 2016, 2015 and 2014, we made $197 million, $198 million and $180 million, respectively, in aggregate of matching contributions to our 401(k) plans. The matching contributions are made in cash and invested according to each participant's investment elections. The plan trustee held 7 million shares of our common stock for plan participants at December 31, 2016. At December 31, 2016, 34 million shares of our common stock were reserved for issuance under the Aetna 401(k) Plan.

11. Income Taxes

The components of our income tax provision in 2016, 2015 and 2014 were as follows:

(Millions)	2016	2015	2014
Current taxes:			
Federal	**$ 1,662**	$ 1,797	$ 1,233
State	**129**	112	84
Total current taxes	**1,791**	1,909	1,317
Deferred taxes (benefits):			
Federal	**(55)**	(59)	114
State	**(1)**	(9)	24
Total deferred income taxes	**(56)**	(68)	138
Total income taxes	**$ 1,735**	$ 1,841	$ 1,455

Income taxes were different from the amount computed by applying the statutory federal income tax rate to income before income taxes as follows:

	2016		2015		2014	
(Millions)	**Amount**	**Percent**	**Amount**	**Percent**	**Amount**	**Percent**
Amount at statutory rate	**$ 1,397**	**35.0 %**	$ 1,483	35.0 %	$ 1,225	35.0 %
Health insurer fee	**293**	**7.3 %**	300	7.1 %	212	6.1 %
State income taxes	**83**	**2.1 %**	63	1.5 %	78	2.2 %
Other, net	**(38)**	**(.9)%**	(5)	(.1)%	(60)	(1.7)%
Income taxes	**$ 1,735**	**43.5 %**	$ 1,841	43.5 %	$ 1,455	41.6 %

The significant components of our net deferred tax liabilities at December 31, 2016 and 2015 were as follows:

(Millions)	2016	2015
Deferred tax assets:		
Insurance reserves	**$ 231**	$ 302
Reserve for anticipated future losses on discontinued products	**225**	268
Employee and postretirement benefits	**196**	220
Net operating losses	**147**	165
Severance and facilities	**135**	18
Investments, net	**80**	92
Debt fair value adjustments	**23**	33
Deferred revenue	**21**	21
Other	**117**	66
Gross deferred tax assets	**1,175**	1,185
Less: Valuation allowance	**118**	128
Deferred tax assets, net of valuation allowance	**1,057**	1,057
Deferred tax liabilities:		
Goodwill and other acquired intangible assets	**814**	863
Cumulative depreciation and amortization	**185**	231
Unrealized gains on investment securities	**42**	138
Other	**20**	2
Total gross deferred tax liabilities	**1,061**	1,234
Net deferred tax liabilities	**$ (4)**	$ (177)

Valuation allowances are provided when we estimate that it is more likely than not that deferred tax assets will not be realized. A valuation allowance has been established primarily related to state net operating losses. We base our estimates of the future realization of deferred tax assets primarily on historic taxable income and existing deferred tax liabilities.

We participate in the Compliance Assurance Process (the "CAP") with the Internal Revenue Service (the "IRS"). Under the CAP, the IRS undertakes audit procedures during the tax year and as the return is prepared for filing. The IRS has concluded its CAP audit of our 2015 tax return as well as all the prior years. We expect the IRS will conclude its CAP audit of our 2016 tax return in 2017.

We are also subject to audits by various state taxing authorities for tax years from 2000 through 2015. We believe we carry appropriate reserves for any exposure to state tax issues.

At both December 31, 2016 and December 31, 2015 we did not have material uncertain tax positions reflected in our consolidated balance sheets.

12. Stock-based Employee Incentive Plans

Our stock-based employee compensation plans (collectively, the "Plans") provide for awards of stock options, SARs, PSARs, restricted stock units RSUs, MSUs, PSUs, deferred contingent common stock and the ability for employees to purchase common stock at a discount. At December 31, 2016, 23 million common shares were available for issuance under the Plans. Executive, middle management and non-management employees may be granted stock options, SARs, PSARs, RSUs, MSUs and PSUs, each of which are described below:

Stock Options, SARs and PSARs

We have not granted stock options since 2005, and no stock options were outstanding as of December 31, 2016. Stock options were granted to purchase our common stock at or above the market price on the date of grant. SARs granted will be settled in stock, net of taxes, based on the appreciation of our stock price on the exercise date over the market price on the date of grant. SARs and stock options generally become 100% vested three years after the grant is made, with one-third vesting each year. Vested SARs and stock options may be exercised at any time during the ten years after grant, except in certain circumstances, generally related to employment termination or retirement. At the end of the ten-year period, any unexercised SARs and stock options expire.

The SARs granted to certain employees during 2016 and 2015 and described above had an estimated grant date fair value per SAR of $34.33 and $32.13, respectively. The grant date fair value was calculated using a modified Black-Scholes option pricing model using the following assumptions:

	2016	2015
Expected term (in years)	**7.11**	6.48
Volatility	**32.9%**	33.4%
Risk-free interest rate	**1.52%**	1.81%
Dividend yield	**0.91%**	1.13%
Initial price	**$ 103.45**	$ 100.50

The expected term is based on historical equity award activity. Volatility is based on a weighted average of the historical volatility of our stock price and implied volatility from traded options on our stock. The risk-free interest rate is based on a U.S. Treasury rate with a life equal to the expected life of the SARs grant. This rate was calculated by interpolating between the 7-year and 10-year U.S. Treasury rates for 2016 SARs grants and the 5-year and 10-year U.S. Treasury rates for 2015 SARs grants. The dividend yield is based on our historical dividends declared in the 12 months prior to the grant date.

PSARs represent the opportunity to vest in SARs. For the PSARs granted in 2013 ("2013 PSARs"), the number of vested PSARs (which could range in specified increments from zero to 700,000 SARs) was dependent on Aetna's total shareholder return over a three year performance period relative to a defined peer group of companies. The 2013 PSARs were subject to a three-year vesting period that ended on August 5, 2016, and vested at 500,000 SARs.

We estimated the grant date fair value of the 2013 PSARs using a Monte Carlo simulation. The 2013 PSARs had a grant date per PSAR fair value of $18.64. That grant date fair value was calculated using the following assumptions:

Expected settlement period (in years)	6.12
Volatility	40.4%
Risk-free interest rate	.6%
Dividend yield	1.25%
Initial price	$ 64.25

The stock option, SAR and PSAR transactions during 2016, 2015 and 2014 were as follows:

(Millions, except exercise price and remaining life)	Number of Stock Options, SARs and PSARs	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life	Aggregate Intrinsic Value
2014				
Outstanding, beginning of year	10.5	$ 43.27	3.5	$ 265
Granted	1.4	72.36	—	—
Exercised	(3.7)	40.50	—	132
Expired or forfeited	(.1)	46.94	—	—
Outstanding, end of year [1]	8.1	$ 49.37	4.2	$ 318
Exercisable, end of year	6.1	$ 42.86	2.6	$ 280
2015				
Outstanding, beginning of year	8.1	$ 49.37	4.2	$ 318
Granted	2.0	101.41	—	—
Exercised	(2.5)	43.90	—	155
Expired or forfeited	(.2)	91.25	—	—
Outstanding, end of year [1]	7.4	$ 64.11	5.3	$ 325
Exercisable, end of year	4.1	$ 45.88	2.6	$ 252
2016				
Outstanding, beginning of year	**7.4**	**$ 64.11**	**5.3**	**$ 325**
Granted	**2.4**	**104.47**	**—**	**—**
Exercised	**(1.4)**	**52.99**	**—**	**85**
Expired or forfeited	**(.4)**	**83.25**	**—**	**—**
Outstanding, end of year	**8.0**	**$ 77.20**	**5.9**	**$ 373**
Exercisable, end of year	**4.3**	**$ 57.26**	**3.6**	**$ 287**

(1) PSARs are included in this table in 2015 and 2014 at the maximum amount that could potentially vest.

The following is a summary of information regarding SARs outstanding at December 31, 2016 (millions, except remaining contractual life and exercise price):

	Outstanding				Exercisable		
Range of Exercise Prices	Number Outstanding	Weighted Average Remaining Contractual Life (Years)	Weighted Average Exercise Price	Aggregate Intrinsic Value	Number Exercisable	Weighted Average Exercise Price	Aggregate Intrinsic Value
20.00-30.00 [1]	—	2.4	$ 24.97	$ 2	—	$ 24.97	$ 2
30.00-40.00	1.1	2.1	32.11	98	1.1	32.11	98
40.00-50.00	.7	.4	45.55	53	.7	45.55	53
50.00-60.00	.8	1.1	50.70	59	.8	50.70	59
60.00-70.00	.5	6.6	64.25	30	.5	64.25	30
70.00-80.00	1.0	6.8	72.34	50	.6	72.34	31
100.00-110.00	3.6	8.6	102.36	79	.6	101.05	14
110.00-120.00	.3	9.2	115.29	2	—	—	—
$20.00-$130.00 [2]	8.0	5.9	$ 77.20	$ 373	4.3	$ 57.26	$ 287

[1] The number of outstanding and exercisable SARs and PSARs with exercise prices between $20 and $30 rounded to zero.
[2] The number of outstanding SARs with exercise prices between $80 and $100 and between $120 and $130 rounded to zero.

During 2016, 2015 and 2014, the following activity occurred under the Plans:

(Millions)	2016	2015	2014
Cash received from stock option exercises	$ —	$ 7	$ 32
Intrinsic value of stock options/SARs exercised and stock units vested	384	413	323
Tax benefits realized for the tax deductions from stock options and SARs exercised and stock units vested	77	101	87
Fair value of stock options, SARs, PSARs and stock units vested [1]	223	126	107

[1] The fair value represents the aggregate grant date fair value of the stock options, SARs, PSARs and stock units as of the respective grant dates.

We settle our SARs and stock units with newly-issued common stock and generally utilized the proceeds from stock options to repurchase our common stock in the open market in the same period.

RSUs, MSUs and PSUs

For each RSU granted, employees receive one share of common stock, net of taxes, at the end of the vesting period. RSUs generally become 100% vested approximately three years from the grant date, with one-third vesting each December. The grant date fair value is determined based on the market price of our common stock on the date of grant.

The number of vested MSUs (which could range from zero to 150% of the original number of units granted) is dependent on the weighted average closing price of our common stock for the thirty trading days prior to the vesting date, including the vesting date. Each vested MSU represents one share of common stock and will be paid in shares of common stock, net of taxes. MSUs representing 50% of the grant date fair value of the MSUs granted in 2012 were subject to a two-year vesting period while the remaining MSUs granted in 2012 were subject to a three-year vesting period. MSUs granted in 2014 and 2013 are subject to a three-year vesting period. There were no MSUs granted in 2016 or 2015.

The number of vested PSUs (which could range from zero to 200% of the original number of units granted) is dependent upon the degree to which we achieve performance goals, which for the most part, are set at the time of grant as determined by our Board's Committee on Compensation and Talent Management (the "Compensation Committee"). Each vested PSU represents one share of common stock and will be paid in shares of common stock, net of taxes. The grant date fair value is determined based on the market price of our common stock on the date of grant. Below is a summary of the performance period and vesting percentages for each tranche of PSUs granted by the Company:

- *PSUs granted in 2013 ("2013 PSUs"):* Certain PSUs granted in 2013 were subject to a single three-year performance period that ended on December 31, 2015, and vested at 74.61% of the original number of units granted. Certain PSUs granted in 2013 were subject to a two-year vesting period with two separate performance periods. Half of these PSUs

were subject to a one-year performance period that ended on December 31, 2013, and vested at 127.08% of the original number of units granted. The remaining half were subject to a one-year performance period that ended on December 31, 2014, and vested at 131.62% of the original number of units granted.

- *PSUs granted in 2014 ("2014 PSUs"):* The 2014 PSUs had a two-year performance period that ended on December 31, 2015, and vested at 200% of the original number of units granted. The 2014 PSUs are subject to a three-year vesting period.
- *PSUs granted in 2015 ("2015 PSUs"):* The 2015 PSUs have a three-year performance period that will end on December 31, 2017, and are subject to a three-year vesting period.
- PSUs granted in 2016 ("2016 PSUs"): The 2016 PSUs have a three-year performance period that will end on December 31, 2018, and are subject to a three-year vesting period

From 2010 through 2014, we granted MSUs to certain employees. We did not grant any MSUs in 2015 or 2016. We estimate the grant date fair value of MSUs using a Monte Carlo simulation. MSUs granted in 2014 had a weighted average per MSU grant date fair value of $74.99. The weighted-average per MSU grant date fair value was calculated using the following assumptions:

	2014
Volatility	26.4%
Risk-free interest rate	.7%
Dividend yield	1.3%
Initial price	$ 72.26

The annualized volatility of the price of our common stock was calculated over the three-year period preceding the grant date of the MSUs. The risk-free interest rates for periods within the expected life of the MSUs were based on a constant maturity yield curve in effect on the grant date of the MSUs. The dividend yield assumption was based on our expected 2014 annual dividend payout.

RSU, MSU and PSU transactions in 2016, 2015 and 2014 were as follows (number of units in millions):

	2016		2015		2014	
	RSUs, MSUs and PSUs	**Weighted Average Grant Date Fair Value**	**RSUs, MSUs and PSUs**	**Weighted Average Grant Date Fair Value**	**RSUs, MSUs and PSUs**	**Weighted Average Grant Date Fair Value**
RSUs, MSUs and PSUs at beginning of year	**3.9**	**$ 73.40**	5.1	$ 58.57	5.3	$ 48.82
Granted	**2.1**	**98.60**	1.8	100.52	2.7	71.88
Vested	**(2.7)**	**68.87**	(2.6)	59.72	(2.5)	50.11
Forfeited	**(.4)**	**71.17**	(.4)	70.94	(.4)	56.89
RSUs, MSUs and PSUs at end of year	**2.9**	**$ 91.95**	3.9	$ 73.40	5.1	$ 58.57

Stock Compensation Expense

In 2016, 2015 and 2014 we recorded share-based compensation expense of $191 million, $181 million and $163 million, respectively, in general and administrative expenses. We also recorded related tax benefits of $33 million in 2016 and $37 million in both 2015 and 2014, respectively. At December 31, 2016, $185 million of total unrecognized compensation costs related to SARs is expected to be recognized over a weighted-average period of 1.7 years.

13. Shareholders' Equity

Share Repurchases

From time to time, our Board authorizes us to repurchase our common stock. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. The activity under Board authorized share repurchase programs in 2016, 2015 and 2014 was as follows:

		Shares Purchased					
	Purchase Not to Exceed	2016		2015		2014	
(Millions)		Shares	Cost	Shares	Cost	Shares	Cost
Authorization date:							
November 21, 2014	$ 1,000	—	$ —	—	$ —	—	$ —
February 28, 2014	1,000	—	—	3.0	296	7.6	621
September 27, 2013	750	—	—	—	—	8.3	597
Total repurchases	N/A	—	$ —	3.0	$ 296	15.9	$ 1,218
Repurchase authorization remaining at December 31,		**N/A**	**$ 1,083**	N/A	$ 1,083	N/A	$ 1,379

As described above, from time to time we enter into accelerated share repurchase agreements with unrelated third party financial institutions. The number of shares repurchased under each agreement is based on the volume-weighted average price of our common stock during the purchase period. We completed the following accelerated share repurchase programs with repurchase periods during the years ended December 31, 2016 and 2015:

Trade Date:	Value of Repurchase Program (Millions)	Repurchase Period	Number of Shares Repurchased (Millions)
March 2, 2015	$ 100.0	April 2015	0.9

On February 17, 2017, our Board approved a new share repurchase program that authorized us to repurchase up to $4.0 billion of our common stock.

Dividends

Prior to termination of the Merger Agreement, Aetna was not permitted to declare, set aside or pay any dividend or other distribution other than a regular quarterly cash dividend in the ordinary course of business, which could not exceed $.25 per share. In addition, the Term Loan Agreement contained a covenant limiting "Restricted Payments" (as defined in the Term Loan Agreement) by Aetna, subject to certain exceptions and baskets, including an exception permitting the payment of regular cash dividends. Our dividend policy following termination of the Merger Agreement will be determined by our Board. Declaration and payment of future dividends is at the discretion of our Board and may be adjusted as business needs or marketplace conditions change. In 2016 and 2015 our Board declared the following cash dividends:

Date Declared	Dividend Amount Per Share	Stockholders of Record Date	Date Paid/ To be Paid	Total Dividends (Millions)
Year ended December 31, 2015				
February 27, 2015	$ .25	April 9, 2015	April 24, 2015	$ 87
May 15, 2015	.25	July 16, 2015	July 31, 2015	87
September 25, 2015	.25	October 15, 2015	October 30, 2015	87
December 4, 2015	.25	January 14, 2016	January 29, 2016	87
Year ended December 31, 2016				
February 19, 2016	$ .25	April 14, 2016	April 29, 2016	88
May 20, 2016	.25	July 14, 2016	July 29, 2016	88
September 30, 2016	.25	October 13, 2016	October 28, 2016	88
December 2, 2016	.25	January 12, 2017	January 27, 2017	88

On February 17, 2017, our Board declared a cash dividend of $.50 per share that will be paid on April 28, 2017 to shareholders of record at the close of business on April 13, 2017.

Preferred Stock and Undesignated Shares

In addition to the common stock disclosed on our balance sheets, 8 million shares of Class A voting preferred stock, $.01 par value per share, have been authorized and none are issued or outstanding at December 31, 2016. At December 31, 2016, there were also 442 million undesignated shares that our Board has the power to divide into such classes and series, with such voting rights, designations, preferences, limitations and special rights as our Board determines.

Regulatory Requirements

Our business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. Our HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP. The combined statutory net income for the years ended and combined statutory capital and surplus at December 31, 2016, 2015 and 2014 for our insurance and HMO subsidiaries were as follows:

(Millions)	**2016**	**2015**	**2014**
Statutory net income	**$ 2,229**	$ 2,186	$ 2,127
Statutory capital and surplus	**10,413**	9,883	9,406

During 2016, our insurance and HMO subsidiaries paid approximately $2.3 billion of dividends to the Company.

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. At December 31, 2016, these amounts were as follows:

(Millions)	
Minimum statutory surplus required by regulators	$ 3,738
Investments on deposit with regulatory bodies	561
Maximum dividend distributions permitted in 2016 without state approval	1,902

14. Other Comprehensive (Loss) Income

Shareholders' equity included the following activity in accumulated other comprehensive loss in 2016, 2015 and 2014:

	At December 31,		
(Millions)	**2016**	**2015**	**2014**
Previously impaired debt securities: [1]			
Beginning of period balance	**$ 19**	$ 35	$ 34
Net unrealized (losses) gains *($(31), $(69) and $1 pretax)*	**(20)**	(45)	1
Less: Net reclassification of (losses) gains to earnings *($(26) and $(44))* [2]	**(17)**	(29)	—
Other comprehensive (loss) income	**(3)**	(16)	1
End of period balance	**16**	19	35
All other securities:			
Beginning of period balance	**312**	568	327
Net unrealized (losses) gains *($(12), $(490) and $365 pretax)*	**(8)**	(318)	237
Less: Net reclassification of gains (losses) to earnings *($11, $(97) and $(7) pretax)* [2]	**7**	(62)	(4)
Other comprehensive (loss) income	**(15)**	(256)	241
End of period balance	**297**	312	568
Derivatives and foreign currency:			
Beginning of period balance	**(74)**	$ (61)	$ —
Net unrealized losses *($(273), $(26) and $(90) pretax)*	**(177)**	(17)	(58)
Less: Net reclassification of (losses) gains to earnings *($(25), $(6) and $4 pretax)* [3]	**(16)**	(4)	3
Other comprehensive loss	**(161)**	(13)	(61)
End of period balance	**(235)**	(74)	(61)
Pension and OPEB plans:			
Beginning of period balance	**(1,587)**	(1,653)	(1,273)
Net unrealized net actuarial (losses) gains arising during the period *($(126), $41 and $(739) pretax)*	**(82)**	27	(481)
Less: Net pension settlement charge *($(112) pretax)* [4]	**—**	—	(73)
Less: Net amortization of net actuarial losses *($(64), $(64) and $(48) pretax)* [4]	**(42)**	(42)	(31)
Less: Net amortization of prior service credit *($5, $4 and $4 pretax)* [4]	**3**	3	3
Other comprehensive (loss) income	**(43)**	66	(380)
End of period balance	**(1,630)**	(1,587)	(1,653)
Total beginning of period accumulated other comprehensive loss	**(1,330)**	(1,111)	(912)
Total other comprehensive loss	**(222)**	(219)	(199)
Total end of period accumulated other comprehensive loss	**$ (1,552)**	$ (1,330)	$ (1,111)

(1) Represents specifically identified unrealized gains on the non-credit related component of impaired debt securities that we do not intend to sell and subsequent changes in the fair value of any previously impaired security.

(2) Reclassifications out of accumulated other comprehensive income for specifically identified previously impaired debt securities and all other securities are reflected in net realized capital gains (losses) within the Consolidated Statements of Income.

(3) Reclassifications out of accumulated other comprehensive income for specifically identified foreign currency gains (losses) and derivatives are reflected in net realized capital gains (losses) within the Consolidated Statements of Income, except for the specifically identified effective portion of derivatives related to interest rate swaps which are reflected in interest expense. Refer to Note 9 for additional information.

(4) Reclassifications out of accumulated other comprehensive income for specifically identified pension and OPEB plan expenses are reflected in general and administrative expenses within the Consolidated Statements of Income. During 2014, our reclassifications out of accumulated other comprehensive income for the Aetna Pension Plan reflect a pension settlement charge of $73 million ($112 million pretax). (Refer to Note 10 for additional information).

15. Earnings Per Common Share

Basic earnings per common share ("EPS") is computed by dividing net income attributable to Aetna by the weighted-average number of common shares outstanding during the reporting period. Diluted EPS is computed in a similar manner, except that the weighted average number of common shares outstanding is adjusted for the dilutive effects of our outstanding stock-based compensation awards, but only if the effect is dilutive.

The computations of basic and diluted EPS for 2016, 2015 and 2014 are as follows:

(Millions, except per common share data)	2016	2015	2014
Net income attributable to Aetna	**$ 2,271**	$ 2,390	$ 2,041
Weighted average shares used to compute basic EPS	**351.3**	349.3	355.5
Dilutive effect of outstanding stock-based compensation awards	**3.0**	3.3	3.6
Weighted average shares used to compute diluted EPS	**354.3**	352.6	359.1
Basic EPS	**$ 6.46**	$ 6.84	$ 5.74
Diluted EPS	**$ 6.41**	$ 6.78	$ 5.68

The stock-based compensation awards excluded from the calculation of diluted EPS for 2016, 2015 and 2014 are as follows:

(Millions)	2016	2015	2014
Stock appreciation rights ("SARs") [(1)]	**.1**	.5	.3
Other stock-based compensation awards [(2)]	**.7**	.8	1.2

(1) SARs are excluded from the calculation of diluted EPS if the exercise price is greater than the average market price of Aetna common shares during the period (i.e., the awards are anti-dilutive).

(2) Performance stock units ("PSUs"), certain market stock units ("MSUs") with performance conditions, and performance stock appreciation rights ("PSARs") are excluded from the calculation of diluted EPS if all necessary performance conditions have not been satisfied at the end of the reporting period (refer to Note 12 for additional information about PSARs).

All outstanding stock options were included in the calculation of diluted EPS for 2014. There were no stock options outstanding at December 31, 2016 or 2015.

16. Reinsurance

We utilize reinsurance agreements primarily to reduce our required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit us to recover a portion of our losses from reinsurers, although they do not discharge our primary liability as the direct insurer of the risks reinsured.

Effective October 1, 1998, we reinsured certain policyholder liabilities and obligations related to individual life insurance in conjunction with our former parent company's sale of this business. These transactions were in the form of indemnity reinsurance arrangements, whereby the assuming companies contractually assumed certain policyholder liabilities and obligations, although we remain directly obligated to policyholders. The liability related to our obligation is recorded in future policy benefits and policyholders' funds on our balance sheets. Assets related to and supporting these policies were transferred to the assuming companies, and we recorded a reinsurance recoverable.

Effective 2013 to 2016, we entered into certain three to five-year reinsurance agreements with unrelated reinsurers that allowed us to reduce our required capital and provided collateralized excess of loss reinsurance coverage on a portion of our group Commercial Insured Health Care business. In January 2017, we entered into two four-year reinsurance agreements with an unrelated reinsurer that allowed us to reduce our required capital and provided collateralized excess of loss reinsurance coverage on a portion of our group Commercial Insured Health Care business.

The ACA established a temporary reinsurance program that expired at the end of 2016. Under this program, all issuers of major medical commercial insurance products and self-insured plan sponsors were required to contribute funding in amounts set by HHS. Funds collected were utilized to reimburse issuers' high claims costs incurred for qualified individual members. The expense related to this required funding is reflected in general and administrative expenses for all of our insurance products with the exception of products associated with qualified individual members; this expense for qualified individual members is reflected as a reduction of premium revenue. When annual claim costs incurred by our qualified individual members exceed a

specified attachment point, we are entitled to certain reimbursements from this program. We record a receivable and offset health care costs to reflect our estimate of these recoveries. Refer to Note 2 for additional information about the ACA's temporary three-year reinsurance program.

Reinsurance recoverables recorded at December 31, 2016 and 2015 were as follows:

(Millions)	Total Recoverables	
Reinsurer	**2016**	**2015**
Lincoln Life & Annuity Company of New York	**$ 444**	$ 458
VOYA Retirement Insurance and Annuity Company	**209**	223
Affordable Care Act	**202**	395
All Other	**164**	138
Total	**$ 1,019**	$ 1,214

Direct, assumed and ceded health care premiums earned for the years ended December 31 were as follows:

(Millions)	**2016**	**2015**	**2014**
Direct	**$ 54,062**	$ 51,539	$ 49,497
Assumed	**402**	368	316
Ceded	**(348)**	(289)	(251)
Net health care premiums	**$ 54,116**	$ 51,618	$ 49,562

The impact of reinsurance on health care costs for the years ended December 31 were as follows:

(Millions)	**2016**	**2015**	**2014**
Direct	**$ 44,341**	$ 42,038	$ 40,980
Assumed	**339**	298	263
Ceded	**(425)**	(624)	(496)
Net health care costs	**$ 44,255**	$ 41,712	$ 40,747

Assumed and ceded other premiums and current and future benefit expense related to our Group Insurance and Large Case Pensions segments were not material during the years ended 2016, 2015 or 2014. There is not a material difference between premiums on a written basis versus an earned basis.

We also have various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. We entered into these contracts to reduce the risk of catastrophic loss which in turn reduces our capital and surplus requirements surrounding certain portions of our group term life, group accidental death and dismemberment, Medicare Advantage and group Commercial Insured Health Care businesses. Total deposit assets and liabilities related to reinsurance agreements that do not quality for reinsurance accounting under GAAP were not material as of December 31, 2016 or 2015.

17. Commitments and Contingencies

Guarantees

We have the following significant guarantee and indemnification arrangements at December 31, 2016.

- ASC Claim Funding Accounts - We have arrangements with certain banks for the processing of claim payments for our ASC customers. The banks maintain accounts to fund claims of our ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, we guarantee that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million. We can limit our exposure to this guarantee by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.

- Indemnification Agreements - In connection with certain acquisitions and dispositions of assets and/or businesses, our various issuances of long-term debt and certain of our reinsurance agreements, we have incurred certain customary indemnification obligations to the applicable seller, purchaser, underwriters and/or various other participants. In general, we have agreed to indemnify the other party for certain losses relating to the assets or business that we or they purchased or sold or for other matters on terms that are customary for similar transactions. Certain portions of our indemnification obligations are capped at the applicable transaction price, while other arrangements are not subject to such a limit. At December 31, 2016, we do not believe that our future obligations under any of these agreements will be material to our financial position.
- Separate Accounts assets - Certain Separate Accounts assets associated with the Large Case Pensions business represent funds maintained as a contractual requirement to fund specific pension annuities that we have guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $1.8 billion and $2.0 billion at December 31, 2016 and 2015, respectively. Refer to Note 2 for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Account balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Account assets to meet the annuity guarantees, we would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2016 exceeded the value of the guaranteed benefit obligation. As a result, we were not required to maintain any additional liability for our related guarantees at December 31, 2016.
- Minimum Volume Commitments - In connection with the Coventry acquisition we assumed certain supplier agreements with minimum volume commitments which require us to make payments to the suppliers if the level of medical membership subject to the agreements falls below specified levels. The maximum potential amount of future payments we could be required to make over the remaining terms of the agreements, assuming the medical membership subject to the agreements is zero, is $24 million.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner (the "Commissioner") placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. In 2012, the state court denied the Commissioner's petition for liquidation. The Pennsylvania Supreme Court affirmed that ruling in July 2015. Between April 2013 and October 2014, the Commissioner filed proposed rehabilitation plans, which have been withdrawn. In July 2016, the Commissioner again petitioned the state court to convert the rehabilitation into a liquidation. A hearing to consider that petition was held in late 2016. If Penn Treaty is placed in liquidation, we and other insurers likely would be assessed immediately and/or over a period of years by guaranty associations for the payments the guaranty associations are required to make to Penn Treaty policyholders. We anticipate that Penn Treaty will be placed in liquidation in the first half of 2017. If Penn Treaty is placed in liquidation in the first half of 2017, we expect to record an estimated liability and expense of approximately $230 million pretax at the time of such event. It is reasonably possible that in the future we may record a liability and expense relating to other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment, and the ultimate liability is not known at the balance sheet date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Terminated Acquisition of Humana and Related Matters
On February 14, 2017, Aetna and Molina entered into the APA Termination Agreement pursuant to which Aetna terminated the Molina APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, among other things, Aetna agreed to pay Molina in cash approximately 70% of Molina's transaction costs. We expect to pay Molina the applicable transaction costs during the first quarter of 2017.

In June 2016, we issued $13.0 billion of 2016 senior notes to partially fund the Humana Acquisition. In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for the entire $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem the Special Mandatory Redemption Notes on or about March 16, 2017. As a result of the redemption of the Special Mandatory Redemption Notes, in the first quarter of 2017, we will recognize on a pretax basis in our net income the entire approximately $420 million unamortized portion of the related cash flow hedge losses, debt issuance costs and debt issuance discounts and the entire approximately $100 million redemption premium paid on the Special Mandatory Redemption Notes upon such redemption.

Litigation and Regulatory Proceedings
Humana Acquisition - Department of Justice Litigation
On July 21, 2016, the DOJ and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that the Humana Acquisition would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Acquisition.

Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of

plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to defend ourselves vigorously against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing risk adjustment data of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years or the current contract year. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes,

marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, patent infringement and other intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings."

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $36 million ($55 million pretax). Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of further changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulation Proceedings", and it is reasonably possible that their outcome could be material to us.

Other Obligations

We have operating leases for office space and certain computer and other equipment. Rental expenses for these items were $167 million, $165 million and $177 million in 2016, 2015 and 2014, respectively. For 2017 through 2021, our future net minimum payments under non-cancelable leases and funding obligations relating to equity limited partnership investments, commercial mortgage loans and real estate partnerships were as following:

(Millions)	2017	2018	2019	2020	2021
Future net minimum payments under non-cancelable leases	$ 143	$ 121	$ 81	$ 47	$ 37
Funding requirements for equity limited partnership investments, commercial mortgage loans and real estate partnerships	177	127	94	56	37
Total	$ 320	$ 248	$ 175	$ 103	$ 74

18. Segment Information

Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment; it is added to our business segments to reconcile to our consolidated results. The Corporate Financing segment includes interest expense on our outstanding debt and the financing components of our pension and OPEB plan expense (the prior service cost components of this expense are allocated to our business segments). Non-GAAP financial measures we disclose, such as operating earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

Summarized financial information of our segment operations [1] for 2016, 2015 and 2014 were as follows:

(Millions)	Health Care	Group Insurance	Large Case Pensions	Corporate Financing	Total Company
2016					
Revenue from external customers	**$ 59,860**	**$ 2,251**	**$ 48**	**$ —**	**$ 62,159**
Net investment income	**458**	**226**	**226**	**—**	**910**
Interest expense	**—**	**—**	**—**	**604**	**604**
Depreciation and amortization expense	**681**	**—**	**—**	**—**	**681**
Income taxes (benefits)	**1,856**	**26**	**44**	**(191)**	**1,735**
Operating earnings (loss) [2]	**2,948**	**124**	**14**	**(169)**	**2,917**
2015					
Revenue from external customers	$ 57,203	$ 2,240	$ 42	$ —	$ 59,485
Net investment income	408	238	271	—	917
Interest expense	—	—	—	369	369
Depreciation and amortization expense	671	—	—	—	671
Income taxes (benefits)	1,908	38	(9)	(96)	1,841
Operating earnings (loss) [2]	2,712	136	17	(148)	2,717
2014					
Revenue from external customers	$ 54,677	$ 2,214	$ 86	$ —	$ 56,977
Net investment income	368	261	317	—	946
Interest expense	—	—	—	334	334
Depreciation and amortization expense	627	2	—	—	629
Income taxes (benefits)	1,587	57	1	(190)	1,455
Operating earnings (loss) [2]	2,377	171	21	(164)	2,405

(1) Total assets by segment are not disclosed as this information is not reviewed by the Chief Executive Officer.

(2) Operating earnings (loss) excludes net realized capital gains or losses, amortization of other acquired intangible assets and the other items described in this Note 18.

A reconciliation of net income attributable to Aetna to operating earnings[1] in 2016, 2015 and 2014 was as follows.

(Millions)	2016	2015	2014
Net income attributable to Aetna	**$ 2,271**	$ 2,390	$ 2,041
Transaction and integration-related costs	**517**	258	201
Restructuring costs	**404**	15	—
Reduction of reserve for anticipated future losses on discontinued products	**(128)**	—	—
Litigation-related proceeds	**—**	(110)	—
Loss on early extinguishment of long-term debt	**—**	—	181
Pension settlement charge	**—**	—	112
Release of litigation-related reserve	**—**	—	(103)
Amortization of other acquired intangible assets	**247**	255	243
Net realized capital (gain) losses	**(86)**	65	(80)
Income tax benefit	**(308)**	(156)	(190)
Operating earnings	**$ 2,917**	$ 2,717	$ 2,405

[1] In addition to net realized capital gains and losses and amortization of other acquired intangible assets, the following other items are excluded from operating earnings because we believe they neither relate to the ordinary course of our business nor reflect our underlying business performance:

- We incurred transaction and integration-related costs during 2016 and 2015 related to the acquisitions of Coventry, InterGlobal, bswift and the proposed Humana Acquisition. We incurred transaction and integration-related costs during 2014 related to the acquisitions of Coventry, bswift and InterGlobal. Transaction costs include advisory, legal and other professional fees which are not deductible for tax purposes and are reflected in our GAAP Consolidated Statements of Income in general and administrative expenses, as well as the cost of the Bridge Credit Agreement and the Term Loan Agreement executed in connection with the proposed Humana Acquisition, which are reflected in our GAAP Consolidated Statements of Income in interest expense. Transaction costs also include the negative cost of carry associated with the 2016 senior notes. Prior to the termination of the Merger Agreement, the negative cost of carry associated with the 2016 senior notes was excluded from operating earnings. The components of the negative cost of carry are reflected in our GAAP Consolidated Statements of Income in interest expense and net investment income. Subsequent to the termination of the Merger Agreement, the interest expense and net investment income associated with the 2016 senior notes no longer will be excluded from operating earnings.
- Restructuring costs for 2016 include costs related to our voluntary early retirement program, severance and real estate consolidation costs associated with our expense management and cost control initiative and an accrual for minimum volume commitments which require us to make payments to suppliers if the level of medical membership subject to the agreements falls below specified levels. We no longer expect to meet these minimum volume commitments as a result of our previously announced reduced participation on the ACA's individual Public Exchanges in 2017. Restructuring costs for 2015 include severance costs associated with our expense management and cost control initiative. The 2016 and 2015 restructuring costs are reflected in the GAAP Consolidated Statements of Income in general and administrative expenses.
- In 1993, we discontinued the sale of our fully guaranteed large case pensions products and established a reserve for anticipated future losses on these products, which we review quarterly. During 2016, we reduced the reserve for anticipated future losses on discontinued products. We believe excluding any changes in the reserve for anticipated future losses on discontinued products from operating earnings provides more useful information as to our continuing products and is consistent with the treatment of the operating results of these discontinued products, which are credited or charged to the reserve and do not affect our operating results. Refer to Note 19 for additional information on the reduction of the reserve for anticipated future losses on discontinued products.
- In 2015, we received proceeds net of legal costs, in connection with a litigation settlement. These net proceeds were recorded in fees and other revenue in our GAAP Consolidated Statements of Income.
- In 2014, we incurred losses on the early extinguishment of long-term debt related to the redemption of certain of our outstanding senior notes.
- During 2014, we enhanced the Aetna Pension Plan to allow certain current and former employees to elect a 100% lump-sum distribution. In addition, we also announced a limited-time offer permitting certain former employees with deferred vested balances to elect a 100% lump-sum distribution. The distributions in 2014 were funded from existing Aetna Pension Plan assets, and we recorded a related non-cash settlement charge during 2014 in general and administrative expenses. Refer to Note 10 for additional information on the pension settlement charge.
- In 2012, we recorded a charge related to the settlement of purported class action litigation regarding our payment practices related to out-of-network health care providers. That charge included the estimated cost of legal fees of plaintiffs' counsel and the costs of administering the settlement. In 2014, we exercised our right to terminate the settlement agreement. As a result, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced 2014 other general and administrative expenses. Refer to Note 17 for additional information on the termination of the settlement agreement.
- The corresponding tax benefit or expense related to the items excluded from operating earnings discussed above. The tax benefit or expense was calculated utilizing the appropriate tax rate for each individual item excluded from operating earnings.

Revenues from external customers by product in 2016, 2015 and 2014 were as follows:

(Millions)	2016	2015	2014
Health care premiums	**$ 54,116**	$ 51,618	$ 49,562
Health care fees and other revenue	**5,744**	5,585	5,115
Group insurance premiums	**2,143**	2,139	2,110
Group insurance fees and other revenues	**108**	101	104
Large case pensions premiums	**39**	32	76
Large case pensions other revenue	**9**	10	10
Total revenue from external customers [1] [2]	**$ 62,159**	$ 59,485	$ 56,977

(1) All within the U.S., except approximately $642 million, $1.3 billion and $1.2 billion in 2016, 2015 and 2014, respectively, which were derived from foreign customers.

(2) Revenue from the U.S. federal government was approximately $20.5 billion, $17.8 billion and $16.5 billion in 2016, 2015 and 2014, respectively, in the Health Care and Group Insurance segments. These amounts exceeded 10 percent of our total revenue from external customers in each of 2016, 2015 and 2014.

The following is a reconciliation of revenue from external customers to total revenues included in our statements of income in 2016, 2015 and 2014:

(Millions)	2016	2015	2014
Revenue from external customers	**$ 62,159**	$ 59,485	$ 56,977
Net investment income	**910**	917	946
Net realized capital gains (losses)	**86**	(65)	80
Total revenue	**$ 63,155**	$ 60,337	$ 58,003

Long-lived assets, which are principally within the U.S., were $579 million and $622 million at December 31, 2016 and 2015, respectively.

19. Discontinued Products

Prior to 1993, we sold single-premium annuities ("SPAs") and guaranteed investment contracts ("GICs"), primarily to employer sponsored pension plans. In 1993, we discontinued selling these products to Large Case Pensions customers, and now we refer to these products as discontinued products. In November 2016, the last outstanding GIC matured.

We discontinued selling these products because they were generating losses for us, and we projected that they would continue to generate losses over their life (which is currently greater than 30 years for SPAs); so we established a reserve for anticipated future losses at the time of discontinuance. This reserve represents the present value (at the risk-free rate of return consistent with the duration of the liabilities) of the difference between the expected cash flows from the assets supporting these products and the cash flows expected to be required to meet the obligations of the outstanding contracts.

Key assumptions in setting the reserve for anticipated future losses include future investment results, payments to retirees, mortality and retirement rates and the cost of asset management and customer service. In 2014, we modified the mortality tables used in order to reflect the more up-to-date 2014 Retired Pensioner's Mortality table. The mortality tables were previously modified in 2012, in order to reflect the more up-to-date 2000 Retired Pensioner's Mortality table, and in 1995, in order to reflect the more up-to-date 1994 Uninsured Pensioner's Mortality table. In 1997, we began the use of a bond default assumption to reflect historical default experience. Other than these changes, since 1993 there have been no significant changes to the assumptions underlying the reserve.

We review the adequacy of this reserve quarterly based on actual experience. As long as our expected future losses remain consistent with prior projections, the results of the discontinued products are applied against the reserve and do not impact net income attributable to Aetna. If actual or expected future losses are greater than we currently estimate, we may increase the reserve, which could adversely impact net income attributable to Aetna. If actual or expected future losses are less than we currently estimate, we may decrease the reserve, which could favorably impact net income attributable to Aetna. As a result of this review, $84 million ($128 million pretax) of the reserve was released during 2016. This reserve release was primarily due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made

in estimating the reserve. The reserve at each of December 31, 2016 and 2015 reflects management's best estimate of anticipated future losses, and is included in future policy benefits on our balance sheet.

The activity in the reserve for anticipated future losses on discontinued products in 2016, 2015 and 2014 was as follows (pretax):

(Millions)	**2016**	**2015**	**2014**
Reserve, beginning of period	**$ 1,067**	$ 1,015	$ 980
Operating (loss) income	**(34)**	(9)	6
Net realized capital gains	**57**	61	29
Reserve reduction	**(128)**	—	—
Reserve, end of period	**$ 962**	$ 1,067	$ 1,015

During 2016, our discontinued products reflected operating losses and net realized capital gains, primarily attributable to gains from the sale of debt securities. During 2015, our discontinued products reflected operating losses and net realized capital gains, primarily attributable to gains from the sale of other invested assets and investment real estate. During 2014, our discontinued products reflected operating income and net realized capital gains, primarily attributable to gains from the sale of debt securities. We evaluated these 2016 results against the expectations of future cash flows assumed in estimating the reserve for anticipated future losses and do not believe that an adjustment to the reserve was required at December 31, 2016.

The anticipated run-off of the discontinued products reserve balance at December 31, 2016 (assuming that assets are held until maturity and that the reserve run-off is proportional to the liability run-off) is as follows:

(Millions)	
2017	$ 54
2018	53
2019	51
2020	50
2021	48
Thereafter	706

Assets and liabilities supporting discontinued products[1] at December 31, 2016 and 2015 were as follows:

(Millions)	2016	2015
Assets:		
Debt and equity securities available for sale	**$ 1,913**	$ 2,020
Mortgage loans	**370**	396
Other investments	**646**	643
Total investments	**2,929**	3,059
Other assets	**104**	129
Current and deferred income taxes	**—**	21
Receivable from continuing products [2]	**554**	602
Total assets	**$ 3,587**	$ 3,811
Liabilities:		
Future policy benefits	**$ 2,326**	$ 2,494
Reserve for anticipated future losses on discontinued products	**962**	1,067
Current and deferred income taxes	**42**	—
Other liabilities [3]	**257**	250
Total liabilities	**$ 3,587**	$ 3,811

(1) Assets supporting the discontinued products are distinguished from assets supporting continuing products.

(2) At the time of discontinuance, a receivable from Large Case Pensions' continuing products was established on the discontinued products balance sheet. This receivable represented the net present value of anticipated cash shortfalls in the discontinued products, which will be funded from continuing products. Interest on the receivable is accrued at the discount rate that was used to calculate the reserve. The offsetting payable, on which interest is similarly accrued, is reflected in continuing products. Interest on the payable generally offsets investment income on the assets available to fund the shortfall. These amounts are eliminated in consolidation.

(3) Net unrealized capital gains on the available-for-sale debt securities are included in other liabilities and are not reflected in consolidated shareholders' equity.

The discontinued products investment portfolio has changed since inception. Mortgage loans have decreased from $5.4 billion (37% of the investment portfolio) at December 31, 1993 to $370 million (13% of the investment portfolio) at December 31, 2016. This was a result of maturities, prepayments and the securitization and sale of commercial mortgages. Also, real estate decreased from $500 million (4% of the investment portfolio) at December 31, 1993 to $108 million (4% of the investment portfolio) at December 31, 2016, primarily as a result of sales. The resulting proceeds were primarily reinvested in debt securities, equity securities and other investments. Over time, the then-existing mortgage loan and real estate portfolios and the reinvested proceeds have resulted in greater investment returns than we originally assumed in 1993.

At December 31, 2016, the expected run-off of the SPA liabilities, including future interest, was as follows:

(Millions)	
2017	$ 348
2018	332
2019	316
2020	301
2021	285
Thereafter	3,540

The liability expected as of December 31, 1993 and the actual liability balances at December 31, 2016, 2015 and 2014 for the GIC and SPA liabilities were as follows:

	Expected		Actual	
(Millions)	**GIC**	**SPA**	**GIC**	**SPA**
2014	$ 12	$ 2,281	$ —	$ 2,646
2015	10	2,112	—	2,494
2016	**9**	**1,942**	**—**	**2,326**

The GIC balances were lower than expected in each period because several contract holders redeemed their contracts prior to contract maturity. In November 2016, the last outstanding GIC matured. The SPA balances in each period were higher than expected because of additional amounts received under existing contracts.

The distributions on our discontinued products consisted of scheduled contract maturities, settlements and benefit payments of $364 million, $356 million and $378 million for the years ended December 31, 2016, 2015 and 2014, respectively. Participant-directed withdrawals from our discontinued products were not significant in the years ended December 31, 2016, 2015 or 2014. Cash required to fund these distributions was provided by earnings and scheduled payments on, and sales of, invested assets.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
Aetna Inc.:

We have audited the accompanying consolidated balance sheets of Aetna Inc. and subsidiaries (the "Company") as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the years in the three-year period ended December 31, 2016. We also have audited the Company's internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on these consolidated financial statements and an opinion on the Company's internal control over financial reporting based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the consolidated financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2016 and 2015, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by COSO.

/s/ KPMG LLP

Hartford, Connecticut
February 17, 2017

Quarterly Data (unaudited)

(Millions, except per share and common stock data)	First	Second	Third	Fourth
2016				
Total revenue	**$ 15,694**	**$ 15,952**	**$ 15,782**	**$ 15,727**
Income before income taxes	**$ 1,289**	**$ 1,354**	**$ 1,073**	**$ 275**
Income taxes	**(551)**	**(561)**	**(476)**	**(147)**
Net income including non-controlling interests	**738**	**793**	**597**	**128**
Less: Net (loss) income attributable to non-controlling interests	**1**	**2**	**(7)**	**(11)**
Net income attributable to Aetna	**$ 737**	**$ 791**	**$ 604**	**$ 139**
Net income attributable to Aetna per share - basic [(1)]	**$ 2.10**	**$ 2.25**	**$ 1.72**	**$ .40**
Net income attributable to Aetna per share - diluted [(1)]	**2.09**	**2.23**	**1.70**	**.39**
2015				
Total revenue	$ 15,094	$ 15,241	$ 14,953	$ 15,049
Income before income taxes	$ 1,366	$ 1,262	$ 1,023	$ 585
Income taxes	(590)	(527)	(461)	(263)
Net income including non-controlling interests	776	735	562	322
Less: Net income (loss) attributable to non-controlling interests	(1)	3	2	1
Net income attributable to Aetna	$ 777	$ 732	$ 560	$ 321
Net income attributable to Aetna per share - basic [(1)]	$ 2.22	$ 2.10	$ 1.60	$ .92
Net income attributable to Aetna per share - diluted [(1)]	2.20	2.08	1.59	.91

(1) Calculation of net income attributable to Aetna per share is based on weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Disclosure Controls and Procedures
We maintain disclosure controls and procedures, which are designed to ensure that information that we are required to disclose in the reports we file or submit under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.

An evaluation of the effectiveness of our disclosure controls and procedures as of December 31, 2016 was conducted under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures as of December 31, 2016 were designed to ensure that material information relating to Aetna Inc. and its consolidated subsidiaries would be made known to the Chief Executive Officer and Chief Financial Officer by others within those entities, particularly during the periods when periodic reports under the Exchange Act are being prepared and were effective. Refer to the Certifications by our Chief Executive Officer and Chief Financial Officer filed as Exhibits 31.1 and 31.2 to this Annual Report on Form 10-K.

Management's Report on Internal Control Over Financial Reporting
Management is responsible for establishing and maintaining adequate internal control over financial reporting ("ICOFR") for the Company. ICOFR is defined as a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Our ICOFR process includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the consolidated financial statements in accordance with GAAP, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on our consolidated financial statements.

Because of its inherent limitations, ICOFR may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Under the supervision and with the participation of management, including our Chief Executive and Chief Financial Officers, management assessed the effectiveness of our ICOFR at December 31, 2016. In making this assessment, management used the framework set forth by the Committee of Sponsoring Organizations of the Treadway Commission in "*Internal Control - Integrated Framework*" *(2013)*. Based on this assessment, management concluded that our ICOFR was effective at December 31, 2016. Our ICOFR as well as our consolidated financial statements have been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which appears on page 150.

Management's Responsibility for Financial Statements
Management is responsible for our consolidated financial statements, which have been prepared in accordance with GAAP. Management believes the consolidated financial statements, and other financial information included in this report, fairly present in all material respects our financial position, results of operations and cash flows as of and for the periods presented in this report.

The financial statements are the product of a number of processes that include the gathering of financial data developed from the records of our day-to-day business transactions. Informed judgments and estimates are used for those transactions not yet complete or for which the ultimate effects cannot be measured precisely. We emphasize the selection and training of personnel who are qualified to perform these functions. In addition, our personnel are subject to rigorous standards of ethical conduct that are widely communicated throughout the organization.

The Audit Committee of Aetna's Board of Directors engages KPMG LLP, an independent registered public accounting firm, to audit our consolidated financial statements and express their opinion thereon. Members of that firm also have the right of full

access to each member of management in conducting their audits. The report of KPMG LLP on their audit of our consolidated financial statements appears on page 150.

Audit Committee Oversight
The Audit Committee of Aetna's Board of Directors is comprised solely of independent directors. The Audit Committee meets regularly with management, our internal auditors and KPMG LLP to oversee and monitor the work of each and to inquire of each as to their assessment of the performance of the others in their work relating to our consolidated financial statements and ICOFR. Both KPMG LLP and our internal auditors have, at all times, the right of full access to the Audit Committee, without management present, to discuss any matter they believe should be brought to the attention of the Audit Committee.

Changes in Internal Control over Financial Reporting
There has been no change in our internal control over financial reporting identified in connection with the evaluation of such control that occurred during our fourth fiscal quarter that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

None.

Part III

Item 10. Directors, Executive Officers and Corporate Governance

Information concerning our Directors, our Directors' and certain of our executives' compliance with Section 16(a) of the Exchange Act, our Code of Conduct (our written code of ethics) and our audit committee and audit committee financial experts is incorporated herein by reference to the information under the captions "Nominees for Directorships," "Section 16(a) Beneficial Ownership Reporting Compliance," "Aetna's Code of Conduct" and "Board and Committee Membership; Committee Descriptions" in the Proxy Statement.

EXECUTIVE OFFICERS OF THE REGISTRANT
Aetna's Chairman is elected by Aetna's Board of Directors (our "Board"). All of Aetna's other executive officers listed below are appointed by our Board, generally at its Annual Meeting, and such persons hold office until the next Annual Meeting of our Board or until their successors are elected or appointed. None of these officers has a family relationship with any other executive officer or Director. In addition, there are no arrangements or understandings, other than those with Directors or executive officers acting solely in their capacities as such, pursuant to which these executive officers were appointed.

Name of Executive Officer	Position*	Age *
Mark T. Bertolini	Chairman and Chief Executive Officer	60
Karen S. Lynch	President	54
Shawn M. Guertin	Executive Vice President, Chief Financial Officer and Chief Enterprise Risk Officer	53
Gary W. Loveman, Ph.D.	Executive Vice President, Consumer Health and Services	56
Margaret M. McCarthy	Executive Vice President, Operations and Technology	63
Harold L. Paz, M.D, M.S.	Executive Vice President, Chief Medical Officer	62
Thomas J. Sabatino, Jr.	Executive Vice President and General Counsel	58
Francis S. Soistman, Jr.	Executive Vice President, Government Services	60

*As of February 17, 2017

Executive Officers' Business Experience During Past Five Years

Mark T. Bertolini serves as Aetna's Chairman, having held that position since April 8, 2011. Mr. Bertolini was elected to Aetna's Board and has served as Chief Executive Officer since November 29, 2010. Mr. Bertolini also served as President from July 24, 2007 to December 31, 2014.

Karen S. Lynch became President of Aetna on January 1, 2015, having served as Executive Vice President, Local and Regional Businesses since February 2013 and Executive Vice President, Head of Specialty Products since July 23, 2012. Prior to joining Aetna, Ms. Lynch served as President of Magellan Health Services, a position she assumed in August 2009.

Shawn M. Guertin became Executive Vice President, Chief Financial Officer and Chief Enterprise Risk Officer on January 2, 2014, having served as Senior Vice President, Chief Financial Officer and Chief Enterprise Risk Officer since February 25, 2013. Prior to that, Mr. Guertin served as the Head of Business Segment Finance since April 2011. Prior to joining Aetna, Mr. Guertin had served as a consultant to Coventry Health Care, Inc. from January 1, 2010 to December 31, 2010.

Gary W. Loveman, Ph.D. became Executive Vice President, Consumer Health and Services on October 26, 2015. Prior to joining Aetna, Mr. Loveman served as Chairman, Chief Executive Officer and President of Caesars Entertainment Corporation through June 30, 2015, and executive Chairman through December 31, 2016. Mr. Loveman continues to serve as the non-executive Chairman of its Board. Mr. Loveman joined Caesars as Chief Operating Officer in 1998 and became President in April 2001, Chief Executive Officer in January 2003 and Chairman of the Board on January 1, 2005. Mr. Loveman also serves as Chairman of the Board of Caesars Entertainment Operating Company, Inc. ("CEOC", a subsidiary of Caesars Entertainment Corporation). Mr. Loveman resigned as President and Chief Executive Officer of CEOC on July 30, 2014 and from other offices held with certain of CEOC's subsidiaries on January 14, 2015 and March 12, 2015. CEOC and those subsidiaries filed a voluntary petition under Chapter 11 of the Federal bankruptcy laws on January 15, 2015.

Margaret M. McCarthy became Executive Vice President, Operations and Technology on November 29, 2010, having served as Chief Information Officer since June 3, 2005 and Senior Vice President Innovation, Technology and Service Operations since January 1, 2010.

Harold J. Paz, M.D, M.S. became Executive Vice President, Chief Medical Officer on July 28, 2014. Prior to joining Aetna, Dr. Paz served as Chief Executive Officer of Penn State Hershey Medical Center and Health System, Senior Vice President for Health Affairs for Penn State University, dean of its College of Medicine and professor of medicine and public health sciences, a position he assumed in April 2006.

Thomas J. Sabatino, Jr. became Executive Vice President and General Counsel on April 25, 2016. Prior to joining Aetna, Mr. Sabatino served as Senior Executive Vice President, Chief Administrative Officer and General Counsel of Hertz Global Holdings, Inc. from February 2015 through April 2016; Executive Vice President, Global Legal and Chief Administrative Officer of Walgreens Boots Alliance from September 2011 through January 2015; and Senior Vice President and General Counsel of UAL Corporation and United Airlines, Inc. from March 2010 to December 2010.

Francis S. Soistman, Jr. became Executive Vice President, Government Services on June 14, 2013, having served as Vice President, Medicare since May 20, 2013 and Head of Medicare since January 14, 2013. Prior to joining Aetna, Mr. Soistman served as Executive Vice President of Jessamine Healthcare, a position he assumed in 2010.

Item 11. Executive Compensation

The information under the captions “Compensation Discussion and Analysis,” “Director Compensation Philosophy and Elements,” “2016 Nonmanagement Director Compensation,” “Additional Director Compensation Information,” “Executive Compensation,” “Compensation Committee Interlocks and Insider Participation” and “Compensation Committee Report” in the Proxy Statement is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The information under the caption “Security Ownership of Certain Beneficial Owners, Directors, Nominees and Executive Officers” and “Equity Compensation Plans” in the Proxy Statement is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information under the captions “Director Independence” and “Related Party Transaction Policy” in the Proxy Statement is incorporated herein by reference.

Item 14. Principal Accounting Fees and Services

The information under the captions "Fees Incurred for 2016 and 2015 Services Performed by the Independent Registered Public Accounting Firm" and "Nonaudit Services and Other Relationships Between the Company and the Independent Registered Public Accounting Firm" in the Proxy Statement is incorporated herein by reference.

Part IV

Item 15. Exhibits, Financial Statement Schedules

The following documents are filed as part of this Annual Report on Form 10-K:

1. Financial Statements. See "Index to Consolidated Financial Statements" in Part II, Item 8 of this Annual Report on Form 10-K.

2. Financial Statement Schedule. The following financial statement schedule of the Company is included in this Item 15:

   Schedule I: Condensed Financial Information of Aetna Inc. (Parent Company Only)

3. Exhibits. The exhibits listed in the accompanying "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K.

Index to Financial Statement Schedule

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
Aetna Inc.:

Under the date of February 17, 2017, we reported on the consolidated balance sheets of Aetna Inc. and subsidiaries (the "Company") as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the years in the three-year period ended December 31, 2016, as contained in the Annual Report on Form 10-K for the year ended December 31, 2016. In connection with our audits of the aforementioned consolidated financial statements, we also audited the related financial statement schedule listed in the accompanying index. The financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the financial statement schedule based on our audits.

In our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ KPMG LLP

Hartford, Connecticut
February 17, 2017

Schedule I - Financial Information of Aetna Inc.

Aetna Inc. (Parent Company Only)
Balance Sheets

	At December 31,	
(Millions)	**2016**	**2015**
Assets:		
Current assets:		
Cash and cash equivalents	**$ 14,972**	$ 176
Investments	**4**	—
Other receivables, net	**—**	98
Income taxes receivable	**48**	34
Other current assets	**109**	197
Total current assets	**15,133**	505
Investment in affiliates [1]	**23,415**	23,236
Long-term investments	**—**	19
Deferred income taxes	**285**	270
Other long-term assets	**107**	88
Total assets	**$ 38,940**	$ 24,118
Liabilities and shareholders' equity:		
Current liabilities:		
Accrued expenses and other current liabilities	**$ 792**	$ 626
Current portion of long-term debt	**1,248**	—
Total current liabilities	**2,040**	626
Long-term debt, less current portion	**18,366**	6,708
Employee benefit liabilities	**545**	552
Income taxes payable	**—**	6
Other long-term liabilities	**46**	47
Total liabilities	**20,997**	7,939
Shareholders' equity:		
Common stock ($.01 par value; 2.5 billion shares authorized and 351.7 million shares issued and outstanding in 2016; 2.5 billion shares authorized and 349.5 million shares issued and outstanding in 2015) and additional paid-in capital	**4,716**	4,647
Retained earnings	**14,717**	12,797
Accumulated other comprehensive loss	**(1,552)**	(1,330)
Total Aetna shareholders' equity	**17,881**	16,114
Non-controlling interests	**62**	65
Total equity	**17,943**	16,179
Total liabilities and equity	**$ 38,940**	$ 24,118

[1] Includes goodwill and other acquired intangible assets of $12.1 billion and $12.3 billion at December 31, 2016 and 2015, respectively.

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Statements of Income

	For the Years Ended December 31,		
(Millions)	**2016**	**2015**	**2014**
Other revenue [1]	**$ —**	110	—
Net investment income	**31**	—	1
Net realized capital (losses) gains	**(6)**	—	28
Total revenue	**25**	110	29
Operating expenses	**289**	183	275
Interest expense	**578**	343	303
Loss on early extinguishment of long-term debt	**—**	—	181
Total expenses	**867**	526	759
Loss before income tax benefit and equity in earnings of affiliates, net	**(842)**	(416)	(730)
Income tax benefit	**249**	93	248
Equity in earnings of affiliates, net [2]	**2,864**	2,713	2,523
Net income attributable to Aetna	**$ 2,271**	$ 2,390	$ 2,041

[1] In the year ended December 31, 2015, other revenue includes litigation-related proceeds, net of legal costs. Refer to Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

[2] Includes after-tax amortization of other acquired intangible assets of $161 million, $166 million and $158 million for the years ended December 31, 2016, 2015 and 2014, respectively.

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Statements of Comprehensive Income

(Millions)	For the Years Ended December 31, 2016	2015	2014
Net income attributable to Aetna	**$ 2,271**	$ 2,390	$ 2,041
Other comprehensive (loss) income, net of tax:			
Previously impaired debt securities	**(3)**	(16)	1
All other securities	**(15)**	(256)	241
Derivatives and foreign currency	**(161)**	(13)	(61)
Pension and OPEB plans	**(43)**	66	(380)
Other comprehensive loss	**(222)**	(219)	(199)
Comprehensive income attributable to Aetna	**$ 2,049**	$ 2,171	$ 1,842

Refer to Note 14 “Other Comprehensive (Loss) Income” included in Part II, Item 8 of this Annual Report on Form 10-K for further information about other comprehensive income or loss.

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Statements of Shareholders' Equity

		Attributable to Aetna					
(Millions)	Number of Common Shares Outstanding	Common Stock and Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Total Aetna Shareholders' Equity	Non-Controlling Interests	Total Equity
Balance at December 31, 2013	362.2	$ 4,382	$ 10,555	$ (912)	$ 14,025	$ 53	$ 14,078
Net income	—	—	2,041	—	2,041	4	2,045
Other increases in non-controlling interests	—	—	—	—	—	12	12
Other comprehensive loss	—	—	—	(199)	(199)	—	(199)
Common shares issued for benefit plans, including tax benefits, net of employee tax withholdings	3.5	160	—	—	160	—	160
Repurchases of common shares	(15.9)	—	(1,218)	—	(1,218)	—	(1,218)
Dividends declared	—	—	(326)	—	(326)	—	(326)
Balance at December 31, 2014	349.8	4,542	11,052	(1,111)	14,483	69	14,552
Net income	—	—	2,390	—	2,390	5	2,395
Other decreases in non-controlling interests	—	—	—	—	—	(9)	(9)
Other comprehensive loss	—	—	—	(219)	(219)	—	(219)
Common shares issued for benefit plans, including tax benefits, net of employee tax withholdings	2.7	105	—	—	105	—	105
Repurchases of common shares	(3.0)	—	(296)	—	(296)	—	(296)
Dividends declared	—	—	(349)	—	(349)	—	(349)
Balance at December 31, 2015	**349.5**	**4,647**	**12,797**	**(1,330)**	**16,114**	**65**	**16,179**
Net income (loss)	**—**	**—**	**2,271**	**—**	**2,271**	**(15)**	**2,256**
Other increases in non-controlling interests	**—**	**—**	**—**	**—**	**—**	**12**	**12**
Other comprehensive loss	**—**	**—**	**—**	**(222)**	**(222)**	**—**	**(222)**
Common shares issued for benefit plans, net of employee tax withholdings	**2.2**	**69**	**—**	**—**	**69**	**—**	**69**
Dividends declared	**—**	**—**	**(351)**	**—**	**(351)**	**—**	**(351)**
Balance at December 31, 2016	**351.7**	**$ 4,716**	**$ 14,717**	**$ (1,552)**	**$ 17,881**	**$ 62**	**$ 17,943**

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Statements of Cash Flows

	For the Years Ended December 31,		
(Millions)	**2016**	**2015**	**2014**
Cash flows from operating activities:			
Net income attributable to Aetna	**$ 2,271**	$ 2,390	$ 2,041
Adjustments to reconcile net income including non-controlling interests to net cash (used for) provided by operating activities:			
Loss on early extinguishment of long-term debt	**—**	—	181
Pension settlement charge	**—**	—	112
Equity earnings of affiliates, net [1]	**(2,864)**	(2,713)	(2,523)
Amortization of interest rate hedges	**20**	6	6
Stock-based compensation expense	**191**	181	163
Net realized capital losses (gains)	**6**	—	(28)
Net change in other assets and other liabilities	**308**	(245)	127
Net cash (used for) provided by operating activities	**(68)**	(381)	79
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	**—**	66	18
Cost of investments	**—**	—	(86)
Dividends received from affiliates, net	**2,742**	1,733	895
Net cash provided by investing activities	**2,742**	1,799	827
Cash flows from financing activities:			
Repayment of long-term debt	**—**	—	(1,423)
Issuance of long-term debt	**12,886**	—	1,482
Net (repayment) issuance of short-term debt	**—**	(500)	500
Common shares issued under benefit plans, net	**(139)**	(143)	(60)
Stock-based compensation tax benefits	**—**	53	41
Common shares repurchased	**—**	(296)	(1,218)
Net payment on interest rate derivatives	**(274)**	(25)	(77)
Dividends paid to shareholders	**(351)**	(349)	(321)
Net cash provided by (used for) financing activities	**12,122**	(1,260)	(1,076)
Net increase (decrease) in cash and cash equivalents	**14,796**	158	(170)
Cash and cash equivalents, beginning of period	**176**	18	188
Cash and cash equivalents, end of period	**$ 14,972**	$ 176	$ 18
Supplemental cash flow information:			
Interest paid	**$ 485**	$ 276	$ 286
Income taxes refunded	**252**	282	198

[1] Includes after-tax amortization of other acquired intangible assets of $161 million, $166 million and $158 million for the years ended December 31, 2016, 2015 and 2014, respectively.

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Notes to Financial Statements

1. Organization

The financial statements reflect financial information for Aetna Inc. (a Pennsylvania corporation) only (the "Parent Company"). The financial information presented herein includes the balance sheet of the Parent Company as of December 31, 2016 and 2015 and the related statements of income, comprehensive income, shareholders' equity and cash flows for the years ended December 31, 2016, 2015 and 2014. The accompanying financial statements should be read in conjunction with the consolidated financial statements and notes thereto in the Annual Report.

2. Summary of Significant Accounting Policies

Refer to Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for the summary of significant accounting policies.

3. Dividends

Gross cash dividends received from subsidiaries and included in net cash provided by investing activities in the Statements of Cash Flows were $2.9 billion, $2.2 billion and $1.5 billion in 2016, 2015 and 2014, respectively.

4. Acquisitions and Dispositions

Refer to Note 3 "Acquisitions, Terminated Acquisition and Terminated Divestiture" included in Part II, Item 8 of this Annual Report on Form 10-K for a description of acquisitions and dispositions.

5. Other Comprehensive Income (Loss)

Refer to Note 14 "Other Comprehensive (Loss) Income" included in Part II, Item 8 of this Annual Report on Form 10-K for a description of accumulated other comprehensive income (loss).

6. Debt

Long-term debt on the Parent Company Only balance sheet excludes long-term debt of a subsidiary. That debt was acquired in our acquisition of Coventry Health Care, Inc. Refer to Note 9 "Debt" included in Part II, Item 8 of this Annual Report on Form 10-K for a description of the Parent Company's consolidated total debt.

INDEX TO EXHIBITS

*Exhibits**

Exhibits to this Form 10-K are as follows:

2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Agreement and Plan of Merger dated as of July 2, 2015 among Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc, incorporated herein by reference to Exhibit 2.1 to Aetna's Form 8-K filed on July 7, 2015.
2.2	Letter agreement dated December 21, 2016 among Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc, incorporated herein by reference to Exhibit 10.1 to Aetna's Form 8-K filed on December 22, 2016.
2.3	Termination Agreement dated as of February 14, 2017 among Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc. incorporated herein by reference to Exhibit 10.1 to Aetna's Form 8-K filed on February 14, 2017.
3	**Articles of Incorporation and By-Laws**
3.1	Amended and Restated Articles of Incorporation of Aetna Inc., incorporated herein by reference to Exhibit 3.1 to Aetna Inc.'s Form 8-K filed on June 4, 2014.
3.2	Amended and Restated By-Laws of Aetna Inc., incorporated herein by reference to Exhibit 3.2 to Aetna Inc.'s Form 8-K filed on June 4, 2014.
4	**Instruments defining the rights of security holders, including indentures**
4.1	Form of Aetna Inc. Common Share certificate, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Amendment No. 2 to Registration Statement on Form 10 filed on December 1, 2000.
4.2	Senior Indenture dated as of March 2, 2001, between Aetna Inc. and U.S. Bank National Association, successor in interest to State Street Bank and Trust Company, incorporated herein by reference to Exhibit 4.2 to Aetna Inc.'s Registration Statement on Form S-3 filed on December 1, 2014.
4.3	Form of Subordinated Indenture between Aetna Inc. and U.S. Bank National Association, incorporated herein by reference to Exhibit 4.3 to Aetna Inc.'s Registration Statement on Form S-3 filed on December 1, 2014.
4.4	Supplemental Indenture dated as of May 20, 2011 between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 4.125% Senior Notes due June 1, 2021, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on May 20, 2011.
4.5	Supplemental Indenture dated as of May 4, 2012 between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 1.750% Senior Notes due May 15, 2017 and 4.500% Senior Notes due May 15, 2042, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on May 4, 2012.
4.6	Supplemental Indenture dated as of November 7, 2012 between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 1.500% Senior Notes due November 15, 2017, 2.750% Senior Notes due November 15, 2022 and 4.125% Senior Notes due November 15, 2042, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on November 7, 2012.
4.7	Supplemental Indenture dated as of March 7, 2014 between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 2.200% Senior Notes due March 15, 2019 and 4.750% Senior Notes due March 15, 2044, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on March 7, 2014.
4.8	Supplemental Indenture dated as of November 10, 2014 between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 3.500% Senior Notes due November 15, 2024, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on November 10, 2014.
4.9	Supplemental Indenture dated as of June 9, 2016 between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating the Aetna Inc.'s Floating Rate Senior Notes due December 8, 2017, 1.700% Senior Notes due June 7, 2018, 1.900% Senior Notes due June 7, 2019, 2.400% Senior Notes due June 15, 2021, 2.800% Senior Notes due June 15, 2023, 3.200% Senior Notes due June 15, 2026, 4.250% Senior Notes due June 15, 2036 and 4.375% Senior Notes due June 15, 2046, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on June 9, 2016.
4.10	Indenture, dated as of March 20, 2007, between Coventry Health Care, Inc., as Issuer, and The Bank of New York, as Trustee (incorporated by reference to Exhibit 4.1 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on March 20, 2007 (SEC file number 001-16477)), incorporated herein by reference to Exhibit 4.4 to Aetna Inc.'s Form 10-Q filed July 30, 2013.
4.11	Officers' Certificate pursuant to the Indenture, dated as of March 20, 2007 (incorporated by reference to Exhibit 4.2 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on March 20, 2007 (SEC file number 001-16477)), incorporated herein by reference to Exhibit 4.5 to Aetna Inc.'s Form 10-Q filed July 30, 2013.

4.12 Global Note for the 2017 Notes, dated March 20, 2007, of Coventry Health Care, Inc. (incorporated by reference to Exhibit 4.3 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on March 20, 2007 (SEC file number 001-16477)), incorporated herein by reference to Exhibit 4.6 to Aetna Inc.'s Form 10-Q filed July 30, 2013.

4.13 Second Supplemental Indenture, dated as of June 7, 2011, among Coventry Health Care, Inc. and Union Bank, National Association, as Trustee (incorporated by reference to Exhibit 4.3 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on June 7, 2011), incorporated herein by reference to Exhibit 4.10 to Aetna Inc.'s Form 10-Q filed July 30, 2013.

4.14 Officers' Certificate pursuant to the Indenture, dated as of June 7, 2011 (incorporated by reference to Exhibit 4.4 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on June 7, 2011), incorporated herein by reference to Exhibit 4.11 to Aetna Inc.'s Form 10-Q filed July 30, 2013.

4.15 Global Note for the 2021 Notes, dated June 7, 2011, of Coventry Health Care, Inc. (incorporated by reference to Exhibit 4.5 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on June 7, 2011), incorporated herein by reference to Exhibit 4.12 to Aetna Inc.'s Form 10-Q filed July 30, 2013.

10 Material contracts

10.1 $1,500,000,000 Five-Year Credit Agreement dated as of March 27, 2012, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on March 28, 2012.

10.2 First Amendment dated as of September 24, 2012, to the $1,500,000,000 Five Year Credit Agreement dated as of March 27, 2012, incorporated herein by reference to Exhibit 99.2 to Aetna Inc.'s Form 8-K filed on September 27, 2012.

10.3 Incremental Commitment Agreement dated as of September 24, 2012, incorporated herein by reference to Exhibit 99.3 to Aetna Inc.'s Form 8-K filed on September 27, 2012.

10.4 Extension of the Maturity Date of the Five-Year Credit Agreement dated March 27, 2012, as amended, incorporated herein by reference to Exhibits 99.1 to 99.22 to Aetna Inc.'s Form 8-K filed on March 27, 2013.

10.5 Extension of the Maturity Date of the Five-Year Credit Agreement dated March 27, 2012, as amended, incorporated herein by reference to Exhibits 99.1 through 99.22 to Aetna Inc.'s Form 8-K filed on March 28, 2014.

10.6 Maturity Data Extension Request, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on March 5, 2015.

10.7 Second Amendment dated as of March 2, 2015, to $1,500,000,000 Five-Year Credit Agreement dated as of March 27, 2012, incorporated herein by reference to Exhibit 99.2 to Aetna Inc.'s Form 8-K filed on March 5, 2015.

10.8 Notice of closing dated March 2, 2015, incorporated herein by reference to Exhibit 99.3 to Aetna Inc.'s Form 8-K filed on March 5, 2015.

10.9 Third Amendment dated as of July 30, 2015, to the Five-Year Credit Agreement dated as of March 27, 2012, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on July 31, 2015.

10.10 Notice of Effectiveness (Third Amendment), incorporated herein by reference to Exhibit 99.2 to Aetna Inc.'s Form 8-K filed on July 31, 2015.

10.11 $3.2 billion Term Loan Credit Agreement dated as of July 30, 2015, incorporated herein by reference to Exhibit 99.5 to Aetna Inc.'s Form 8-K filed on July 31, 2015.

10.12 Notice of Effectiveness (Term Loan Credit Agreement), incorporated herein by reference to Exhibit 99.6 to Aetna Inc.'s Form 8-K filed on July 31, 2015.

10.13 First Amendment, dated as of November 21, 2016, to Term Loan Credit Agreement dated July 30, 2015, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on November 22, 2016.

10.14 Amended and Restated Aetna Inc. 2000 Stock Incentive Plan, incorporated herein by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-K filed on February 27, 2009 (SEC file number 001-16095). **

10.15 Form of Aetna Inc. 2000 Stock Incentive Plan - Stock Appreciation Right Terms of Award, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on October 26, 2006 (SEC file number 001-16095). **

10.16 Amended Aetna Inc. 2010 Stock Incentive Plan, as amended May 30, 2014, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on June 4, 2014. **

10.17 Form of Aetna Inc. 2010 Stock Incentive Plan – Restricted Stock Unit Terms of Award (with non-compete provision), incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on April 28, 2011. **

10.18 Form of Aetna Inc. 2010 Stock Incentive Plan – Market Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on April 28, 2011. **

10.19 Form of Aetna Inc. 2010 Stock Incentive Plan – Performance Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on April 28, 2011. **

10.20 Form of Aetna Inc. 2010 Stock Incentive Plan – Performance Stock Unit Terms of Award (2015), incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on April 28, 2015. **

10.21 Form of Aetna Inc. 2010 Stock Incentive Plan – Executive Restricted Stock Unit Terms of Award (2015), incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on April 28, 2015. **

10.22 Form of Aetna Inc. 2010 Stock Incentive Plan – Restricted Stock Unit Terms of Award (2011, with retirement vesting), incorporated herein by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-Q filed on April 28, 2011. **

10.23 Form of Aetna Inc. 2010 Stock Incentive Plan – Restricted Stock Unit Terms of Award (2011, without retirement vesting), incorporated herein by reference to Exhibit 10.5 to Aetna Inc.'s Form 10-Q filed on April 28, 2011. **

10.24 Form of Aetna Inc. 2010 Stock Incentive Plan – Stock Appreciation Right Terms of Award (2015), incorporated herein by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-Q filed on April 28, 2015. **

10.25 Form of Aetna Inc. 2010 Stock Incentive Plan – Stock Appreciation Right Agreement, incorporated herein by reference to Exhibit 10.6 to Aetna Inc.'s Form 10-Q filed on April 28, 2011. **

10.26 Amended and Restated Aetna Inc. 2001 Annual Incentive Plan, incorporated herein by reference to Exhibit 10.5 to Aetna Inc.'s Form 10-Q filed on April 29, 2010 (SEC file number 001-16095). **

10.27 Aetna Inc. 2010 Non-Employee Director Compensation Plan, incorporated herein by reference to Annex C to Aetna Inc.'s definitive proxy statement on Schedule 14A filed on April 12, 2010 (SEC file number 001-16095). **

10.28 Aetna Inc. Non-Employee Director Compensation Plan as Amended through December 5, 2008, incorporated herein by reference to Exhibit 10.13 to Aetna Inc.'s Form 10-K filed on February 27, 2009 (SEC file number 001-16095). **

10.29 Form of Aetna Inc. Non-Employee Director Compensation Plan - Restricted Stock Unit Agreement, incorporated herein by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-Q filed on October 26, 2006 (SEC file number 001-16095). **

10.30 1999 Director Charitable Award Program, as Amended and Restated on January 25, 2008, incorporated herein by referenced to Exhibit 10.15 to Aetna Inc.'s Form 10-K filed on February 29, 2008 (SEC file number 001-16095). **

10.31 Aetna Inc. 2016 Employee Stock Purchase Plan, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on August 2, 2016. **

10.32 Amended and Restated Employment Agreement dated October 19, 2010 between Aetna Inc. and Mark T. Bertolini, incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed November 3, 2010 (SEC file number 001-16095). **

10.33 Amendment No. 1, dated as of August 4, 2013, to Amended and Restated Employment Agreement dated October 19, 2010 between Aetna Inc. and Mark T. Bertolini, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 8-K filed on August 5, 2013. **

10.34 Letter agreement dated March 23, 2011 between Aetna Life Insurance Company and Shawn M. Guertin, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on April 30, 2013. **

10.35 Letter agreement dated September 17, 2015 between Aetna Inc. and Gary W. Loveman, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed April 28, 2016. **

10.36 Letter agreement dated May 18, 2012 between Aetna Life Insurance Company and Karen S. Rohan (Lynch), incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on April 30, 2013. **

10.37 Employment Agreement dated December 10, 2014 between Aetna Inc. and Karen S. Rohan (Lynch), incorporated herein by reference to Exhibit 10.29 to Aetna Inc.'s Form 10-K filed on February 27, 2015. **

10.38 Letter agreement dated December 17, 2012 between Aetna Life Insurance Company and Francis S. Soistman, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on April 28, 2015. **

10.39 Form of Non-Competition, Non-Solicitation, Confidentiality and Assignment Agreement, incorporated herein by reference to Exhibit 10.32 to Aetna Inc.'s Form 10-K filed on February 27, 2015. **

10.40 Descriptions of certain arrangements not embodied in formal documents as described under the headings "2016 Nonmanagement Director Compensation" and "Additional Director Compensation Information" are incorporated herein by reference to the Proxy Statement (when filed). **

11 Statement re: computation of per share earnings

11.1 "Computation of per share earnings" is incorporated herein by reference to Note 15 of Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

12 Statement re: computation of ratios

12.1 Computation of ratio of earnings to fixed charges.

21	**Subsidiaries of the registrant**
21.1	Subsidiaries of Aetna Inc.
23	**Consents of experts and counsel**
23.1	Consent of Independent Registered Public Accounting Firm.
24	**Power of Attorney**
24.1	Power of Attorney.
31	**Rule 13a - 14(a)/15d - 14(e) Certifications**
31.1	Certification.
31.2	Certification.
32	**Section 1350 Certifications**
32.1	Certification.
32.2	Certification.
101	**XBRL Documents**
101.INS	XBRL Instance Document.
101.SCH	XBRL Taxonomy Extension Schema.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase.
101.DEF	XBRL Taxonomy Extension Definition Linkbase.
101.LAB	XBRL Taxonomy Extension Label Linkbase.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase.

* Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Copies of exhibits, including exhibits that are not required to be listed, will be furnished without charge upon written request to the Office of the Corporate Secretary, Aetna Inc., 151 Farmington Avenue, Hartford, Connecticut 06156.

** Management contract or compensatory plan or arrangement.

Item 16. Form 10-K Summary

None.

Signatures

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: February 17, 2017 Aetna Inc.

By: /s/ Sharon A. Virag
Sharon A. Virag
Vice President, Controller and Chief Accounting Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signer	Title	Date
/s/ Mark T. Bertolini Mark T. Bertolini	Chairman and Chief Executive Officer and Director (Principal Executive Officer)	February 17, 2017
/s/ Shawn M. Guertin Shawn M. Guertin	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 17, 2017
/s/ Sharon A. Virag Sharon A. Virag	Vice President, Controller and Chief Accounting Officer (Principal Accounting Officer)	February 17, 2017
Fernando Aguirre *	Director	
Frank M. Clark *	Director	
Betsy Z. Cohen *	Director	
Molly J. Coye, M.D. *	Director	
Roger N. Farah *	Director	
Jeffrey E. Garten *	Director	
Ellen M. Hancock *	Director	
Richard J. Harrington *	Director	
Edward J. Ludwig *	Director	
Joseph P. Newhouse *	Director	
Olympia J. Snowe *	Director	

* By: /s/ Sharon A. Virag
Sharon A. Virag
Attorney-in-fact
February 17, 2017

Exhibit 12.1

Statement re: Computation of Ratios

The computation of the ratio of earnings to fixed charges for the years ended December 31, 2012 through 2016 are as follows:

	Years Ended December 31,				
(Millions)	**2016**	**2015**	**2014**	**2013**	**2012**
Income from continuing operations before income taxes	**$ 3,991**	**$ 4,234**	$ 3,497	$ 2,937	$ 2,545
Add back fixed charges	**663**	**426**	396	396	321
Income as adjusted ("earnings")	**$ 4,654**	**$ 4,660**	$ 3,893	$ 3,333	$ 2,866
Fixed charges:					
Interest expense	**$ 604**	**$ 369**	$ 334	$ 336	$ 271
Portion of rents representative of interest factor	**59**	**57**	62	60	50
Total fixed charges	**$ 663**	**$ 426**	$ 396	$ 396	$ 321
Ratio of earnings to fixed charges	**7.0**	**10.94**	9.83	8.42	8.93

Exhibit 21.1

Subsidiaries of Aetna Inc.

Listed below are subsidiaries of Aetna Inc. at December 31, 2016 with their jurisdictions of organization shown in parentheses. Subsidiaries excluded from the list below would not, in the aggregate, constitute a "significant subsidiary" of Aetna Inc., as that term is defined in Rule 1-02(w) of Regulation S-X.

- Aetna Health Holdings, LLC (Delaware)
    - Aetna Health of California Inc. (California)
    - Aetna Health Inc. (Connecticut)
    - Aetna Health Inc. (Florida)
    - Aetna Health Inc. (Georgia)
    - Aetna Health Inc. (Maine)
    - Aetna Health Inc. (Michigan)
    - Aetna Health Inc. (New Jersey)
    - Aetna Health Inc. (New York)
        - Aetna Better Health Inc. (New York)
    - Aetna Health Inc. (Pennsylvania)
    - Aetna Health Inc. (Texas)
    - Aetna Better Health of California Inc. (California)
    - Aetna Better Health of Iowa Inc. (Iowa)
    - Aetna Better Health of Texas Inc. (Texas)
    - Aetna Better Health Inc. (Georgia)
    - Aetna HealthAssurance Pennsylvania, Inc. (Pennsylvania)
    - Aetna Dental of California Inc. (California)
    - Aetna Dental Inc. (New Jersey)
    - Aetna Dental Inc. (Texas)
    - Aetna Rx Home Delivery, LLC (Delaware)
    - Aetna Health Management, LLC (Delaware)
    - Aetna Ireland Inc. (Delaware)
    - Aetna Specialty Pharmacy, LLC (Delaware)
    - Cofinity, Inc. (Delaware)
    - @Credentials Inc. (Delaware)
    - Strategic Resource Company (South Carolina)
    - Aetna Better Health Inc. (Pennsylvania)
    - Aetna Better Health Inc. (Connecticut)
    - Aetna Better Health Inc. (Illinois)
    - Aetna Better Health of Kansas Inc. (Kansas)
    - Aetna Better Health, Inc. (Louisiana)
    - Aetna Florida Inc. (Florida)
    - Aetna Better Health Inc. (Ohio)
    - Aetna Better Health of Oklahoma Inc. (Oklahoma)
    - Aetna Better Health of Nevada Inc. (Nevada)
    - Aetna Better Health Inc. (New Jersey)
    - Aetna Network Services LLC (Connecticut)
    - Aetna Risk Assurance Company of Connecticut Inc. (Connecticut)
    - Aetna Student Health Agency Inc. (Massachusetts)
    - Delaware Physicians Care, Incorporated (Delaware)
    - Schaller Anderson Medical Administrators, Incorporated (Delaware)
    - Aetna Medicaid Administrators LLC (Arizona)
    - iTriage, LLC (Delaware)
    - bswift LLC (Illinois)
        - Corporate Benefit Strategies, Inc. (Delaware)
    - Prodigy Health Group, Inc. (Delaware)
        - Niagara Re, Inc. (New York)
        - Performax, Inc. (Delaware)
        - Scrip World, LLC (Utah)
        - Precision Benefit Services, Inc. (Delaware)

        - American Health Holding, Inc. (Ohio)
        - Meritain Health, Inc. (New York)
            - ADMINCO, Inc. (Arizona)
            - Administrative Enterprises, Inc. (Arizona)
            - U.S Healthcare Holdings, LLC (Ohio)
            - Prime Net, Inc. (Ohio)
            - Professional Risk Management, Inc. (Ohio)
    - Coventry Transplant Network, Inc. (Delaware)
    - Aetna Health of Iowa Inc. (Iowa)
    - Coventry Health Care of Nebraska, Inc. (Nebraska)
    - Aetna Health Inc. (Louisiana)
    - HealthAssuance Pennsylvania, Inc. (Pennsylvania)
    - Coventry Prescription Management Services Inc. (Nevada)
    - Coventry Health and Life Insurance Company (Missouri)
        - Aetna Better Health of Kentucky Insurance Company (Kentucky)
    - Coventry Health Care of Virginia, Inc. (Virginia)
    - Coventry Health Care of Missouri, Inc. (Missouri)
    - Aetna Better Health of Missouri LLC (Missouri)
    - Coventry Health Care of Illinois, Inc. (Illinois)
    - Coventry Health Care of West Virginia, Inc. (West Virginia)
    - Coventry HealthCare Management Corporation (Delaware)
    - Coventry Health Care of Kansas, Inc. (Kansas)
    - Coventry Health Care National Accounts, Inc. (Delaware)
    - Aetna Better Health of Michigan Inc. (Michigan)
    - Aetna Health of Utah Inc. (Utah)
    - Aetna Better Health Inc. (Tennessee)
    - Coventry Health Care National Network, Inc. (Delaware)
    - Coventry Consumer Advantage, Inc. (Delaware)
    - MHNet Specialty Services, LLC (Maryland)
        - Mental Health Network of New York IPA, Inc. (New York)
        - Mental Health Associates, Inc. (Louisiana)
        - MHNet of Florida, Inc. (Florida)
        - MHNet Life and Health Insurance Company (Texas)
    - Group Dental Service, Inc. (Maryland)
        - Group Dental Service of Maryland, Inc. (Maryland)
    - Florida Health Plan Administrators, LLC (Florida)
        - Coventry Health Care of Florida, Inc. (Florida)
        - Carefree Insurance Services, Inc. (Florida)
        - Coventry Health Plan of Florida, Inc. (Florida)
    - First Health Group Corp. (Delaware)
        - First Health Life & Health Insurance Company (Texas)
        - Claims Administration Corp. (Maryland)
    - Coventry Health Care Workers' Compensation, Inc. (Delaware)
        - Coventry Rehabilitation Services, Inc. (Delaware)
        - First Script Network Services, Inc. (Nevada)
        - FOCUS HealthCare Management, Inc. (Tennessee)
        - Medical Examinations of New York, P.C. (New York)
        - MetraComp, Inc. (Connecticut)
- Continental Life Insurance Company of Brentwood, Tennessee (Tennessee)
    - American Continental Insurance Company (Tennessee)
- Aetna Life Insurance Company (Connecticut)
    - AHP Holdings, Inc. (Connecticut)
        - Aetna Insurance Company of Connecticut (Connecticut)
        - AE Fourteen, Incorporated (Connecticut)
        - Aetna Life Assignment Company (Connecticut)
    - Aetna ACO Holdings Inc. (Delaware)
        - Innovation Health Holdings, LLC (Delaware)
            - Innovation Health Insurance Company (Virginia)
                - Innovation Health Plan, Inc. (Virginia)

        - Texas Health + Aetna Health Insurance Holding Company LLC (Texas)
            - Texas Health + Aetna Health Insurance Company (Texas)
            - Texas Health + Aetna Health Plan Inc. (Texas)
    - PE Holdings, LLC (Connecticut)
    - Aetna Resources LLC (Delaware)
    - Canal Place, LLC (Delaware)
    - Aetna Ventures, LLC (Delaware)
    - Broadspire National Services, Inc. (Florida)
    - Aetna Multi-Strategy 1099 Fund (Delaware)
- Phoenix Data Solutions LLC (Delaware)
- Aetna Financial Holdings, LLC (Delaware)
    - Aetna Asset Advisors, LLC (Delaware)
    - U.S. Healthcare Properties, Inc. (Pennsylvania)
    - Aetna Capital Management, LLC (Delaware)
        - Aetna Partners Diversified Fund, LLC (Delaware)
        - Aetna Partners Diversified Fund (Cayman), Limited (Cayman)
    - Aetna Workers' Comp Access, LLC (Delaware)
    - Aetna Behavioral Health, LLC (Delaware)
    - Managed Care Coordinators, Inc. (Delaware)
    - Horizon Behavioral Services, LLC (Delaware)
        - Employee Assistance Services, LLC (Kentucky)
        - Health and Human Resource Center, Inc. (California)
        - Resources for Living, LLC (Texas)
        - The Vasquez Group Inc. (Illinois)
        - Work and Family Benefits, Inc. (New Jersey)
    - Aetna Card Solutions, LLC (Connecticut)
    - PayFlex Holdings, Inc. (Delaware)
        - PayFlex Systems USA, Inc. (Nebraska)
- Aetna Health and Life lnsurance Company (Connecticut)
- Aetna Health Insurance Company (Pennsylvania)
- Aetna Health Insurance Company of New York (New York)
- Aetna International Inc. (Connecticut)
    - Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
    - Aetna Global Holdings Limited (England & Wales)
        - Healthagen International Limited (England & Wales)
            - Futrix Limited (New Zealand)
        - Aetna Korea Ltd. (South Korea)
    - Aetna Global Benefits (Bermuda) Limited (Bermuda)
        - Goodhealth Worldwide (Global) Limited (Bermuda)
        - Aetna Global Benefits (Europe) Limited (England & Wales)
        - Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)
        - Goodhealth Worldwide (Asia) Limited (Hong Kong)
        - Aetna Global Benefits Limited (DIFC, UAE)
        - Spinnaker Topco Limited (Bermuda)
            - Spinnaker Bidco Limited (England and Wales)
                - Aetna Holdco (UK) Limited (England and Wales)
                    - InterGlobal Japan Corporation Limited (Japan)
                    - Aetna Global Benefits (UK) Limited (England and Wales)
                    - Aetna Insurance Company Limited (England and Wales)
    - Aetna Insurance (Singapore) Pte. Ltd. (Singapore)
    - Aetna Health Insurance Company of Europe Limited (Ireland)
    - Aetna (Shanghai) Enterprise Services Co. (China)
        - Aetna (Beijing) Enterprise Management Services Co., Ltd. (China)
    - Aetna Global Benefits (Singapore) PTE. LTD. (Singapore)
        - Indian Health Organisation Private Limited (India)
- AUSHC Holdings, Inc. (Connecticut)
    - PHPSNE Parent Corporation (Delaware)
- Active Health Management, Inc. (Delaware)
    - Health Data & Management Solutions, Inc. (Delaware)

    - Aetna Integrated Informatics, Inc. (Pennsylvania)
- Health Re, Inc. (Vermont)
- ASI Wings, LLC (Delaware)
- Healthagen LLC
- Echo Merger Sub, LLC (Delaware)
- Echo Merger Sub, Inc. (Delaware)
- Medicity, Inc. (Delaware)
    - Novo Innovations, LLC (Delaware)
    - Allviant Corporation (Delaware)

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

The Board of Directors

Aetna Inc:

We consent to the incorporation by reference in the registration statement (No. 333‑200647) on Form S-3, and the registration statements (No. 333-52120, 52122, 52124, 73052, 87722, 87726, 124619, 124620, 136176, 136177, 168497, 168498, 176009, 176011, 188792, 188814, 190272, 197707, and 212841) on Form S-8 of Aetna Inc. of our reports dated February 17, 2017 with respect to the consolidated balance sheets of Aetna Inc. and subsidiaries as of December 31, 2016 and 2015 and the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the years in the three-year period ended December 31, 2016 and the related financial statement schedule, and the effectiveness of internal control over financial reporting as of December 31, 2016, which reports appear in the December 31, 2016 Annual Report on Form 10‑K of Aetna Inc.

/s/ KPMG LLP

Hartford, Connecticut
February 17, 2017

Exhibit 24.1

Power of Attorney

We, the undersigned Directors of Aetna Inc. (the "Company"), hereby severally constitute and appoint Shawn M. Guertin, Sharon A. Virag and William C. Baskin III, and each of them individually, our true and lawful attorneys-in-fact, with full power to them and each of them to sign for us, and in our names and in the capacities indicated below, the Company's 2016 Annual Report on Form 10-K and any and all amendments thereto to be filed with the Securities and Exchange Commission under the Securities Exchange Act of 1934, hereby ratifying and confirming our signatures as they may be signed by any of our said attorneys to such Form 10-K and to any and all amendments thereto.

Dated: February 17, 2017

/s/ Fernando Aguirre
Fernando Aguirre, Director

/s/ Ellen M. Hancock
Ellen M. Hancock, Director

/s/ Frank M. Clark
Frank M. Clark, Director

/s/ Richard J. Harrington
Richard J. Harrington, Director

/s/ Betsy Z. Cohen
Betsy Z. Cohen, Director

/s/ Edward J. Ludwig
Edward J. Ludwig, Director

/s/ Molly J. Coye, M.D.
Molly J. Coye, M.D., Director

/s/ Joseph P. Newhouse
Joseph P. Newhouse, Director

/s/ Roger N. Farah
Roger N. Farah, Director

/s/ Olympia J. Snowe
Olympia J. Snowe, Director

/s/ Jeffrey E. Garten
Jeffrey E. Garten, Director

Exhibit 31.1

Certification

I, Mark T. Bertolini, certify that:

1. I have reviewed this annual report on Form 10-K of Aetna Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 17, 2017

/s/ Mark T. Bertolini

Mark T. Bertolini

Chairman and Chief Executive Officer

Exhibit 31.2

Certification

I, Shawn M. Guertin, certify that:

1. I have reviewed this annual report on Form 10-K of Aetna Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 17, 2017

/s/ Shawn M. Guertin

Shawn M. Guertin

Executive Vice President and Chief Financial Officer

Exhibit 32.1

Certification

The certification set forth below is being submitted to the Securities and Exchange Commission in connection with the Annual Report on Form 10-K of Aetna Inc. for the period ended December 31, 2016 (the "Report") solely for the purpose of complying with Rule 13a-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

Mark T. Bertolini, Chairman and Chief Executive Officer of Aetna Inc., certifies that, to the best of his knowledge:

1. the Report fully complies with the requirements of Section 13(a) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Aetna Inc.

Date: February 17, 2017

/s/ Mark T. Bertolini

Mark T. Bertolini

Chairman and Chief Executive Officer

Exhibit 32.2

Certification

The certification set forth below is being submitted to the Securities and Exchange Commission in connection with the Annual Report on Form 10-K of Aetna Inc. for the period ended December 31, 2016 (the "Report") solely for the purpose of complying with Rule 13a-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

Shawn M. Guertin, Executive Vice President and Chief Financial Officer of Aetna Inc., certifies that, to the best of his knowledge:

1. the Report fully complies with the requirements of Section 13(a) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Aetna Inc.

Date: February 17, 2017

/s/ Shawn M. Guertin

Shawn M. Guertin

Executive Vice President and Chief Financial Officer

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Aetna Form 10-K 2017

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2017

or

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

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☑ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☑ No

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☑Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). ☐ Yes ☑ No

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2017) was $49.2 billion.

There were 326.8 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2018.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement related to Aetna Inc.'s 2018 Annual Meeting of Shareholders, to be filed on or about April 6, 2018 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

Aetna Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2017

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FORWARD-LOOKING INFORMATION

The Private Securities Litigation Reform Act of 1995 (the "1995 Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We want to take advantage of these safe harbor provisions.

Certain information contained in this Annual Report on Form 10-K is forward-looking within the meaning of the 1995 Act or SEC rules. This information includes, but is not limited to: "Outlook for 2018" and "Regulatory Environment" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Part II, Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Part II, Item 7A, and "Risk Factors" included in Part I, Item 1A. In addition, throughout this Annual Report on Form 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions, when we intend to identify forward-looking statements:

· Anticipates	*· Believes*	*· Can*	*· Continue*	*· Could*
· Estimates	*· Evaluate*	*· Expects*	*· Explore*	*· Forecast*
· Guidance	*· Intends*	*· Likely*	*· May*	*· Might*
· Outlook	*· Plans*	*· Potential*	*· Predict*	*· Probable*
· Projects	*· Seeks*	*· Should*	*· View*	*· Will*

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these uncertainties and other factors are outside our control. Certain of these uncertainties and other factors are described under "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K. You should not put undue reliance on forward-looking statements. Any forward-looking statement speaks only as of the date of this report, and we disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events, uncertainties or otherwise.

Unless the context otherwise requires, references to the terms "we", "our" or "us" used throughout this Annual Report on Form 10-K refer to Aetna Inc. (a Pennsylvania corporation) ("Aetna") and its subsidiaries (collectively, the "Company").

Part I

Item 1. Business

General

We are one of the nation's leading diversified health care benefits companies, serving an estimated 37.9 million people. We have the information and resources to help our members, in consultation with their health care professionals, make better informed decisions about their health care. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, medical management capabilities, Medicaid health care management services, Medicare Advantage and Medicare Supplement plans, workers' compensation administrative services and health information technology ("HIT") products and services. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. On November 1, 2017, we sold our domestic group life insurance, group disability insurance and absence management businesses to Hartford Life and Accident Insurance Company ("HLAIC").

Significant Transactions

Proposed Acquisition by CVS Health

On December 3, 2017, we entered into a definitive agreement (the "CVS Merger Agreement") under which CVS Health Corporation ("CVS Health") will acquire all of our outstanding shares for a combination of cash and stock. Under terms of the agreement, our shareholders will receive $145 in cash and 0.8378 of a CVS Health common share for each of our common shares. The proposed transaction (the "CVS Health Transaction") is subject to customary closing conditions, including the approval and adoption of the CVS Merger Agreement by our shareholders, the approval of the issuance of CVS Health shares in the transaction by CVS Health stockholders, the expiration of the federal Hart-Scott-Rodino anti-trust waiting period and approvals of certain state departments of insurance and other regulators. On February 1, 2018, Aetna and CVS Health each received a request for additional information (also known as a "second request") from the U.S. Department of Justice (the "DOJ") in connection with the DOJ's review of the transactions contemplated by the CVS Merger Agreement. The CVS Health Transaction is expected to close in the second half of 2018.

Divestiture of Domestic Group Life Insurance, Group Disability Insurance, and Absence Management Businesses

On November 1, 2017, we completed the sale of a substantial portion of our Group Insurance segment consisting of our domestic group life insurance, group disability insurance and absence management businesses (the "Group Insurance sale") to HLAIC for cash consideration of $1.45 billion. The transaction was accomplished through an indemnity reinsurance arrangement under which HLAIC contractually assumed certain of our policyholder liabilities and obligations, although we remain directly obligated to policyholders. Assets related to and supporting the reinsured life and disability insurance policies were transferred to a trust established by HLAIC for our benefit, and we recorded a reinsurance receivable from HLAIC. The sale is expected to result in an after-tax gain of approximately $710 million ($1.1 billion pre-tax), a significant portion of which has been deferred and will be amortized into earnings: (i) over the remaining contract period (estimated to be approximately 3 years) in proportion to the amount of insurance protection provided for the prospective reinsurance portion of the gain; and (ii) as we recover amounts due from HLAIC over a period estimated to be approximately 30 years for the retrospective reinsurance portion of the gain.

Terminated Acquisition of Humana and Terminated Divestiture to Molina

On July 2, 2015, we entered into a definitive agreement (the "Humana Merger Agreement") to acquire Humana Inc. ("Humana"). On July 21, 2016, the U.S. Department of Justice (the "DOJ") and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that our acquisition of Humana (the "Humana Transaction") would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Transaction.

On February 14, 2017, Aetna and Humana entered into a mutual termination agreement (the "Termination Agreement") pursuant to which the parties thereto (collectively, the "Parties") agreed to terminate the Humana Merger Agreement, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby, entered pursuant thereto or entered in connection therewith (other than certain confidentiality agreements) (collectively with the Humana Merger Agreement, the "Transaction Documents"), effective immediately as of February 14, 2017 (the "Termination Date"). Under the Termination Agreement, Aetna agreed to pay Humana the Regulatory Termination Fee (as defined in the Humana Merger Agreement) of $1.0 billion in cash in full satisfaction of any amounts required to be paid by Aetna under the Humana Merger Agreement. The Parties also agreed to release each other from any and all liability, claims, rights, actions, causes of action, suits, liens, obligations, accounts, debts, demands, agreements, promises, liabilities, controversies, costs, charges, damages, expenses and fees, however arising, in connection with, arising out of or related to the Transaction Documents, the transactions contemplated therein or thereby or certain related matters. We paid Humana the Regulatory Termination Fee on February 16, 2017 and recorded the expense in general and administrative expenses. We funded that payment with the proceeds of the 2016 senior notes (as defined below).

In June 2016, we issued $13.0 billion of senior notes to partially fund the Humana Transaction (collectively, the "2016 senior notes"). In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for $10.2 billion aggregate principal amount of certain of the 2016 senior notes (collectively, the "Special Mandatory Redemption Notes") at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We redeemed the Special Mandatory Redemption Notes on March 16, 2017, and we funded the redemption with the proceeds of the 2016 senior notes. As a result of the redemption of the Special Mandatory Redemption Notes, we recognized on a pretax basis in our net income during the year ended December 31, 2017 a loss on early extinguishment of long-term debt of $192 million and a realized capital loss for the remaining unamortized effective portion of the related hedge loss of $323 million that was previously recorded in accumulated other comprehensive income.

In order to address the DOJ's perceived competitive concerns regarding Medicare Advantage relating to the Humana Transaction, on August 2, 2016, we entered into a definitive agreement (the "Aetna APA") to sell for cash to Molina Healthcare, Inc. ("Molina") certain of our Medicare Advantage assets. On February 14, 2017, Aetna and Molina entered into a Termination Agreement (the "APA Termination Agreement") pursuant to which Aetna terminated the Aetna APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, Aetna agreed to pay Molina in cash (a) a termination fee of $53 million and (b) approximately 70% of Molina's transaction costs. We paid Molina the termination fee on February 16, 2017 and the applicable transaction costs of $7 million on February 27, 2017 and recorded the expense in general and administrative expenses. The payments were funded with the proceeds of the 2016 senior notes.

Heath Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") has made broad-based changes to the U.S. health care system. We anticipate continued efforts in 2018 and beyond to modify, repeal or replace the ACA, and the future of the ACA is uncertain. We expect aspects of the ACA and/or their implementation or enforcement, including the January 2018 suspension of the ACA's industry-wide health insurer fee (the "HIF") for 2019, and uncertainty about the future of the ACA to continue to significantly impact our business operations and operating results, including our pricing and our medical benefit ratios ("MBRs").

The ACA has presented us with business opportunities, but also with significant financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, and the ACA's temporary Reinsurance and Risk Corridor programs expired at the end of 2016. The effects of existing provisions of the ACA are reflected in our operating results. If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2022.

It may be particularly challenging for us to include all of our portion of the industry-wide $14.3 billion 2018 HIF in our premium rates beginning with 2017 medical customer renewals that have member months in 2018 because of the temporary suspension of the HIF for 2017 or in our premium rates for other years following a year for which the HIF is suspended.

In October 2017, the federal government announced that the Centers for Medicare & Medicaid Services ("CMS") will curtail payments related to the Cost-Sharing Subsidy program. While the details regarding implementation of this new policy are not yet finalized, and it is the subject of pending litigation, we do not anticipate a material impact to our financial statements as a result of this action.

The federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system. We cannot predict whether pending or future federal or state legislative or regulatory activity or court

proceedings, including Federal budget negotiations and future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or the ACA or the implementation and/or enforcement of the ACA or the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

For additional information on federal and state health care reform, including the ACA, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K. For a discussion of certain factors that may cause our actual results to differ from currently anticipated results in connection with health care reform, see "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K.

Reportable Segments
Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. We derive our revenues primarily from insurance premiums, administrative service fees, net investment income and other revenue. Refer to MD&A included in Part II, Item 7 and Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our business segments, including revenue and profit information for each of our business segments and revenue and asset information about geographic areas. The following is a description of each of our business segments.

Health Care Segment
Products and Services
We refer to insurance products (where we assume all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care products and services consist of the following:

- ***Commercial Medical:*** We offer point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Our Commercial medical products also include health savings accounts ("HSAs") and Aetna HealthFund®, consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Our principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. We no longer sell individual Commercial products, and we exited the individual Public Exchanges in 2018.
- ***Government Medical:*** In select geographies, we offer Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participate in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participate in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government products are further described below:
    - *Medicare:* Through annual contracts with CMS, we offer HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over Original Medicare fee-for-service coverage, including reduced cost-sharing for preventive care, vision and other services. We offered network-based HMO and/or PPO plans in 1,213 counties in 40 states and Washington, D.C. in 2017. We are expanding to 1,317 counties in 40 states and Washington, D.C. in 2018. We are a national provider of the Medicare Part D Prescription Drug Program ("PDP") in all 50 states and Washington, D.C. to both individuals and employer groups. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. For certain qualifying employer groups, we offer our Medicare PPO products nationally. When combined with our PDP product, these national PPO plans form an integrated national fully-insured Medicare product for employers that provides medical and pharmacy benefits.
    - *Medicare Supplement:* For certain Medicare eligible members, we offer supplemental coverage for certain health care costs not covered by Original Medicare. The products included in our Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. We offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2017.
    - *Medicaid and CHIP*: We offer health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. We offered these services on an Insured or ASC basis in 16 states in 2017.
    - *Duals:* We provide health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this

coverage. We coordinate 100% of the care for these members and may provide them with additional services in order to manage their health care costs. During 2017, we offered services on an Insured basis to members who were dually eligible in four states under demonstration projects.

- ***Dental:*** We offer managed dental plans on an Insured and ASC basis. We are one of the nation's largest providers of dental coverage, based on membership at December 31, 2017.
- ***Behavioral Health:*** Our behavioral health and employee assistance products provide members who experience stress, depression and other types of mental health related illness with integrated behavioral health benefit administration, access to a network of providers and innovative wellness programs. We provide customized behavioral health solutions to members in all 50 states.
- ***Stop Loss:*** We offer medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under this product, we assume risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.
- ***Provider Network Access ("First Health" and "Cofinity"):*** Through our First Health and Cofinity products, we provide access to health care provider networks to other insurance companies, third-party administrators, health plans and employers. First Health products are marketed nationally, while Cofinity products are marketed in certain states.
- ***Aetna Vision℠ Preferred:*** We offer vision benefits that provide members with access to one of the largest vision networks in the U.S. The Aetna Vision Preferred program can be customized with a wide range of benefit levels and co-payments.
- ***Workers' Compensation Administrative Services:*** Our workers' compensation administrative services products and services consist of fee-based, managed care services, such as provider network access, cost containment services, pharmacy benefit management, durable medical equipment and ancillary services, and care management services to underwriters and administrators of workers' compensation insurance.
- ***Consumer Health and Services:*** We have a portfolio of products and services aimed at creating an holistic and integrated approach to individual health and wellness. These products and services complement our Commercial, Medicare and Medicaid products and enable enhanced service delivery to and experience for our customers:
    - *Pharmacy:* We offer pharmacy benefit management services and specialty and home delivery pharmacy services. Our pharmacy fulfillment services are provided to our Commercial and Medicare members through Aetna Specialty Pharmacy ("ASP") and Aetna Rx Home Delivery®. ASP dispenses specialty medications and offers certain support services associated with specialty medications. Specialty medications include injectable or infused medications that may not be readily available at local pharmacies. Aetna Rx Home Delivery® provides home delivery prescription drug services. We also perform various pharmacy benefit management services for Aetna pharmacy customers consisting of: product development, Commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs. CaremarkPCS Health, L.L.C. (a wholly-owned subsidiary of CVS Health) performs the administration of selected functions for our retail pharmacy network contracting and claims administration; home delivery and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services. Other suppliers also provide certain pharmacy benefit management services.
    - *Advanced Provider Models ("APM"):* We are focused on growing membership in our medical products through provider collaborations that are designed to lower medical costs for us and our customers and make our products more affordable. These collaboration models include joint ventures and accountable care organizations ("ACOs"). We offer a suite of solutions designed to facilitate delivery system reform and help reduce the cost of care by enabling population health management for providers. Our APM products facilitate providers changing their business model from episodic acute care to patient population management which allows them to convert from volume-based reimbursement to value-based reimbursement. Our APM products deploy Aetna's population health management assets to collaborate with providers in new ways to improve the quality and efficiency of care for all patients, whether they are Aetna members or members of other payors. In 2017, we continued expanding our offering of APM products and services to employers and individuals in more geographic areas to create mutually beneficial relationships with providers through a variety of methods, including alignment of financial incentives based on cost and quality, implementation of innovative HIT and deploying leading care management programs. Our APM relationships include joint ventures with Allina Health, Banner Health Network, Inova Health System, Sutter Health, and Texas Health Resources.

- *ActiveHealth Management:* Through the use of our patented CareEngine® system, our ActiveHealth Management products provide evidence-based medical management and data analytics products and services to a broad range of customers, including health plans, employers and others. ActiveHealth Management also is a key component of our APM solutions.
- *Consumer:* We believe the role of the consumer in health care is changing and that consumers will become the primary decision makers when it comes to choosing their health-related benefits. As a result, we are developing a portfolio of products and tools, including bswift and PayFlex, that are designed for a retail model in the health benefits industry that is consumer-centric, affordable and convenient. Our Consumer business is focusing on developing a simplified, integrated offering to help consumers navigate the health care system and manage their health care costs.
    - *bswift:* bswift provides benefit administration technology and services to employers nationwide, streamlining the benefits process. bswift's technology also provides the shopping, buying and enrolling experience for public health insurance exchanges ("Public Exchanges"), private health insurance exchanges ("Private Exchanges" and together with Public Exchanges "Insurance Exchanges") and individuals.
    - *PayFlex:* PayFlex provides services to employers, their employees, and their former employees in the areas of tax-advantaged account reimbursement administration (flexible spending, health reimbursement, health savings, transit and parking), Consolidated Omnibus Budget Reconciliation Act ("COBRA") administration and special-member billing administration.

Provider Networks

We contract with physicians, hospitals and other health care providers for services they provide to our members. The health care providers who participate in our networks are independent contractors and are neither our employees nor our agents, except for providers who work in our home delivery and specialty pharmacy facilities.

We use a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with health care providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with our providers, the development and implementation of guidelines for the appropriate utilization of medical services and the provision of data to providers to enable them to improve health care quality.

At December 31, 2017, Aetna's underlying nationwide provider network had approximately 1.2 million participating health care providers, including over 683,000 primary care and specialist physicians and approximately 5,700 hospitals.

- ***Advanced Provider Models:*** We collaborate with hospitals and other providers through our APM products. Our arrangements focus on high value narrow network solutions to provide high-quality, low-cost options in local geographies. We are able to help enhance our relationships with hospitals and other providers through a variety of methods, including a re-alignment of financial incentives for providing high quality care, total cost management initiatives and risk sharing arrangements.
- ***Primary Care Physicians:*** We compensate primary care physicians ("PCPs") participating in our networks on both a fee-for-service and capitated basis, with capitation generally limited to HMO products in certain geographic areas and representing approximately 3 percent of health care costs in 2017 and 4 percent in both 2016 and 2015. In a fee-for-service arrangement, physicians are paid for health care services provided to the member based upon a set fee for the services provided. Under a capitation arrangement, physicians receive a monthly fixed fee for each member, regardless of the volume of health care services provided to the member. In some cases, PCPs who are paid on a fee-for-service or capitated basis also receive additional incentive fees if certain performance metrics are attained.
- ***Specialist Physicians:*** Specialist physicians participating in our networks are generally reimbursed at contracted rates per visit or per procedure.
- ***Hospitals:*** We typically enter into contracts with hospitals that provide for per-day and/or per-case rates, often with fixed rates for ambulatory, surgery and emergency room services. We also have hospital contracts that provide for reimbursement based on a percentage of the charges billed by the hospital. Our medical plans generally require notification of elective hospital admissions, and we monitor the length of hospital stays. Physicians who participate in our networks generally admit their patients in network-based products to participating hospitals using referral procedures that direct the hospital to contact our patient management unit in order to confirm the patient's membership status and facilitate the patient management process. This unit also assists members and providers with related

activities, including, if necessary, the subsequent transition to the home environment and home care. Case management assistance for complex cases is provided by a special unit.

- ***Other Providers:*** Laboratory, imaging, urgent care and other freestanding health facility providers are generally paid under fee-for-service arrangements, except for certain laboratory services.

Quality Assessment

CMS uses a 5-star rating system to monitor plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. Refer to "Pricing" below in this Item 1 for further discussion of our star ratings.

We seek Health Plan accreditation for our Aetna HMO plans from the National Committee for Quality Assurance (the "NCQA"), a national organization established to review the quality and medical management systems of health care plans. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of Aetna, has received nationwide NCQA PPO Health Plan accreditation, through December 13, 2019. As of December 31, 2017, all of our Aetna Health Inc. Commercial HMO and ALIC PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

NCQA and URAC (formally known as American Accreditation HealthCare Commission, Inc.), are national organizations founded to establish standards for the health care industry. Purchasers and consumers look to NCQA's and URAC's accreditation and certification as an indication that a health care organization has the necessary structures and processes to promote high-quality care and preserve patient rights. In addition, regulators in over 80% of the states recognize NCQA's accreditation and certification standards.

Our provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, we are certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options through January 5, 2019. Our URAC CVO accreditation is valid through October 1, 2018.

Our quality assessment programs for contracted providers who participate in our networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by us or in some cases by the practitioner's affiliated group or organization. We generally require participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

We also offer quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Principal Markets and Sales

Our medical membership is dispersed throughout the United States, and we serve a limited number of members in certain countries outside the United States. Refer to Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our foreign customers. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, we market to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by United States and other geographic region and funding arrangement at December 31, 2017, 2016 and 2015:

	2017			2016			2015		
(Thousands)	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Northeast	**1,994**	**3,367**	**5,361**	2,121	2,966	5,087	2,166	2,952	5,118
Southeast	**1,828**	**2,942**	**4,770**	2,260	3,076	5,336	2,173	3,183	5,356
Mid-America	**1,919**	**2,746**	**4,665**	2,506	2,673	5,179	2,507	2,913	5,420
West	**1,712**	**4,887**	**6,599**	1,954	4,848	6,802	1,837	5,008	6,845
Other	**580**	**262**	**842**	331	375	706	440	308	748
Total medical membership	**8,033**	**14,204**	**22,237**	9,172	13,938	23,110	9,123	14,364	23,487

Additional information on Health Care's membership is included in the "Healthcare - Membership" section of the MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

We market both Commercial Insured and ASC products and services primarily to employers that sponsor our products (also called "plan sponsors") for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. We also sold Commercial Insured plans directly to individual consumers in a number of states, including through Public Exchanges. We no longer sell individual Commercial products, and we exited the individual Public Exchanges in 2018. Some Health Care products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly.

We offer Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. We also offer Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care products are sold through our sales personnel; through independent brokers, agents and consultants who assist in the production and servicing of business; and Private Exchanges. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, we may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. In certain cases, our customer pays the broker for services rendered, and we may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. We support our marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under our ASC plans are generally fixed for a period of one year.

We use prospective rating methodologies in determining the premium rates charged to the majority of employer groups, and we also use retrospective rating methodologies for a limited number of groups. Premium rates for customers with more than approximately 125 employees generally take into consideration the individual plan sponsor's historical and anticipated claim experience where permitted by law. Some states may prohibit the use of one or more of these rating methods for some customers, such as small employer groups, or all customers.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We typically cannot recover unanticipated increases in health care costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Our future operating results could be adversely affected if the premium rates we request are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the actual claim costs and other expenses are less than expected, we may issue a refund to the plan sponsor based on this favorable experience. If the experience is unfavorable, in certain instances we may recover the resulting deficit through contractual provisions or consider the deficit in setting future premium levels. However, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating may be used for Commercial Insured plans that cover more than approximately 300 lives.

We have Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays us a fixed capitation payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. Our PDP contracts also provide a risk-sharing arrangement with CMS to limit our exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to us under the Medicare arrangements are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Premiums paid to us for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some of our Medicare Advantage products and all of our PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial products, Medicare contracts generate higher per member per month revenues and health care costs.

The ACA ties a portion of each Medicare Advantage plan’s reimbursement to the plan’s “star ratings.” Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released our 2018 star ratings in October 2017. Our 2018 star ratings will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2019. Based on our membership at December 31, 2017, 87% of our Medicare Advantage members were in plans with 2018 star ratings of at least 4.0 stars, compared to 92% of our Medicare Advantage members being in plans with 2017 star ratings of at least 4.0 stars based on our membership at December 31, 2016.

Rates for our Medicare Supplement products are regulated at the state level and vary by state and plan.

Under our Insured Medicaid contracts, state government agencies pay us fixed monthly rates per member that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. We also receive fees from our customers where we provide services under ASC Medicaid contracts. Our ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and our financial risk share obligations are typically limited to a percentage of the fees otherwise payable to us. Payments to us under our Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under our Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if we fail to comply with CMS regulations or other contractual requirements.

We offer HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes. In December 2015, the Consolidated Appropriation Act was enacted, which included a one year suspension of the HIF for 2017. In January 2018, the HIF was suspended for 2019. Refer to Note 2 “Summary of Significant Accounting Policies” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the ACA fees, assessments and taxes. Our goal is to collect in premiums and fees or solve for all of these estimated fees, assessments and taxes.

Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that

are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Public and Private Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated herein by reference, are for illustrative or comparison purposes only and do not indicate that these companies are our only competitors or are our closest competitors.

We believe that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. We believe that we are competitive on each of these factors. Our ability to increase the number of persons covered by our plans or to increase our revenues is affected by our ability to differentiate ourselves from our competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Our Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. Our largest competitor in our Medicare products is Original Medicare. Additional competitors include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. Our ability to increase the number of persons enrolled in our Insured products also is affected by the desire and ability of employers to self-fund their health coverage.

Our ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and third-party administrators.

Our international products compete with local, global and U.S. based health plans and commercial health care benefit insurance companies, many of whom have a longer operating history and better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and provider solutions and HIT products are evolving rapidly. We compete for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many of our information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting our ability to obtain new customers or retain existing customers, our membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the U.S. and industries where our membership is concentrated.

Reinsurance

We currently have several reinsurance agreements with non-affiliated insurers that relate to Health Care insurance policies. We entered into these contracts to reduce the risk of catastrophic losses which in turn reduces our capital and surplus requirements. We frequently evaluate reinsurance opportunities and refine our reinsurance and risk management strategies on a regular basis.

Group Insurance Segment
On November 1, 2017, we completed the sale of a substantial portion of our Group Insurance segment consisting of our domestic group life insurance, group disability insurance and absence management businesses to HLAIC for cash consideration of $1.45 billion. The transaction was accomplished through an indemnity reinsurance arrangement under which HLAIC contractually assumed certain of our policyholder liabilities and obligations, although we remain directly obligated to policyholders. Assets related to and supporting the reinsured life and disability insurance policies were transferred to a trust established by HLAIC for our benefit, and we recorded a reinsurance receivable from HLAIC.

Refer to Note 3 "Acquisition, Divestiture, Terminated Acquisition and Terminated Divestiture" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

Principal Products
Group Insurance products consist primarily of the following:

- ***Life Insurance:*** Our life insurance products principally consist of group term life insurance, the amounts of which may be fixed or linked to individual employee wage levels. We also offer voluntary spouse and dependent term life insurance, and group universal life and accidental death and dismemberment insurance. We offer life insurance products on an Insured basis.
- ***Disability Insurance:*** Our Disability products provide employee income replacement benefits for both short-term and long-term disability (and products which combine both). Similar to Health Care products, we offer disability benefits on both an Insured and employer-funded basis. We also provide absence management services to employers, including short-term and long-term disability administration and leave management.
- ***Long-Term Care Insurance:*** Our Long-Term Care Insurance products provide benefits to cover the cost of care in private home settings, adult day care, assisted living or nursing facilities. We no longer solicit or accept new long-term care customers. Long-term care benefits were offered primarily on an Insured basis. The product was available on both a service reimbursement and disability basis.

Principal Markets and Sales
We offer our Group Insurance products in 49 states as well as Washington, D.C., Guam, Puerto Rico, the U.S. Virgin Islands and Canada. Depending on the product, we market to a range of customers from small employer groups to large, multi-site and/or multi-state employer programs.

We market Group Insurance products and services primarily to employers that sponsor our products for the benefit of their employees and their employees' dependents. Frequently, employers offer employees a choice of benefits, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Group Insurance products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly.

Group Insurance products are sold through our sales personnel, as well as through independent brokers, agents and consultants who assist in the production and servicing of business. For large plan sponsors, independent consultants and brokers are frequently involved in employer plan selection decisions and sales. We pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. We support our marketing and sales efforts with an advertising program that may include direct marketing efforts as well as television, radio, billboards, print media and social media, supplemented by market research.

Pricing
For Insured and employer-funded Group Insurance plans, employer group contracts containing the pricing and other terms of the relationship are generally established in advance of the policy or contract period. We use prospective and retrospective rating methodologies to determine the premium rates charged to employer groups on our Insured products. Contracts are typically offered with rate guarantees that generally range from one to five years.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We typically cannot recover unanticipated increases in mortality or morbidity costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the actual claim costs and other expenses are less than expected, we may issue a refund to the plan sponsor based on this favorable experience. If the experience is unfavorable, we consider the deficit in setting future premium levels, and in certain instances, we may recover the deficit through contractual provisions such as offsets against refund credits that develop for future policy periods. However, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating is most often used for Insured plans that cover more than approximately 3,000 lives.

Competition

For the group insurance industry, we believe that the significant factors that distinguish competing companies are cost, quality of service, financial strength of the insurer, comprehensiveness of coverage, and product array and design. We believe we are reasonably competitive on each of these factors; however, some of our competitors have greater scale, financial and other resources, better brand recognition and lower expenses. The group life and group disability marketplaces remain highly competitive.

Reinsurance

We currently have several reinsurance agreements with non-affiliated insurers that relate to both life and long-term disability products, including our domestic group life insurance and group disability insurance businesses sold to HLAIC. Certain of our reinsurance arrangements are established on a case-by-case basis, and a subset of our reinsurance agreements cover closed blocks of business and canceled cases. We also have a reinsurance arrangement to mitigate long-term disability claim severity risk at the individual claim level, and another reinsurance arrangement that provides a limited degree of catastrophic risk protection for certain of our life products.

Large Case Pensions Segment

Principal Products

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. We do not actively market Large Case Pensions products, but continue to accept deposits from existing customers and manage the run-off of our existing business. Contracts provide non-guaranteed, experience-rated and guaranteed investment options through general and separate account products. Large Case Pensions products that use separate accounts provide contract holders with a vehicle for investments under which the contract holders primarily assume the investment risk. Large Case Pensions earns a management fee on these separate accounts.

In 1993, we discontinued our fully-guaranteed Large Case Pensions products. Refer to Note 19 “Discontinued Products” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

Other Matters

Access to Reports and Other Information

Our reports to the U.S. Securities and Exchange Commission (the “SEC”), including our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and any amendments to those reports, are available without charge on our website at www.aetna.com as soon as practicable after they are electronically filed with or furnished to the SEC. The information on or linked to our website is neither a part of nor incorporated by reference in this Annual Report on Form 10-K or any of our other SEC filings. Copies of these reports are also available, without charge, from Aetna's Investor Relations Department, 151 Farmington Avenue, Hartford, CT 06156.

You also can download from our website our articles of incorporation, by-laws and corporate governance policies, including our Corporate Governance Guidelines, the charters of the key standing Committees of our Board of Directors and our Code of Conduct. Copies of these documents are also available, without charge, from Aetna’s Corporate Secretary, 151 Farmington Avenue, RW61, Hartford, CT 06156.

Our transfer agent, Computershare Trust Company, N.A., can help with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person or other administrative services. Shareholders can write to our transfer agent by mail at P.O. Box 505000, Louisville, KY 40233, or contact them by telephone at 1-800-446-2617.

Regulation

For information regarding significant regulation that affects us, refer to “Regulatory Environment” of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K and for a discussion of certain factors that may cause our actual results to differ from currently anticipated results in connection with regulation that affects us, see “Risk Factors” included in Part I, Item 1A of this Annual Report on Form 10-K.

Patents and Trademarks
We own a number of trademarks and patents that are important to Aetna. Some of the trademarks include Aetna, as well as the corresponding Aetna design logo, Aetna Navigator®, ActiveHealth®, bswift®, CareEngine®, Coventry®, DocFind®, Healthy Merits®, iTriage®, Meritain Health®, NeoCare Solutions®, PayFlex®, Springboard Marketplace®, Wellmatch®, You Don't Join Us, We Join You®, Resources for Living®, Aetna vHealthSM and Building a Healthier World®. Some of our patents include the CareEngine patent that expires in 2021 and the Master Patient Index patent that expires in 2029. We consider these patents and trademarks and our other patents, trademarks and trade names important in the operation of our business. However, our business, including that of each of our individual segments, is not dependent on any individual patent, trademark or trade name.

Employees
We had approximately 47,950 employees at December 31, 2017.

Customer Concentration
The U.S. federal government is a significant customer of both the Health Care segment and the Company as described below:

- Premiums and fees and other revenue paid by the federal government accounted for 36% of the Health Care segment's revenue and 34% of our consolidated total revenue in 2017.

- Contracts with CMS for coverage of Medicare-eligible individuals accounted for 87% of our federal government premiums and fees and other revenue, with the balance coming from federal employee-related benefit programs and ACA programs. No other individual customer, in any of our segments, accounted for 10% or more of our consolidated total revenue in 2017.

- Our Medicaid products accounted for 14% of our Health Care segment's revenue and 13% of our consolidated total revenue in 2017. However, no individual state government agency accounted for more than 10% of our consolidated total revenue or the Health Care segment's revenue in 2017.

Other than our contracts with CMS, our segments are not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of a segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on our earnings or the earnings of any of our segments. Refer to Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

Item 1A. Risk Factors

Risk Factors
You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this Annual Report on Form 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this Annual Report on Form 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect our business. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, these events or circumstances could have a material adverse effect on our business, cash flows, financial position or operating results. In that case, our stock price could decline materially, among other effects on us.

Effectiveness of our enterprise strategy, talent management and alignment of talent to our business needs and risks to our brand and reputation present overarching risks to our enterprise in 2018.

We expect to face significant business challenges and uncertainties in 2018. Effectiveness of our enterprise strategy, talent management and alignment of talent to our business needs and risks to our brand and reputation present overarching risks to our enterprise in 2018. There can be no assurance regarding the effectiveness of our enterprise strategy, our ability to manage and align our talent to our business needs or our ability to avoid harm to our brand and reputation. In addition, there can be no assurance that the CVS Health Transaction, U.S. government fiscal policy, repeal or other changes to the ACA or additional

changes to the U.S. health care system will not require us to revise the ways in which we conduct business, put us at risk of loss of business or materially adversely affect our business, cash flows, financial position or operating results.

While we consider the foregoing to be the overarching risks we face in 2018, they are not the only material risks we face. We face numerous other challenges, as described elsewhere in this Annual Report, including below in this "Risk Factors" discussion, and other unanticipated risks may develop.

Our enterprise strategy may not be an effective response to the changing dynamics in the health and related benefits industry, or we may not be able to implement our strategy and related strategic projects.

Our strategy includes effectively investing our capital and human resources in appropriate strategic projects, current operations and acquisitions to transform our business in response to the changing dynamics in the health and related benefits industry, including the evolution toward a direct-to-consumer marketing and operating model, the declining number of commercially insured people and the potential shift to a defined contribution model for health benefits. Our strategic projects include, among other things: significant investments in human and technology resources to expand our Consumer Health and Services product line, including to develop and expand our consumer business, and compete effectively in a direct-to-consumer marketplace; transforming our business model through consumer engagement, joint ventures, ACOs and collaborative provider networks; optimizing our business platforms; managing certain significant technology projects; further improving relations with health care providers; negotiating contract changes with customers and providers; implementing other business process improvements; and participating in Private Exchanges and select small group Public Exchanges (collectively, "Insurance Exchanges"). Implementing our strategic initiatives will require significant investments of capital and human resources. Among other things, we will need to simultaneously acquire and develop new personnel, products and systems to serve existing and new customers with existing and new products, to expand our Consumer Health and Services product line, and to enhance our existing customer service, information technology, control and compliance processes and systems. The future performance of our businesses will depend in large part on our ability to design and implement our strategic initiatives, some of which will occur over several years. If these initiatives do not achieve their objectives, our operating results could be adversely affected.

Our enterprise strategy may not be an effective response to the changing dynamics in the health and related benefits industry, and we may fail to recognize and position ourselves to capitalize upon market opportunities. We may not have sufficient advance notice and resources to develop and effectively implement an alternative strategy. Competitors who develop a superior strategy, or more effectively implement their strategy, may develop capabilities, competitive advantages and competitive positions that are difficult to match or overcome.

We are dependent on our ability to recruit, retain and develop a very large and diverse workforce. We must transform our culture in order to successfully grow our business.

Our products and services and our operations require a large number of employees. Our success is dependent on our ability to transform our culture, align our talent with our business needs, engage our employees and inspire our employees to be open to change, to innovate and to maintain consumer-focus when delivering services to our customers. Our business would be adversely affected if we fail to adequately plan for succession of our executives and senior management; or if we fail to effectively recruit, integrate, retain and develop key talent and/or align our talent with our business needs, in light of the current rapidly changing environment. While we have succession plans in place and we have employment arrangements with a limited number of key executives, these do not guarantee that the services of these or suitable successor executives will continue to be available to us. In addition, as we expand internationally, we face the challenge of recruiting, integrating, educating, managing, retaining and developing a more culturally diverse workforce.

Our brand and reputation are two of our most important assets; negative public perception of the health and related benefits industry, or of the industry's or our practices, can adversely affect our operating results.

The health and related benefits industry regularly is negatively perceived by the public and subject to negative publicity, including as a result of litigation against us and other industry participants, adverse media coverage, the ongoing public debate over the future of the ACA, proposed transactions in our industry (including the CVS Health Transaction and related litigation), governmental hearings and/or investigations and actual or perceived shortfalls regarding the industry's or our own products and/or business practices (including insurance coverage determinations, withdrawing from participation in Public Exchanges and social media and other media relations activities). This risk may be increased as the federal government continues to consider alternatives to amend, repeal and/or replace the ACA (including Medicaid expansion) and as states seek to maintain, replace or repeal elements of the ACA such as Public Exchanges and Medicaid expansion within increasingly challenging budget constraints. This risk will increase further if we implement significant increases in premium rates to price for additional risk and/or expanded benefits resulting from, and fees, assessments and taxes imposed by, the federal and state governments as

well as any acceleration in medical cost inflation. This risk also may be increased as states and the federal government continue to debate the ACA and implement any amendment, repeal or replacement of the ACA, as we continue to offer products that make greater use of data and products for people who are eligible for Medicare or Medicaid or dually eligible for Medicare and Medicaid and other products that are beyond those in our core Commercial business and as our business model becomes more focused on consumers and direct-to-consumer sales, including as a result of us developing and expanding our Consumer Health and Services product line, competing for sales on select Insurance Exchanges and withdrawing from participation on individual Public Exchanges. Significant reductions or interruptions in funding for government health programs we serve also may lead us to reduce our exposure to these programs, which could adversely affect our brand and reputation.

Negative public perception and/or publicity of the health and related benefits industry in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our operating results and our stock price by:

- Adversely affecting our brand and reputation;
- Adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- Requiring us to change our products and/or services; and/or
- Increasing or significantly changing the regulatory and legislative requirements with which we must comply.

Risks Relating to Our Proposed Acquisition by CVS Health

CVS Health's acquisition of Aetna is subject to various closing conditions, including governmental, regulatory and shareholder and stockholder approvals as well as other uncertainties, and there can be no assurances as to whether and when it may be completed.

On December 3, 2017, we entered into an Agreement and Plan of Merger (which we refer to as the "CVS Merger Agreement"), with CVS Health Corporation (or "CVS Health") and Hudson Merger Sub Corp. (or "Merger Sub"), a wholly owned subsidiary of CVS Health. Under the terms and subject to the conditions set forth in the CVS Merger Agreement, Merger Sub will merge with and into Aetna (the "Merger"). In the Merger, each of our outstanding common shares will be converted into the right to receive (i) $145 in cash without interest and (ii) 0.8378 shares of CVS Health common stock, subject to any required withholding taxes. On February 1, 2018, Aetna and CVS Health each received a request for additional information (also known as a "second request") from the U.S. Department of Justice (the "DOJ") in connection with the DOJ's review of the transactions contemplated by the CVS Merger Agreement. The Merger is expected to close in the second half of 2018.

Completion of the Merger is subject to customary closing conditions, a number of which are not within our or CVS Health's control, and it is possible that such conditions may prevent, delay or otherwise materially adversely affect the completion of the Merger. These conditions include, among other things, (i) approval and adoption of the CVS Merger Agreement by the holders of a majority of our outstanding common shares, (ii) approval of the issuance of CVS Health common stock in the Merger by a majority of votes cast by CVS Health stockholders, (iii) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of our subsidiaries, (iv) the absence of legal restraints and prohibitions on the completion of the Merger, (v) the effectiveness of the registration statement in respect of the CVS Health common stock to be issued in the Merger, (vi) listing of the CVS Health common stock to be issued in the Merger on the New York Stock Exchange, (vii) subject to the relevant standards set forth in the CVS Merger Agreement, the accuracy of the representations and warranties made by each party, (viii) material compliance by each party with its covenants in the CVS Merger Agreement, and (ix) no "Company Material Adverse Effect" with respect to us and no "Parent Material Adverse Effect" with respect to CVS Health, in each case since the execution of and as defined in the CVS Merger Agreement. In addition, CVS Health's obligation to complete the Merger is subject to the condition that the required regulatory approvals do not impose any condition that, individually or in the aggregate, would reasonably be expected to have a "Regulatory Material Adverse Effect" (as such term is defined in the CVS Merger Agreement). We cannot predict with certainty whether and when any of the required closing conditions will be satisfied or if another uncertainty may arise.

Negative public perception and/or publicity of the health and related benefits industry in general, or us or CVS Health or one of our respective key vendors, brokers or product distribution networks in particular, may delay and/or make it more difficult to obtain the required regulatory approvals and clearances necessary to complete the Merger. If the Merger does not receive, or timely receive, the required regulatory approvals and clearances, or if any regulatory agencies impose certain conditions relating to the required regulatory approvals that would reasonably be expected to have a "Regulatory Material Adverse Effect", or if an event occurs that delays or prevents the Merger, such failure or delay to complete the Merger may cause uncertainty or

other negative consequences that may materially and adversely affect our operating results, financial position and/or cash flows and/or our stock price.

The CVS Merger Agreement limits our ability to pursue alternative transactions to the pending Merger.

The CVS Merger Agreement restricts us from initiating, soliciting, knowingly encouraging, knowingly facilitating or entering into discussions or negotiations with any third party regarding alternative acquisition proposals. This restriction limits our ability to affirmatively seek offers from other possible acquirers that may be superior to the pending Merger, although we are permitted, subject to compliance with certain procedures specified in the CVS Merger Agreement, to respond to certain unsolicited proposals from third parties to allow our Board of Directors to comply with its fiduciary duties. If we receive an unsolicited proposal from a third party that our Board of Directors determines is a superior proposal (as defined in the CVS Merger Agreement), our Board of Directors may withdraw or otherwise change its recommendation of the Merger. If our Board of Directors withdraws or otherwise changes its recommendation of the Merger, or if we materially breach our obligation not to solicit alternative acquisition proposals, CVS Health may terminate the CVS Merger Agreement and we would be contractually obligated to pay a termination fee of $2.1 billion to CVS Health. This termination fee may make it less likely that a third party will make an alternative acquisition proposal for us.

The number of shares of CVS Health common stock that our shareholders will receive in the Merger is based on a fixed exchange ratio. Because the market price of CVS Health's common stock has fluctuated and will continue to fluctuate, our shareholders cannot be certain of the value of the portion of the merger consideration to be paid in CVS Health common stock.

Upon completion of the Merger, each of our outstanding common shares will be converted into the right to receive (i) $145 in cash without interest and (ii) 0.8378 shares of CVS Health common stock, subject to any required withholding taxes. The exchange ratio for determining the number of shares of CVS Health common stock that our shareholders will receive in the Merger is fixed and will not be adjusted for changes in the market price of CVS Health's common stock, which will likely fluctuate before and after the completion of the Merger. Fluctuations in the value of CVS Health's common stock could result from changes in the business, operations or prospects of CVS Health and/or us prior to or following the closing of the Merger, regulatory considerations, general market and economic conditions and other factors both within and beyond the control of us or CVS Health. In addition, the Merger is expected to be completed a considerable amount of time after the date of our special meeting of shareholders to consider and vote on the approval and adoption of the CVS Merger Agreement. As such, at the time of our special meeting of shareholders to consider and vote on the approval and adoption of the CVS Merger Agreement, our shareholders will not know or be able to determine the value of the CVS Health share consideration that they will receive in the Merger for each of our common shares.

While the Merger is pending, we are subject to business uncertainties and contractual restrictions that could materially adversely affect our operating results, financial position and/or cash flows or result in a loss of employees, customers, members, providers or suppliers.

The CVS Merger Agreement includes restrictions on the conduct of our business prior to the completion of the Merger or termination of the CVS Merger Agreement, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of specified limitations absent CVS Health's prior written consent. We may find that these and other contractual restrictions in the CVS Merger Agreement delay or prevent us from responding, or limit our ability to respond, effectively to competitive pressures, industry developments and future business opportunities that may arise during such period, even if our management believes they may be advisable. The pendency of the proposed Merger may also divert management's attention and our resources from ongoing business and operations.

Our employees, customers, members, providers and suppliers may experience uncertainties about the effects of the Merger. In connection with the pending Merger, it is possible that some customers, members, providers, suppliers and other parties with whom we have a business relationship may delay or defer certain business decisions or might decide to seek to terminate, change or renegotiate their relationship with us as a result of the Merger. Similarly, current and prospective employees may experience uncertainty about their future roles with us following completion of the Merger, which may materially adversely affect our ability to attract and retain key employees. If any of these effects were to occur, it could materially and adversely impact our operating results, financial position and/or cash flows and/or our stock price.

If the CVS Merger Agreement is terminated, we may, under certain circumstances, be obligated to pay a termination fee to CVS Health.

If the CVS Merger Agreement is terminated, in certain circumstances, we would be required to pay a termination fee of $2.1 billion to CVS Health. If the CVS Merger Agreement is terminated under such circumstances, the termination fee we may be required to pay under the CVS Merger Agreement may require us to use available cash that would have otherwise been available for general corporate purposes and other matters.

Failure to complete the Merger could negatively impact our stock and/or bond prices, operating results, financial position and/or cash flows.

If the Merger is not completed for any reason, our ongoing businesses may be materially and adversely affected, and we will not have realized any of the potential benefits of having completed the transaction, and we will be subject to a number of risks, including the following:

- we may experience negative reactions from the financial markets, including negative impacts on our stock and bond prices, and from our customers, vendors, regulators and employees;
- matters relating to the pending Merger (including integration planning) may require substantial commitments of time and resources by our management, which could otherwise have been devoted to other opportunities that may have been beneficial to us;
- the CVS Merger Agreement includes restrictions on the conduct of our business prior to the completion of the Merger or termination of the CVS Merger Agreement, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of specified limitations absent CVS Health's prior written consent. We may find that these and other contractual restrictions in the CVS Merger Agreement delay or prevent us from responding, or limit our ability to respond, effectively to competitive pressures, industry developments and future business opportunities that may arise during such period, even if our management believes they may be advisable. The pendency of the proposed Merger may also divert management's attention and our resources from ongoing business and operations;
- we may be required to pay a $2.1 billion termination fee to CVS Health and would have incurred expenses relating to the Merger;
- we also could be subject to litigation related to our failure to complete the Merger or to perform our obligations under the CVS Merger Agreement; and
- matters relating to the pending acquisition (including integration planning) will require substantial commitments of time and resources by our management, which would otherwise have been devoted to day-to-day operations and other opportunities that may have been beneficial to us as an independent company.

There can be no assurance that the risks described above will not materialize. If any of those risks materialize, they may materially and adversely affect our businesses, financial position, operating results and stock and/or bond prices.

In addition, we could be subject to litigation related to any failure to complete the proposed acquisition or related to any enforcement proceeding to specifically enforce our performance of our obligations under the CVS Merger Agreement. If the proposed acquisition is not completed, these risks may materialize and may materially and adversely affect our businesses, financial position, operating results and stock and/or bond prices.

If the Merger is not completed, these risks may materially and adversely affect our operating results, financial position and/or cash flows and/or our stock price.

Lawsuits have been filed against Aetna and our board of directors and CVS Health and its board of directors, and other lawsuits may be filed against Aetna, CVS Health and/or their respective boards of directors challenging the CVS Health Transaction. An adverse ruling in any such lawsuit may prevent the CVS Health Transaction from being completed.

As of February 22, 2018, seven complaints had been filed by purported Aetna shareholders challenging the CVS Health Transaction. The first, a putative class action complaint, was filed by Olivier Miramond in the United States District Court for the District of Connecticut and is captioned *Miramond v. Aetna, Inc., et al.* The second complaint, filed in the United States District Court for the District of Connecticut by Shiva Stein individually, is captioned *Stein v. Aetna, Inc., et al*. The third complaint, a putative class action, was filed by Robert Freedman in the United States District Court for the Eastern District of Pennsylvania and is captioned *Freedman v. Aetna, Inc., et al*. The fourth complaint, filed in the United States District Court for the District of Connecticut by Luan Pham individually, is captioned *Pham v. Aetna, Inc., et al.* The fifth complaint, filed in the United States District Court for the Eastern District of Pennsylvania by Vladimir Gusinsky Rev. Trust individually, is captioned *Vladimir Gusinsky Rev. Trust v. Aetna Inc. et al.* The sixth complaint, a putative class action complaint, was filed by Dr. Eli Inzlicht-Sprei in the United States District Court for the District of Connecticut and is captioned *Inzlicht-Sprei v. Aetna, Inc., et al.* The seventh complaint, a putative class action complaint, was filed by Joel Rosenfeld in the United States District Court for the District of Connecticut and is captioned *Rosenfeld v. Aetna, Inc. et al.* The complaints name as defendants Aetna and each member of our board of directors. In addition, the *Vladimir Gusinsky Rev. Trust* complaint names CVS Health and Merger Sub

as defendants. The complaints generally allege, among other things, that the merger consideration in the CVS Health Transaction is unfair, inadequate and undervalues Aetna; that the defendants failed to conduct a fair and reasonable sales process; that the CVS Merger Agreement's deal protection provisions improperly deter other suitors from submitting a superior offer for Aetna; that our board of directors and executive officers are conflicted because they have secured unique benefits for themselves from the CVS Health Transaction not available to Aetna shareholders generally; and that the defendants authorized the filing of a materially incomplete and misleading registration statement. Among other remedies, the complaints seek to enjoin (a) the special meeting of our shareholders with respect to the CVS Health Transaction and (b) the closing of the Merger, as well as costs and attorneys' fees. Defendants believe that the complaints are without merit.

As of February 22, 2018, one complaint has been filed by a purported CVS Health stockholder challenging the CVS Health Transaction. A putative class action complaint was filed by Ken Gawrych in Providence County, Rhode Island Superior Court. The case is captioned *Gawrych v. Merlo et al.* The complaint names as defendants CVS Health and each member of its board of directors. The complaint generally alleges, among other things, that CVS Health's acquisition of Aetna is not in the best interests of CVS Health stockholders because the consideration being paid by CVS Health is excessive, that the members of CVS Health's board of directors were motivated to enter into the transaction by their own self-interest, and that CVS Health's financial advisors were conflicted. The complaint asserts claims for breach of fiduciary duty and failure to disclose certain material information relating to the CVS Health Transaction. Among other remedies, the complaint seeks certification of a stockholder class, declaratory and injunctive relief, and unspecified monetary damages.

Additional lawsuits arising out of or relating to the CVS Merger Agreement, the Merger and/or the CVS Health Transaction may be filed in the future.

One of the conditions to completion of the Merger is the absence of any applicable law (including any order) being in effect that prohibits completion of the Merger. Accordingly, if a plaintiff is successful in obtaining an order prohibiting completion of the Merger, then such order may prevent the Merger from being completed, or from being completed within the expected timeframe.

Additional information on these risks

Additional information concerning these risks, uncertainties and assumptions can be found in the section entitled "Risk Factors" beginning on page 62 of our joint proxy statement/prospectus filed February 9, 2018 with the SEC.

Risks relating to CVS Health.

Following completion of the Merger, Aetna will also be subject to the risks described in Part I, Item 1A of CVS Health's Annual Report on Form 10-K for the year ended December 31, 2017, filed with the SEC on February 14, 2018, incorporated by reference into this Annual Report on Form 10-K.

Changes in Public Policy and Other Legal and Regulatory Risks

We are subject to potential changes in public policy (in respect of the ACA or otherwise) that can adversely affect the markets for our products and services and our business, operations and operating results.

The political environment in which we operate remains uncertain, including as a result of the current U.S. presidential administration and the control of the U.S. Congress by a single political party. It is reasonably possible that our business operations and operating results could be materially adversely affected by public policy changes at the federal or state level, which include amendment, repeal or replacement of the ACA but also extend to many other public policy initiatives. Such changes may present us with new financial and other challenges, which may, for example, cause membership in our health plans to decrease or make doing business in particular states less attractive. If we fail to adequately respond to such changes, including by implementing effective operational and strategic initiatives, or do not do so as effectively as our competitors, our business, operations and operating results may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our business. At the federal level these proposals include changes in the funding levels and/or design of federally-supported benefit programs, changes in payment methodologies for health plans and/or providers under Medicare and substantial change in the regulations governing our business. At the state level, these proposals include mandating pharmacy benefits; expanded provider network requirements; significant new fees, assessments and taxes on payors, including in response to reduced federal funding or other state budgetary

pressures; mandating lower out of pocket costs for members; and raising Medicaid minimum MLR thresholds above 85%, instituting profit caps on Medicaid contracts and changing the designs of state Medicaid programs. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including substantial changes to federal funding of state Medicaid programs. At the state level, all 50 U.S. states and the District of Columbia will hold regular legislative sessions in 2018. In 2017, state legislatures focused on state budgets and taxes (including new assessments on health care premiums), stabilizing the health insurance marketplace, provider network composition and provider directory accuracy requirements, pharmacy benefit and drug coverage requirements, Medicaid reforms, "surprise" billing of members and health care delivery system transformation. We expect state legislatures to focus on these issues again in 2018, as well as the adverse impact of actual or expected changes to the ACA and other federal programs on state citizens, programs and budgets.

We cannot predict the enactment or content of new legislation and regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or operating results, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of our industry. Examples of such change include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes is increasing due to state and federal budgetary pressures, and our business and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence. For more information on these matters, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

The ACA may be amended, repealed or replaced. If the ACA is not amended, repealed or replaced, certain aspects of the ACA as currently enacted have yet to take full effect, are unclear, or are subject to effective amendment through the implementation process, making their practical effects difficult to predict. Our business and operating results may be materially and adversely affected by the ACA and/or changes to the ACA even if we correctly predict their effects.

If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2022. Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of congressional and state level elections, pending litigation challenging aspects of the law or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Examples of recent administrative policy, legislative and regulatory changes include: the January 2018 suspension of the HIF for 2019 and delay of the "Cadillac" tax on high-cost employer sponsored health coverage until 2022; the December 2017 Tax Cuts and Jobs Act of 2017 (the "TCJA"), which repealed the ACA's individual mandate and related penalties; the January 20, 2017 and October 12, 2017 executive orders relating to the ACA; the federal government's October 2017 curtailment of payments related to the Cost-Sharing Subsidy Program; the November 2016 HHS announcement that risk corridor collections for the 2015 program year would be applied first to amounts owed to plans for the 2014 program year; and the May 2016 final regulations relating to the ACA's non-discrimination requirements.

It may be particularly challenging for us to include all of our portion of the industry-wide $14.3 billion 2018 HIF in our premium rates beginning with 2017 medical customer renewals that have member months in 2018 because of the temporary suspension of the HIF for 2017 or in our premium rates for other years following a year for which the HIF is suspended.

The pending litigation challenging the ACA includes challenges by various states of the federal government's decision to curtail payments related to the Cost-Sharing Subsidy Program. The time frame for conclusion, final outcome and ultimate impact of this litigation are uncertain.

While most of the significant aspects of the ACA became effective during or prior to 2014, as currently enacted, certain components of the ACA will continue to be phased in through 2022. In addition, parts of the ACA continue to evolve through the promulgation of executive orders, regulations and guidance. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing state and federal budgetary pressures make it more likely that any changes, including changes at the state level in response to repeal or replacement of or changes to the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us.

Accordingly, even in the absence of any amendment or repeal, many of the specific aspects and impacts of the ACA as currently enacted will not be known for several years, and given the inherent difficulty of foreseeing how individuals and businesses will respond to the choices afforded to them by the ACA, we cannot predict the full effect of the ACA or the impact of future changes to the ACA on us. Further, even if we correctly predict how parts of the ACA will develop or change and

affect us, our business and operating results may still be materially and adversely affected. For example, we anticipate that some aspects of the ACA and other existing measures and new measures, if enacted, could materially adversely affect our Health Care and/or Group Insurance operations and/or operating results by, among other things:

- Reducing our ability to obtain adequate premium rates for the risk we assume (including denial of or delays in obtaining regulatory approval for and implementation of those rates);
- Significantly reducing the level or changing the design of Medicare and/or Medicaid program payments;
- Restricting our ability to price for the risk we assume and/or reflect reasonable costs or profits in our pricing, and/or limiting the level of margin we can earn, including by mandating minimum medical loss ratios;
- Reducing our ability to manage health care or other benefit costs (including by mandating benefits, restricting our ability to manage our provider network and/or capping member cost sharing or otherwise limiting members' financial responsibility for health care or other covered services they utilize and thus increasing our medical costs);
- Increasing health care or other benefit costs and operating expenses (including duplicate expenses resulting from changes in regulations during implementation);
- Increasing our exposure to lawsuits and other adverse legal proceedings;
- Adversely affecting our product mix;
- Imposing new or increasing existing taxes and financial assessments; and/or
- Increasing the general and administrative expenses of our Group Insurance business relative to its competitors.

Legislative and regulatory changes could create significant challenges to our Medicare Advantage and PDP revenues and operating results, and proposed changes to these programs could create significant additional challenges. Starting in 2017, federal funding for Medicaid expansion has decreased. Entitlement program reform, if it occurs, could have a material adverse effect on our business, operations or operating results.

From time to time the federal government alters the level of funding for government health care programs, including Medicare. Under the Budget Control Act of 2011 (the "BCA") and the American Taxpayer Relief Act of 2012 (the "ATRA"), significant, automatic across-the-board budget cuts (known as sequestration) to several federal government programs started in March 2013. These include Medicare spending cuts of up to 2% of total program costs per year through 2024. The ATRA also contained additional reductions to Medicare reimbursements to health plans that commenced in April 2013 and eliminated funding for certain ACA programs. These reductions could adversely affect us, our customers and our providers.

Medicare Advantage payment rates to health plans have been cut over the last several years, with additional reductions to be phased in through 2018. CMS issued its final notice detailing final Medicare Advantage benchmark payment rates for 2018 (the "Final Notice") in April 2017. Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of coding trend, by less than 1 percent in 2018 compared to 2017. This 2018 rate increase only slightly offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications), the HIF and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on the Medicare Advantage program and our Medicare Advantage operating results. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare operating results.

In addition, the "star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by compliance issues that arise in our Medicare operations, such as our distribution of inaccurate information regarding which pharmacies were part of our Medicare network and related $1 million civil monetary penalty in 2015, notices of non-compliance and warning letters in 2016 and notices of non-compliance in 2017. During 2017, our star ratings resulted in additional revenue of approximately $760 million, inclusive of bonus payments and rebates. If our star ratings fall below 4 for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues and operating results may be significantly adversely affected.

In April 2016, CMS issued a final rule that overhauls the entire Medicaid managed care delivery system. The final rule represented the first update to Medicaid managed care regulations since 2002. Among other things the final rule required Medicaid managed care products to have a minimum MLR of 85%; established a Medicaid managed care quality rating system; and established provider network adequacy requirements. The minimum MLR requirements became effective in 2017.

Federal funding for expanded Medicaid coverage began to decrease in 2017. This reduction is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our Government medical benefit ratio and our operating results.

We anticipate debate concerning entitlement program reform in 2018, particularly over the federal government's funding of the Medicaid program and potential changes to the Medicare program. If entitlement program reform occurs, it could have a material adverse effect on our business, operations or operating results, particularly on our Medicare and/or Medicaid revenues, medical benefit ratios and operating results.

We may not be able to obtain adequate premium rate increases, which would have an adverse effect on our revenues, medical benefit ratios and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases of 10% or more (or another state-specific threshold set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins and operating results of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. The risk of increases in utilization of medical and/or other covered services and/or in health care and other benefit costs is particularly acute during and following periods when utilization has been below recent historical levels, during periods of changing economic conditions and/or employment levels and in products where there is significant turnover in our membership each year. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and/or CHIP premium rates is limited due, among other things, to the budgetary pressures currently facing many state governments. This could magnify the adverse impact on our operating margins and operating results of increases in utilization of medical and other covered services, health care and other benefit costs and/or medical cost trends that exceed our projections.

Since 2013, HHS has issued determinations to health plans that their rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in a number of states also have conducted hearings on proposed premium rate increases, which can result, in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. We requested significant increases in our premium rates in our small group Health Care business for 2018 and expect to continue to request significant increases in those rates for 2019 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for the applicable products (also known as "adverse selection") in our products, particularly in small group products, which we expect to continue and potentially worsen in 2018 following the expiration of the ACA's risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory reaction and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured business. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in any product line or geography. If we are unable to obtain adequate rates and/or rate increases, it could materially and adversely affect our operating margins and our ability to earn adequate returns on Insured business in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured, Medicare Insured and Medicaid Insured businesses while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.

The ACA requires us to pay minimum MLR rebates each year with respect to prior years, and we expect the lower federal income tax rate enacted by the TCJA to increase the minimum MLR rebates we pay for 2018. The ACA's minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. Refer to "Revenue Recognition" in Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on

Form10-K for more information. Certain portions of our Medicaid and Federal Employees Health Benefits ("FEHB") program business are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. Federal and state auditors are challenging our Commercial business' compliance with the ACA's minimum MLR requirements, and our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Federal auditors also are challenging our FEHB plans' compliance with the Office of Personnel Management's ("OPM's") FEHB program specific minimum MLR requirements. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our operating results.

Additionally, we are required to pay minimum MLR rebates in a number of states in which we offer Medicaid coverage. In 2018, there also are pending proposals in a number of states to raise Medicaid minimum MLR thresholds above 85% and/or institute profit caps on state Medicaid contracts. These rebates and proposals are not required by the ACA; they are mandated by our Medicaid contracts or applicable state laws or regulations.

We may be subject to regulatory actions or suffer brand and reputational harm if we do not or cannot adequately implement any amendment, repeal or replacement of the ACA and/or related legislation or regulations, which may have a material adverse effect on our business.

We expect to continue to dedicate significant resources and incur significant expenses to comply with the ACA as currently enacted and implement and comply with any amendment, repeal or replacement of the ACA and/or related legislation or regulations at both the state and federal level, including implementing as well as complying with future legislation and regulations that will provide guidance on and clarification of and changes to significant parts of the legislation. If we fail to effectively implement or comply with the ACA and changes to, or repeal or replacement of, the ACA and/or related legislation or regulations and our related operational and strategic initiatives, or do not do so as effectively as our competitors, our business, operating results, brand and reputation may be materially adversely affected, we may lose customers and we may be subject to penalties, sanctions or other regulatory actions.

If we are unable to include the significant assessments, fees and taxes imposed on us by the ACA or otherwise by federal or state governments in our premiums and fees or otherwise adjust our business model to solve for them, our operating results, financial position and/or cash flows would be materially and adversely affected. The inclusion of these assessments, fees and taxes in our premiums also could adversely affect our ability to grow and/or maintain our medical membership.

The ACA imposes significant assessments, fees and taxes on us and other health insurers, health plans and other industry participants. There is some uncertainty whether we will be able to include all of these assessments, fees and taxes in our premium rates. It may be particularly challenging for us to include all of our portion of the industry-wide $14.3 billion 2018 HIF in our premium rates beginning with 2017 medical customer renewals that have member months in 2018 because of the temporary suspension of the HIF for 2017. The January 2018 suspension of the HIF for 2019 creates similar challenges for 2019 and 2020. Our ability to reflect the ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and CHIP rates is limited due, among other things, to the budgetary pressures currently facing many state governments.

We cannot predict the nature or extent of any new or increased federal or state assessments, fees or taxes associated with changes in the ACA or state actions in 2018 or thereafter. Those new or increased assessments, fees or taxes may be significant. If we are unable to include assessments, fees and taxes in our premiums and fees or otherwise adjust our business model to solve for them, these assessments, fees and taxes could have a material adverse effect on our operating results, financial position and/or cash flows. The increases in our prices caused by including all of these assessments, fees and taxes in our premiums and fees also could adversely affect our ability to profitably grow and/or maintain our medical membership, for example, if our competitors do not seek to include all or a significant portion of these assessments, fees and taxes in their premiums or fees.

Our business activities are highly regulated. Our Medicare, Medicaid, dual eligible, dual eligible special needs plan, specialty and home delivery pharmacy, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our business. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.

Our business is subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently (as evidenced by amendments to, and possible repeal or replacement of, the ACA and the continuing administrative changes in, and pending litigation regarding, the implementation of the ACA as well as other new federal and state laws and regulations), and can be inconsistent or conflicting. In general, these laws and regulations are designed to benefit and protect members and providers rather than us or our investors. In addition, the governmental authorities that administer our business have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year.

Our Medicare, Medicaid, dual eligible, dual eligible special needs plan, specialty and home delivery pharmacy and small group products are more highly regulated than our other Health Care products. The laws and regulations governing participation in Medicare, Medicaid, dual eligible and dual eligible special needs plan programs are complex, are subject to interpretation and can expose us to penalties for non-compliance, including penalties under the federal false claims act (the "False Claims Act") and state false claims acts. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products that are sold on Public Exchanges or otherwise subject to the ACA. The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit. If we are convicted of fraud or other criminal conduct in the performance of a health program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare, Medicaid, dual eligible, dual eligible special needs plan and other programs, cash flows, financial position and operating results. For example, CMS assessed a civil monetary penalty of $1 million against us in 2015 for distributing inaccurate information regarding which pharmacies were part of our Medicare network. Also, from April 2010 through June 2011, we were subject to intermediate sanctions that CMS imposed on us that required us to suspend the enrollment of and marketing to new members of all Aetna Medicare Advantage and PDP contracts. As a result of these sanctions, our 2011 Medicare membership and operating results were adversely affected because we did not participate in the annual enrollment process for 2011 and were not again eligible to receive automatic assignments of low income subsidy PDP members from CMS until September 2012.

Our products providing PBM and specialty and home delivery pharmacy services are subject to:

- The risks inherent in the dispensing, packaging and distribution of pharmaceuticals and other health care products, including claims related to purported dispensing and other operational errors (any failure by us or one of our PBM services suppliers to adhere to the laws and regulations applicable to the dispensing of pharmaceuticals could subject our PBM and/or pharmacy subsidiaries to civil and criminal penalties).
- Federal and state anti-kickback and other laws that govern our relationship with pharmaceutical manufacturers, customers and consumers.
- Compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings.
- Federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices, including the management and breadth of provider networks, the regulation of the development and use of drug formularies (such as the 2014 regulatory activity requiring us and certain other payors to place certain high cost drugs in preferred positions in our drug formularies) and/or maximum allowable cost list pricing, legislation, regulations or regulatory activity increasing the regulation of prescription drug pricing, imposing additional rights to access to drugs for individuals enrolled in health care benefit plans or reducing the cost of such drugs to those individuals, the receipt or required disclosure of rebates from pharmaceutical manufacturers, and restrictions on the use of average wholesale prices.

Our business, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations, including new legislation or regulations that apply to Private Exchanges. For more information regarding these matters, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 and "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices, and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national health and related benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. For example, we have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. Several such audits, investigations and reviews currently are pending, some of which may be resolved in 2018, and the results of which may be adverse to us.

There continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices, including premium rate increases, provider network adequacy, provider network directories, pharmacy formulary tiering, pharmacy network structures, utilization management and payment of providers with whom the payor does not have a contract and other health benefit plan and life insurance claim payment practices. In addition, a significant number of states are investigating life insurers' and health insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by life insurers in connection with related settlement agreements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance and health insurance claim payment and related escheat practices. Given the judicial, legislative and regulatory uncertainty with respect to life insurance and health insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows. For additional information on these life insurance matters, refer to "Regulatory Environment - Life and Disability Insurance" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other market participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our self-insured customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. For example, CMS assessed a civil monetary penalty of $1 million against us in 2015. Any of these audits, investigations or reviews could have a material adverse effect on our financial position, operating results or business or result in significant liabilities and negative publicity for our company. Federal and state auditors are challenging our Commercial business' compliance with the ACA's minimum MLR requirements. Our Commercial business has been subject to audits related to the ACA's risk adjustment and reinsurance data since those programs were implemented in 2014. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Federal auditors also are challenging our FEHB plans' compliance with the OPM's FEHB program specific minimum MLR requirements. For more information on certain CMS and other audits, see *"We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document*

their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act" beginning on page 29.

For more information regarding these matters, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 and "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K.

If our compliance systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our business, cash flows, operating results or financial position.

Our businesses are subject to extensive and complex regulations, and many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems in place to ensure that we comply with all applicable legal, regulatory and contractual requirements. These systems frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our business, cash flows, operating results or financial position.

Our litigation and regulatory risk profile is changing as we offer new products and expand in business areas beyond our historical core business of providing Commercial managed care and health insurance products in the United States. Changes in the ACA at the federal or state level could accelerate that change.

Historically, we focused primarily on providing Commercial managed care and health insurance products in the United States. In comparison, our Medicare and Medicaid products were significantly smaller. In 2017, our Medicare and Medicaid products accounted for 53% of total Health Care premiums. Our business continues to change due to the following:

- *Expansion within the health care marketplace:* We are expanding or seeking to expand our presence in various sectors of the health care marketplace, including Medicare, Medicaid, dual eligibles, dual eligible special needs plans, international, and certain customers who are not subject to ERISA's limits on state law remedies and working to deliver innovative products in those sectors.
- *Entry into new business and new product lines:* We are in the process of developing, operating and expanding our Consumer Health and Services product line. Over the last several years we have entered into new product lines, including Insurance Exchanges, dual eligible and dual eligible special needs plan programs, support services for ACOs, data analytics, recruitment for clinical trials and HIT.
- *ACA Changes:* Changes in the ACA at the federal or state level may create new products or expose us to new or expanded regulatory and/or litigation risk.
- *Acquisitions:* Our 2017 acquisition of Bupa Group's Thailand business expanded our international business.

The increased volume of business in areas beyond our historical core business and new products subject us to litigation and regulatory risks that are different from the risks of providing Commercial managed care and health insurance products and increase significantly our exposure to other risks.

We are routinely subject to litigation and adverse legal proceedings, including class actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our business and operating results.

We are routinely involved in numerous claims, lawsuits, regulatory audits, investigations and other legal proceedings arising in the ordinary course of our businesses. Certain of the lawsuits against us are purported to be class actions. The majority of these proceedings relate to the conduct of our health care operations and allege various violations of law. In addition, we operate in jurisdictions outside the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore more likely to be subject to dispute by customers, members, governmental authorities and others. We are incurring expenses to resolve these proceedings. The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur.

Litigation has been and may be brought against us by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit. When a private individual brings a whistleblower suit, the defendant often will not be made aware of the

suit for many months or even years, until the government commences its own investigation or determines whether it will intervene. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided under the Dodd-Frank Wall Street Reform and Consumer Protection Act increase the risk of whistleblower suits.

Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. For example, since 2007, we have been in class action litigation with non-participating providers over our payments to them, and during 2009, we settled a matter with the New York Attorney General that caused us to transition to different databases to determine the amount we pay non-participating providers under certain benefit plan designs. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

Litigation and other adverse legal proceedings could materially adversely affect our business or operating results because of brand and reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. Refer to "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K.

Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our business. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our members, customers and other constituents in the ordinary course of our business. Some of our information systems rely upon third party systems to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the European Union's ("EU's") General Data Protection Regulation which will apply across the EU effective May 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member information, whether by us, by one of our vendors or by another third party, could require us to expend significant resources to remediate any damage, interrupt our operations and damage our brand and reputation, and could also result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our business, brand, reputation, cash flows and operating results.

Our business depends on our members' and customers' willingness to entrust us with their health related and other sensitive personal information. Events that negatively affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our members' and customers' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction or that of our business associates, vendors or other third parties, including our PBM services suppliers, could adversely affect our brand and reputation, membership and revenues and also can and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our business, cash flows, operating results or financial position. For example during 2017, in connection with the settlement of two purported class actions, a settlement administration vendor sent a notice to certain of our members that potentially revealed members' personal health information due to the size of the window in the envelope. We have settled class action litigation and a state attorney general investigation related to this breach, and we are defending several additional litigation matters and under review by other state attorneys general and departments of insurance and the HHS Office of Civil Rights as a result of this breach. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and of our members' and customers' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.

Premiums and/or fees for Medicare members, certain federal government employee groups and Medicaid beneficiaries are subject to retroactive adjustments and/or withholding by the federal and applicable state governments. Our business that is subject to the ACA, including amounts payable to us or payable by us under the ACA's premium stabilization programs and our risk adjustment and reinsurance data, also is subject to audit by governmental authorities. CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members.

CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes.

CMS is transitioning the process of calculating Medicare members' risk scores from using diagnoses data from the Risk Adjustment Processing System, or RAPS, to using diagnoses data from the Encounter Data System, or EDS. The RAPS process requires Medicare Advantage plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires Medicare Advantage plans to submit all encounter data, and CMS applies the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score will be calculated from claims data submitted through EDS. The transition from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues or filtering logic differences between RAPS and EDS and could have a material adverse effect on our results of operations, financial position or cash flows.

Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage plans for various contract years, including certain of the Company's plans for certain contract years, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The OIG also is auditing risk adjustment data of us and other companies, and we expect CMS and the OIG to continue auditing risk adjustment data. We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers.

Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. In December 2015, CMS released a RFI for a significant expansion of the RADV audit program. As described in the RFI, CMS would use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would require us to change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years or the current contract year. For additional information, refer to "Regulatory Environment - Medicare" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions, including

fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our financial position, cash flows and operating results.

CMS has issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our operating results, financial position or cash flows.

Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results, cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

Any premium or fee refunds, adjustments or withholding or civil or criminal fines or penalties, or other sanctions, including restrictions on or changes in the way we do business, loss of licensure or exclusion from participation in government programs, resulting from regulatory audits or investigations, whether as a result of RADV, Public Exchange related, recovery audit program or other audits or investigations by CMS, the OIG, HHS, the DOJ or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows. For more information refer to "Regulatory Environment" of MD&A included in Part II, Item 7 of this Annual Report on Form10-K and "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to litigation against us.

These risks are particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, where third parties perform pharmacy benefit management, medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our business, cash flows, operating results or financial position. For more information on these matters, see "*Our business activities are highly regulated. Our Medicare, Medicaid, dual eligible, dual eligible special needs plan, specialty and home delivery pharmacy, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our business. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth*" beginning on page 25.

Programs funded in whole or in part by the U.S. federal government account for over half of our revenue. A delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, operating results and cash flows.

The federal government's "debt ceiling", or the amount of debt the federal government is permitted to borrow to meet its legal obligations (including, among other things, interest on the national debt, Medicare and Medicaid premiums, Social Security benefits and contributions to the Federal Employees Health Benefits Program), is limited by statute and can only be raised by an act of Congress.

If Congress does not raise the debt ceiling before the federal government's current obligations approach or exceed its cash on hand and incoming receipts, federal government spending may be subject to delay, reduction, suspension or cancellation, including a federal government shutdown, which may be prolonged. Over half of our revenues are derived from health care coverage programs that are funded in whole or in part by the federal government, including the Medicare, Medicaid, dual eligible and dual eligible specials needs plan programs, CHIP and the Federal Employees Health Benefits Program. If federal spending is delayed, suspended or curtailed, we would continue to receive claims from providers providing services to beneficiaries of these programs, and we could be liable for, and be required to fund, such claims. A failure to timely raise the debt ceiling could have a material adverse effect on our businesses, operating results, cash flows, brand and reputation and, in the case of a prolonged failure to raise the debt ceiling, our financial position.

If the United States defaults on its obligations due to a failure to timely raise the debt ceiling or otherwise, or its credit rating is downgraded by any of the credit rating agencies, interest rates could rise, financial markets could become volatile and/or the availability of credit (and short-term credit in particular) could be adversely affected, thereby increasing our borrowing costs, negatively impacting the value of our investment portfolio, and/or adversely affecting our ability to access the capital markets, which could have a material adverse effect on our operating results, financial position and cash flows and could adversely affect our liquidity.

Risks Related to Our Business

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our operating results. We may not able to obtain appropriate pricing on new or renewal business.

Premiums for our insured Health Care Products, which comprised 86% of our total consolidated revenues for 2017, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and healthcare utilization patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our operating results.

Our health care and other benefit costs can be affected by external events that we cannot forecast or anticipate and over which we have little or no control, such as emerging changes in the economy and/or public policy, additional government mandated benefits or other regulatory changes, changes in our members' behavior and healthcare utilization patterns, changes in health care practices, new technologies, increases in the cost of prescription drugs, influenza related health care costs (which may be substantial and are currently projected to be higher in 2017-2018 than the elevated levels experienced in 2009-2010), direct-to-consumer marketing by pharmaceutical companies, clusters of high cost cases, epidemics, pandemics, terrorist attacks or other man-made disasters, natural disasters or other events that materially increase utilization of medical and/or other covered services, as well as changes in provider billing practices. Our health care and other benefit costs also can be affected by changes in our business mix, product designs, contracts with providers, medical management, underwriting, rating and/or claims processing methods and processes, and our medical management initiatives may not deliver the reduction in utilization and/or medical cost trend that we project.

It is particularly difficult to accurately anticipate, detect, forecast, manage and reserve for medical cost trends and utilization of medical and/or other covered services during and following periods when such utilization and/or trends are below recent historical levels, during periods of changing economic conditions and employment levels and for products with substantial

membership turnover. For example, at December 31, 2017, we held a premium deficiency reserve of $16 million for the 2018 coverage year related to our Medicaid products. Similarly, during calendar year 2014, medical costs in our smaller middle market and individual businesses were higher than we projected, and during the calendar years 2010-2013, medical costs and members' utilization of medical and/or other covered services were lower than we projected and members' utilization was below recent historical levels. We expect utilization to increase in 2018 when compared to 2017.

We have implemented price increases for 2018. If health care and other benefit costs are higher than the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our prices will not reflect the risk we assume, and our operating results will be adversely affected. If health care and other benefit costs are lower than we predict, our prices may be higher than those of our competitors, which may cause us to lose membership. For more information, see "Critical Accounting Estimates - Health Care Costs Payable" of MD&A included in Part II, Item 7 of this Annual Report on Form10-K.

Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and operating results will be negatively affected.

Our customer contracts are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and operating results.

In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and operating results, although such elections also may reduce our health care and other benefit costs.

In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy. These actions may adversely affect our membership, revenues and operating results.

If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care business, our operating results, financial position and cash flows could be materially and adversely affected.

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the marketplace. Our businesses face significant competition in all of the geographies and product areas in which we operate. For example, our largest competitor in our Medicare products is Original Medicare. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods.

In our Health Care business, we compete on the basis of many factors, including perceived overall quality, quality of service, comprehensiveness of coverage, cost (including premium, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, providers available in such networks, and quality of member support and care management programs. Our competitors in our Health Care business include, among others, UnitedHealth Group Incorporated, Anthem, Inc., Humana Inc., Cigna Corporation, WellCare Health Plans, Inc., Centene Corporation, Molina Healthcare, Inc., Kaiser Permanente, health system owned health plans and new entrants into the marketplace, and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. Our largest competitor in our Medicare products is Original Medicare. Additional competitors in our businesses include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of

their members), third-party administrators, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefit plans, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. In particular geographies, competitors may have greater capabilities, resources or membership; a more established reputation; superior supplier or health care professional arrangements; better business relationships; or other factors that give such competitors a competitive advantage. We compete for sales on Insurance Exchanges and are developing and expanding our Consumer Health and Services product line, where we face additional risks from existing and new competitors (including our vendors) who have lower cost structures, greater experience marketing to consumers and/or who target the higher margin portions of our business. Among our international and HIT competitors, many have longer operating histories, better brand recognition and greater market presence in many of the areas in which we are seeking to expand and more experience at rapidly innovating products. If we do not compete effectively in the geographies and product areas in which we operate, our business, operating results, financial position and cash flows could be materially and adversely affected.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our operating results and competitiveness will be adversely affected.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and healthcare utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, the increasing influence of social media on our members' utilization and other behavior, changes in health care practices and inflation. In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, changes in health care practices, general economic conditions (such as inflation and employment levels), new technologies, influenza related health care costs (which may be substantial and are currently projected to be higher in 2017-2018 than the elevated levels experienced in 2009-2010), clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

Our operating results and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and operating results.

The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or may make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs.

Programs funded in whole or in part by the federal government account for over half our revenue, and we expect that percentage to increase. As our government funded business grows, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

Our revenues from government-funded health and other programs, including our Medicare, Medicaid, dual eligible and dual eligible special needs plan businesses and our government customers in our Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

For example, CMS is transitioning the process of calculating Medicare members' risk scores from using diagnoses data from the Risk Adjustment Processing System, or RAPS, to using diagnoses data from the Encounter Data System, or EDS. The RAPS process requires Medicare Advantage plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires Medicare Advantage plans to submit all encounter data, and CMS applies the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score will be calculated from claims data submitted through EDS. The transition from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues or filtering logic differences between RAPS and EDS and could have a material adverse effect on our results of operations, financial position or cash flows.

In addition, while the ACA provided substantial federal funding for the expansion of the number of people who qualify to enroll in Medicaid beginning in 2014, but that funding began to decrease in 2017, and the future of that funding is uncertain. As a result, in 2018, states are preparing for the adverse impact on their budgets and programs of expected changes to the ACA and other federal programs by seeking to reduce their Medicaid expenditures by raising minimum MLR thresholds, instituting profit caps and/or changing the design of their Medicaid programs. These changes could have a material adverse effect on the revenues, medical benefit ratio and operating results of our Medicaid contracts and/or our ability to grow our Medicaid membership, revenues and operating results.

Our government customers also determine the eligibility criteria, premium levels and other aspects of Medicare, Medicaid, dual eligible and dual eligible special needs plan programs that affect the number of persons enrolled in these programs, the services provided to enrollees under the programs, and our administrative and health care and other benefit costs under these programs. In the past, determinations of this type have at times adversely affected our operating results from and willingness to participate in such programs, and they may do so again in the future. If a government customer reduces premium levels or increases premiums by less than the increase in our costs (such as by not allowing us to recover ACA and other applicable fees, taxes and assessments), and we cannot offset the impact of these actions with supplemental premiums and/or changes in benefit plans, then our business and operating results could be adversely affected. In addition, if states allow certain programs to expire, reduce the number of firms with which they contract for Medicaid managed care services or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment or reduced Medicaid enrollment growth, which would adversely affect our business, revenues and operating results.

In addition, the terms of our disability products often provide that the benefits due to beneficiaries are reduced by the amount of certain federal benefits they receive, most notably Social Security Disability Insurance ("SSDI") payments. If such payments are suspended or reduced for any reason, including due to funding shortfalls for the SSDI program, our disability payment obligations and related reinsurance receivable from HLAIC would be increased accordingly, and such increase could be material.

Unanticipated increases in our ACA compliant small group Commercial product health care benefit costs adversely affected our 2016 operating results and could adversely affect our operating results in 2018 and future years. There can be no assurance that our pricing or other actions will maintain or improve the profitability of our ACA compliant small group Commercial products in 2018. There can be no assurance that the future health care benefit costs of our ACA compliant small group Commercial products will not exceed our projections.

Unanticipated increases in our ACA compliant small group Commercial product health care benefit costs adversely affected our 2016 operating results and could adversely affect our operating results in 2018 and future years.

We have set 2018 premium rates for our ACA compliant small group Commercial products based on our projections, including as to the health status and quantity of small group Commercial product membership and utilization of medical and/or other covered services by small group Commercial product members. There can be no assurance that our pricing or other actions will improve the profitability of our ACA compliant small group Commercial products in 2018 or any future year.

The premium rates for our ACA compliant small group Commercial products are set in advance and fixed for one-year periods. As a result, health care benefit costs in excess of the projections reflected in our pricing for those products cannot be recovered in the fixed premium period through higher premiums. The profitability of ACA compliant small group Commercial products is particularly sensitive to the accuracy of our forecasts of health care benefit costs. Those forecasts were made several months before the fixed premium period began, require a significant degree of judgment and are dependent on our ability to detect medical cost trends as well as the accuracy of our projections used in setting our ACA compliant small group Commercial product premium rates.

There can be no assurance regarding the accuracy of the health care benefit cost, membership or other projections reflected in our ACA compliant small group Commercial product pricing. The risks related to the accuracy of projections reflected in our

pricing are magnified by adverse selection among individuals who require or utilize more expensive medical and/or other covered services, other plans' withdrawals from participation in the Insurance Exchanges we serve and legislation, regulations, enforcement activity and/or judicial decisions that cause Insurance Exchanges or Insurance Exchange products to operate in a manner different than what we projected in setting our Insurance Exchange product premium rates, such as ongoing initiatives in several states to require insurers to allow members to pay insurers less for certain high cost drugs than the amounts assumed in pricing of their Public Exchange products. On-going uncertainty regarding the funding of ACA-related programs and subsidies can be expected to create additional instability in the marketplace. For additional information on certain of the medical cost trend, pricing and economic conditions risks associated with our Insurance Exchange and other Health Care products, see "*We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our operating results. We may not able to obtain appropriate pricing on new or renewal business*" beginning on page 31; and "*We may not be able to obtain adequate premium rate increases, which would have an adverse effect on our revenues, medical benefit ratios and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes*" on page 23.

The reserves we hold for expected claims are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the ACA's, CMS's and OPM's minimum MLR rules and the amounts payable by us to, and receivable by us from, the U.S. federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within health care costs. For example, at December 31, 2017, we held a premium deficiency reserve of $16 million for the 2018 coverage year related to our Medicaid products. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable at December 31, 2017 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any negative impact on our operating results. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Refer to "Critical Accounting Estimates - Health Care Costs Payable" of MD&A included in Part II, Item 7 of this Annual Report on Form10-K for more information.

Our medical membership remains concentrated in certain geographic areas and industries, exposing us to unfavorable changes in local benefit costs, reimbursement rates, competition and economic conditions.

Our medical membership remains concentrated in certain geographic areas in the United States and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our operating results. Our membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our membership geographically, by product type

or by customer industry, and our revenue and operating results may be disproportionately affected by adverse changes affecting our customers.

A change in our health care product mix may impact our profit margins.

Our health care products that involve greater potential risk generally tend to be more profitable than administrative services contract products. Small employer groups are more likely to purchase our higher-risk health care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government-sponsored programs also involve our higher-risk health care products and have lower profit margins than our Insured Commercial products, and our membership is projected to continue to shift towards higher revenue, higher MBR Government products in 2018. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our operating results.

We face challenges in growing our Medicare Advantage membership.

We are seeking to substantially grow our Medicare Advantage membership, revenue and operating results in 2018 and over the next several years, including by significantly expanding our Medicare service area. The organic expansion of our Medicare service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise in our Medicare operations. If we are not successful in expanding our Medicare service area, we may not be able to achieve our Medicare Advantage growth goals.

We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.

We are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders. For example, as of January 2018, certain of our winning Medicaid bids are being protested, and during 2017 we were not successful in retaining certain Medicaid contracts. As a result, we are seeking to improve our process for responding to Medicaid requests for proposal. Our ability to maintain and grow membership, revenues and operating results in our Medicaid products is dependent on our remaining competitive on price, performance and preparing successful bids. In cases where our bid is successful, we incur defense costs and may incur unreimbursed implementation and other costs to meet contractual deadlines even if we ultimately lose the challenge.

If we are successful in expanding our Medicaid membership, we may increase our exposure to states that face budgetary pressures, hospitals and other providers that face revenue challenges associated with uncompensated care, and pressures on our operating margins driven by the projected rapid growth in the size of and cost of care for the Medicaid eligible population.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health), life insurance and disability costs and impact our business continuity. We cannot predict whether or when any such events will occur.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the U.S. economy in general, our industry and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health), life insurance and disability costs, which would also be affected by the government's actions and the responsiveness of public health agencies and other insurers. In addition, our life insurance members and our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our business, cash flows, and operating results, and, in the event of extreme circumstances, our financial position or viability, particularly if our responses to such events are less adequate than those of our competitors.

Our business could also be adversely affected if we do not maintain adequate procedures for crisis management, disaster recovery and business continuity during and after such events. Other than obtaining insurance coverage for our facilities and limited reinsurance of our Health Care liabilities, there are few, if any, commercial options through which to transfer the exposure from terrorism or other extreme events away from us.

Risks Related to Our Operations

Unless we are able to develop alternative sources of revenue and earnings and achieve transformational change in our business model, our ability to profitably grow our business could be adversely affected.

We operate in a highly competitive environment and in an industry that is subject to significant ongoing changes from marketplace pressures brought about by public policy forces, the ACA, changes to or repeal or replacement of the ACA, Insurance Exchanges, customer demands, demographic shifts, new and expanding health care capabilities, business consolidations, strategic alliances, new market entrants, legislative and regulatory changes and marketing practices. As a result of these and other factors, our ability to grow profitably through the sale of traditional Insured health care and related benefits products in the United States may be limited. In order to profitably grow our business in the future, we plan to diversify the sources of our revenue and earnings, including by significantly expanding the number of geographies in which we offer our Medicare products, and transform our business model, including through developing and expanding our Consumer Health and Services product line, making investments in consumer engagement capabilities and our Consumer Health and Services' technology and other services for health systems and provider organizations (including joint ventures, ACOs and collaborative provider networks), optimizing our business platforms and expanding internationally. If we do not achieve our diversification and transformation goals, our business, cash flows and operating results could be adversely affected.

Achieving our transformation goals will require us to devote significant senior management and other resources to acquisitions or other transactions and to develop internally or acquire new products, solutions and technology before any significant revenues or earnings are generated from such initiatives. If we are not able to acquire and/or develop and launch new products and solutions, our ability to profitably grow our business could be adversely affected.

We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. Although the impact of such attacks has not been material to our operations or operating results through December 31, 2017, we can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future. As we expand our Consumer Health and Services product line (including through growth of our joint venture and accountable care relationships with providers), increase the amount and types of data we acquire, generate and use, increase the amount of information we make available to members, consumers and providers on mobile devices, expand our use of vendors, expand internationally and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access to and/or disruption of our systems and the customer, member, provider, employee, ACO, joint venture, vendor and other third party information they contain, increases, and the cost of attempting to protect against these risks also increases.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and of our members' and customers' sensitive information. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our business, brand, reputation, cash flows and operating results.

We may not be able to effectively manage our general and administrative expenses to competitive levels, which may reduce our membership or profitability, or we may need to implement expense reduction measures that adversely affect our future growth potential.

Our operating results depend in part on our ability to manage our general and administrative expenses to competitive levels while delivering improved customer, member and provider service, expanding our marketplace presence and accomplishing our strategic initiatives, including developing, operating and expanding our Consumer Health and Services product line. Controlling general and administrative expenses is particularly important in our Health Care businesses that are subject to regulatory changes that may restrict our underwriting margins (calculated as premiums less health care costs), such as minimum MLR requirements. We have significant fixed costs, and our ability to reduce variable costs in the short term is limited. We attempt to manage general and administrative expenses by, among other things, making our processes more efficient, reducing the number of products we offer and controlling costs for salaries and related benefits, information technology and other general and administrative costs. However, we may not be successful in achieving the intended benefits of the cost-cutting and process improvement initiatives we undertake. In addition, our cost-cutting measures may adversely affect our ability to implement changes to the ACA and other regulatory requirements, attract and retain key employees, maintain robust management practices and controls (including internal controls over financial reporting), implement improvements in technology and achieve our strategic goals, including profitable membership growth. Given the foregoing, we can provide no assurance that we will be able to manage our general and administrative expenses to competitive levels, which may reduce our membership, profitability and operating results and adversely affect our business and future growth potential.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, members and vendors, including our PBM services suppliers, in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the Consumer Health and Services products we are developing, operating and expanding and/or to meet current and developing industry and regulatory standards, including with regard to minimum MLR rebates, Insurance Exchanges, and various aspects of the ACA, and to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

Our business strategy involves providing customers with differentiated, easy to use, secure products and solutions that use information to meet customer needs. The types of technology and levels of service that are acceptable to customers and members today will not necessarily be acceptable in the future, requiring us to anticipate and meet marketplace demands for technology. Our success therefore is dependent in large part on our ability, within the context of a limited budget of human resources and capital and our existing and future business relationships, to timely secure, integrate, develop, redesign and enhance our (or contract with vendors to provide) technology systems that support our business strategy initiatives and processes in a compliant, secure, and cost and resource efficient manner. Integration of our acquisitions increases these challenges, and we may not be successful in integrating various systems in a timely or cost-effective manner.

Information technology projects are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care cost and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of providers, employer plan sponsors and members, developing and expanding our Consumer Health and Services product line or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

In order to remain competitive, we must further integrate our businesses, processes and systems. Pursuing multiple initiatives simultaneously could make this integration significantly more challenging.

Many of our businesses, processes and systems, both those we have acquired or will acquire, and those we have developed or are developing, are not integrated, are complex or require disproportionate resources in order to work together effectively. Businesses, processes and systems that are excessively complex or are not effectively integrated may adversely affect our ability to compete by, among other things, increasing our costs relative to competitors, reducing our flexibility and limiting our ability to react quickly to marketplace opportunities or changing circumstances. Accordingly, we must effectively and

efficiently simplify and integrate these businesses, processes and systems to meet changing consumer and vendor needs and improve our productivity. This task is significantly more difficult when we pursue multiple transactions or other initiatives, such as significant acquisitions, strategic alliances, joint ventures and multi-year strategic projects (including developing, operating and expanding our Consumer Health and Services product line and implementing new provider support programs), simultaneously. Our existing business partnership relationships and a limited budget of human resources and capital present further challenges.

If we are unable to successfully simplify and integrate our businesses, processes and systems, including those from acquisitions, to realize anticipated economic and other benefits in a timely manner, it could result in substantial costs or delays and adversely affect our business, operations and operating results.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our Consumer Health and Services product line and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with health plan members in these areas.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We face a wide range of risks, and our success depends on our ability to identify, prioritize and appropriately manage our enterprise risk exposures.

As a large company operating in a complex industry and in many countries, we encounter a variety of risks. The risks we face include, among other matters, the range of industry, competitive, regulatory, financial, operational or external risks identified in this "Risk Factors" discussion. We continue to devote resources to further develop and integrate our enterprise-wide risk management processes. Failure to identify, prioritize and appropriately manage or mitigate these risks, including risk concentrations across different business lines, products (e.g., Insured vs. ASC), industries, customers and geographies, can adversely affect our operating results, our ability to retain or grow business, or, in the event of extreme circumstances, our financial position or business operations.

We also face other risks that could adversely affect our business, operating results, financial position, and/or cash flows, which include:

- Health care benefits fraud by providers, members and/or brokers that is not prevented or detected and impacts our medical cost trends or the medical expenses of our self-insured customers. In addition, in an adverse and/or uncertain economic environment, whether in the United States or abroad, our businesses may see increased fraudulent claims volume, which may lead to additional costs because of an increase in disputed claims and litigation;
- Assessments under guaranty fund laws for obligations of insolvent insurance companies (such as the assessment for Penn Treaty Network America Insurance Company and one of its subsidiaries described in Note 17 "Commitments and Contingencies - Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools"

included in Part II, Item 8 of this Annual Report on Form 10-K), HMOs, ACA co-ops and other payors to policyholders and claimants;
- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;
- Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our operating results and/or a deterioration in the soundness and accuracy of our reported operating results;
- Financial loss from inadequate insurance coverage due to self-insurance levels or unavailability of insurance and reinsurance coverage for credit or other reasons;
- Failure to protect our proprietary information, including as a result of cyber-attacks on us, one or more providers and/or one or more of our vendors; and
- Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including our domestic group life insurance, group disability insurance and absence management businesses.

Risks Related to Customer Perceptions of our Products and Services

In order to be competitive in the increasingly consumer-oriented marketplace for our products and services, we will need to develop and deploy our Consumer Health and Services products and make investments in consumer engagement, reduce our cost structure and face new competitors. If we are unsuccessful, our future growth and profitability may be adversely affected.

Historically, employers have been our most significant customers. However, decisions to buy our products and services are increasingly made or influenced by consumers, either through direct purchasing (for example, Medicare Advantage plans) or through Insurance Exchanges that allow individual choice. In response to this demand, we are expanding our consumer focus, including the development and expansion of our Consumer Health and Services product line. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

We also will have to respond to pricing and other actions taken by existing competitors as well as potentially disruptive new entrants. Regulatory and participation requirements for exchange-based plans tend to emphasize price and make competitive differentiation based on other attributes more difficult. Accordingly, we face competitive pricing pressures from existing and new competitors (including our vendors and others who may have lower cost structures than we do), and these pressures may reduce our operating margins or limit sales of our products and services. Our competitors may bring their Insurance Exchange and other consumer products to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our business. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of Private Exchanges or encourage their employees to purchase health insurance on the Public Exchanges. We can provide no assurance that we will be able to develop or operate successful or profitable consumer products or compete successfully or profitably on Public Exchanges or Private Exchanges or that we will be able to benefit from any opportunities presented by Public Exchanges or Private Exchanges. If we do not develop and expand competitive and profitable consumer products, are not competitive on Insurance Exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely affected.

We may not be able to compete effectively in the HIT business and earn a profit. Our HIT business increases our risk of patent infringement and other intellectual property litigation and may become subject to significant regulation in the future.

With our current focus on consumer engagement, joint ventures, ACOs, collaborative provider networks and optimizing our business platforms and our 2014 acquisition of bswift, we have increased our commitment to HIT products and solutions, a business that is rapidly changing and highly competitive. There is no assurance that we will be able to successfully adapt to changes to the HIT marketplace, or compete effectively and earn a profit in our HIT business. Our technology products and solutions may not operate as intended. Moreover, we may not have identified and mitigated, or be able to identify and mitigate, the significant risks of pursuing the HIT business, including the risk that we will be unable to protect our proprietary rights and the risks of patent infringement and other intellectual property litigation against us. Certain of our HIT products and/or solutions have been subject to patent litigation, which is often associated with significant litigations costs, damages and/or injunctions.

In addition, although the HIT industry is not currently subject to significant regulation, we face an uncertain and rapidly evolving federal, state and international legislative and regulatory framework, and certain of our HIT products and/or solutions could become subject to regulation. New legislation and/or regulations may make it difficult to achieve and maintain

compliance and could adversely affect both our ability to compete in the HIT business and the operating results of our HIT business.

If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow profitable membership may be adversely affected.

We operate in a rapidly evolving industry. Our customers generally, and our larger customers in particular, are well-informed and organized and, along with our individual customers, can easily move between us and our competitors. These factors require us to differentiate our products and solutions, anticipate changes in customer and consumer preferences, anticipate and effectively compete with the products and solutions of new and existing competitors and innovate and deliver new and existing products and solutions that demonstrate value to our customers and members, particularly in response to marketplace changes from public policy. Differentiating our Insurance Exchange products is particularly challenging due to the standardization (for example, network adequacy and standardization of benefits requirements) of these products. Any failure to do so may adversely affect our ability to retain or grow profitable membership, which can adversely affect our operating results.

If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership will be adversely affected.

Our ability to attract and retain membership is dependent upon providing cost effective, quality customer service operations (such as call center operations, claim processing, outsourced PBM functions, home delivery pharmacy prescription delivery, specialty pharmacy prescription delivery, customer case installation and on-line access and tools) that meet or exceed our customers' and members' expectations. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customer and other service and performance. If we misjudge the effects of such measures, customer and other service may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. For example, CaremarkPCS Health, L.L.C. (and its predecessors, collectively, "Caremark", a wholly-owned subsidiary of CVS Health) and Express Scripts provide us with certain PBM services. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or growing profitable membership, which can adversely affect our operating results. For example, noncompliance with any privacy or security laws or regulations or any security breach involving one of our third party vendors could have a material adverse effect on our businesses, operating results, brand and reputation.

Our competitive position and ability to differentiate our products will be adversely affected if we cannot demonstrate that our products and processes result in our members receiving quality affordable care.

One of the key factors on which we compete for customers is the degree to which our products and processes (including our disease management and patient safety programs and our provider credentialing and other quality of care and information management initiatives) result in our members receiving quality affordable care from providers, our vendors (including our PBM services suppliers) and us. If our products and process do not result in our members receiving quality affordable care, or if we are unable to demonstrate that our members receive quality affordable care, then our competitive position and ability to differentiate our product and/or solution offerings from those of our competitors would be adversely affected, which in turn could adversely affect our operating results.

Risks Related to Our Relationships with Providers, Suppliers and Vendors

If we are unable to enter into joint ventures and other collaborative risk-sharing agreements with health care providers on satisfactory terms, it may have an adverse effect on our ability to enhance our provider networks, contain our medical costs, grow our business and/or develop alternative sources of revenue and earnings.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with health care providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow membership, and our ability to profitably grow our business and/or our operating results may be adversely affected.

While we believe joint ventures, ACOs and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our operating results and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint venture. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our operating results and cash flows.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other provider and health systems continue to consolidate across the industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other health care providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our business and operating results.

Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.

Our operating results are dependent in part upon our ability simultaneously to contract competitively with and develop and maintain favorable relationships with hospitals, physicians, pharmaceutical benefit management service providers, pharmaceutical manufacturers and other health care benefits providers. Our relationships with providers may be affected by the CVS Health Transaction and are affected by the rates we pay them for services rendered to our members (including financial incentives to deliver quality services in a cost-effective manner), by our business practices and processes, by our acquisitions and divestitures and proposed acquisitions and divestitures, and by our provider payment and other provider relations practices (including whether we include providers in the various provider network options we make available to our customers). Our relationships with providers also are affected by factors that impact those providers, but are not directly related to us, such as consolidations and strategic relationships among providers and/or among our competitors, changes in Medicare and/or Medicaid reimbursement levels to health care providers (including reductions due to the ATRA, sequestration and/or any amendment, repeal or replacement of the ACA), and increasing revenue and other financial pressures on providers, including increases in uncompensated care resulting from the any amendment, repeal or replacement of the ACA, ongoing reductions by CMS and state governments (including reductions due to recommendations of the Independent Payment Advisory Board, the ATRA, sequestration and/or any repeal or amendment of the ACA) in amounts payable to providers, particularly hospitals, for services provided to Medicare and Medicaid enrollees.

The breadth and quality of our networks of available providers and our ability to offer different provider network options are important factors when customers consider our products and services. Our customers, particularly our self-insured customers, also consider our hospital and other medical provider discounts when evaluating our products and services. For certain of our businesses, we must maintain provider networks that satisfy applicable access to care and/or network adequacy requirements. Regulators also consider the breadth and nature of our provider networks when assessing whether such networks meet network adequacy requirements which, in some cases, are becoming more stringent. For example, a 2016 CMS regulation established network adequacy requirements that apply to all Medicaid managed care plans. Our contracts with providers generally may be terminated by either party without cause on short notice.

The failure to maintain or to secure new cost-effective health care provider contracts, may result in a loss of or inability to grow membership, higher health care or other benefits costs (which we may not be able to reflect in our pricing due to rate reviews or other factors), health care provider network disruptions, less desirable products for our customers and/or difficulty in meeting regulatory or accreditation requirements, any of which could adversely affect our operating results.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our members.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these non-participating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, since 2007, we have been in class action litigation with non-participating providers over our payments to them, and during 2009, we settled a matter with the New York Attorney General that caused us to transition to different databases to determine the amount we pay non-participating providers under certain benefit plan designs. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Certain of these matters are described in more detail in "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K.

We could become overly dependent on key service providers, which could expose us to operational risks and cause us to lose core competencies. If their services become unavailable, we may experience service disruptions, reduced service quality and increased costs and may be unable to meet our obligations to our customers.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. These third parties include our PBM services suppliers, information technology system providers, independent practice associations, accountable care organizations and call center and claim and billing service providers. Certain of these third parties provide us with significant portions of our requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. Certain third parties to whom we delegated selected functions, such as independent practice associations and specialty services providers, have experienced financial difficulties, including bankruptcy. Furthermore, certain legislative authorities have in recent years discussed or proposed legislation that would restrict outsourcing. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruption or unavailability, reduced service quality and effectiveness, increased or duplicative costs, an inability to meet our obligations to our customers or require us to seek alternative service providers on less favorable contract terms, any of which can adversely affect our business, brand, reputation and/or operating results. Furthermore, where our arrangements with these service providers are not acceptable to our customers, we must make alternate arrangements, which may be more costly and difficult to implement.

In particular, we have entered into agreements with our PBM services suppliers to provide us and certain of our customers and members with certain PBM services. If our PBM agreement with Caremark or our agreements with our other PBM services suppliers were to terminate for any reason or one of our PBM services supplier's ability to perform their respective obligations under their agreements with us were impaired, we may not be able to find an alternative supplier in a timely manner or on acceptable financial terms. As a result, our costs may increase, we would not realize the anticipated benefits of our PBM agreement with Caremark or our other agreements for PBM services (including projected operating efficiencies), and we may not be able to meet the full demands of our customers, any of which could have a material adverse effect on our business, brand, reputation and/or operating results.

Risks Related to Our Acquisitions, Joint Ventures and International Operations

We expect to continue to pursue acquisitions and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing business, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to integration risks, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- We frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- The acquired and/or joint venture businesses may not perform as projected;
- The goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become non-recoverable;

- We may not obtain the projected synergies as we integrate the acquired businesses;
- We may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- We may experience difficulties in integrating acquired businesses into our existing operations (including our internal control environment and compliance policies), be unable to integrate acquired businesses successfully or as quickly as expected, and be unable to realize anticipated economic, operational and/or other benefits in a timely manner or at all, which could result in substantial costs and delays or other operational, technical or financial problems;
- The acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- We may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our shareholders;
- We may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- We may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of companies we acquire, which may be difficult or impossible to accomplish;
- We may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, material disruptions to our business and operations and negatively affect our brand and reputation;
- In order to complete a proposed acquisition, we may be required to divest certain portions of our business;
- We may be involved in litigation related to mergers or acquisitions, including for matters which occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- The integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

We expect joint ventures to be a critical part of our business model transformation and inorganic growth strategies. Joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, maintaining positive relationships among the joint venture parties and the customer, and member and business disruption that may occur upon joint venture termination.

As we expand our international operations, we will increasingly face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations. Our exposure to these risks is expected to increase.

As we expand our international operations we will increasingly face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, privacy, data storage, location, protection and security.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the Bribery Act 2010) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and management, financial and other resources over a number of years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our business and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our business, operating results, financial position, brand, reputation and/or long-term growth.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, customs and employee relationships that can be difficult, less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business partners, which requires us to manage our partner relationships and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may have an impact on our revenues, operating results and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Our exposure to all of the above risks is expected to increase as we seek to grow our foreign operations over the next several years.

Financial Risks

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, business, cash flows, financial position and operating results.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by recognized rating organizations. Credit ratings issued by nationally-recognized organizations are broadly distributed and generally used throughout our industry. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our products to certain of our customers. In addition, our credit ratings impact the cost and availability of future borrowings, and accordingly our cost of capital.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Among other things, our ratings may be affected by the assumption and/or issuance of debt in connection with an acquisition. For example, following the announcement of the CVS Health Transaction in December 2017, each of Standard & Poor's, A.M. Best and Fitch placed certain of our debt, financial strength and other credit ratings under review with negative implications. Downgrades or potential downgrades in our ratings, should they occur, could adversely affect our brand and reputation, access to credit markets, business, cash flows, financial position and operating results.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our operating results and/or our financial position.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the United States. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the United States, and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the United States credit markets, and governments' monetary policy, particularly United States monetary policy, can significantly and adversely affect the value of our investment portfolio, our operating results and/or our financial position by:

- Significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders' equity;
- Keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and operating results as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- Reducing the fair values of our investments if interest rates rise;
- Causing non-performance or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;

- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results; and
- Reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure to adequately do so could adversely affect our net income and our financial position and, in extreme circumstances, our cash flows.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our principal office is a building complex that is approximately 1.7 million square feet in size and is located at 151 Farmington Avenue, Hartford, Connecticut. Our principal office is used by all of our business segments. We also own or lease other space in the greater Hartford area, Bethesda, Maryland, Blue Bell, Pennsylvania, and various field locations in the U.S. and several foreign countries. Such properties are primarily used by our Health Care segment. We believe our properties are adequate and suitable for our business as presently conducted.

Item 3. Legal Proceedings

The Information contained under "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K is incorporated by reference herein.

Item 4. Mine Safety Disclosures

Not applicable.

Part II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

Our common shares ("common stock") are listed on the New York Stock Exchange, where they trade under the symbol AET. The following table presents high and low sales prices for our common stock for the periods indicated.

	High	Low
2017		
First quarter	**$ 134.76**	**$ 116.04**
Second quarter	**155.15**	**127.08**
Third quarter	**164.52**	**150.43**
Fourth Quarter	**192.37**	**149.69**
2016		
First quarter	$ 115.52	$ 92.42
Second quarter	123.57	106.30
Third quarter	121.70	111.88
Fourth Quarter	136.50	104.59

Holders of our Common Stock

At January 31, 2018, there were approximately 6,100 record holders of our common stock.

Dividends

The quarterly cash dividend declared by Aetna's Board of Directors (our "Board") was $.50 per share in 2017 and $.25 per share in 2016 and 2015. On February 23, 2018, our Board declared a cash dividend of $.50 per common share that will be paid on April 27, 2018, to shareholders of record at the close of business on April 12, 2018. Under the terms of the CVS Merger Agreement, prior to the completion of the merger contemplated by the CVS Merger Agreement (the "Merger"), Aetna is not permitted to declare, set aside or pay any dividend or make any other distribution other than a regular quarterly cash dividend in the ordinary course of business, which cannot exceed $.50 per share.

Declaration and payment of future dividends is at the discretion of our Board and may be adjusted as business needs or marketplace conditions change. In addition, under the terms of the CVS Merger Agreement, we have agreed with CVS Health to coordinate the declaration and payment of dividends so that our shareholders do not fail to receive a quarterly dividend around the time of the closing of the Merger. Information regarding restrictions on our present and future ability to pay dividends is included in "Liquidity and Capital Resources" of MD&A included in Part II, Item 7 and Note 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under our equity compensation plans is incorporated herein by reference to "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" included in Part III, Item 12 of this Annual Report on Form 10-K.

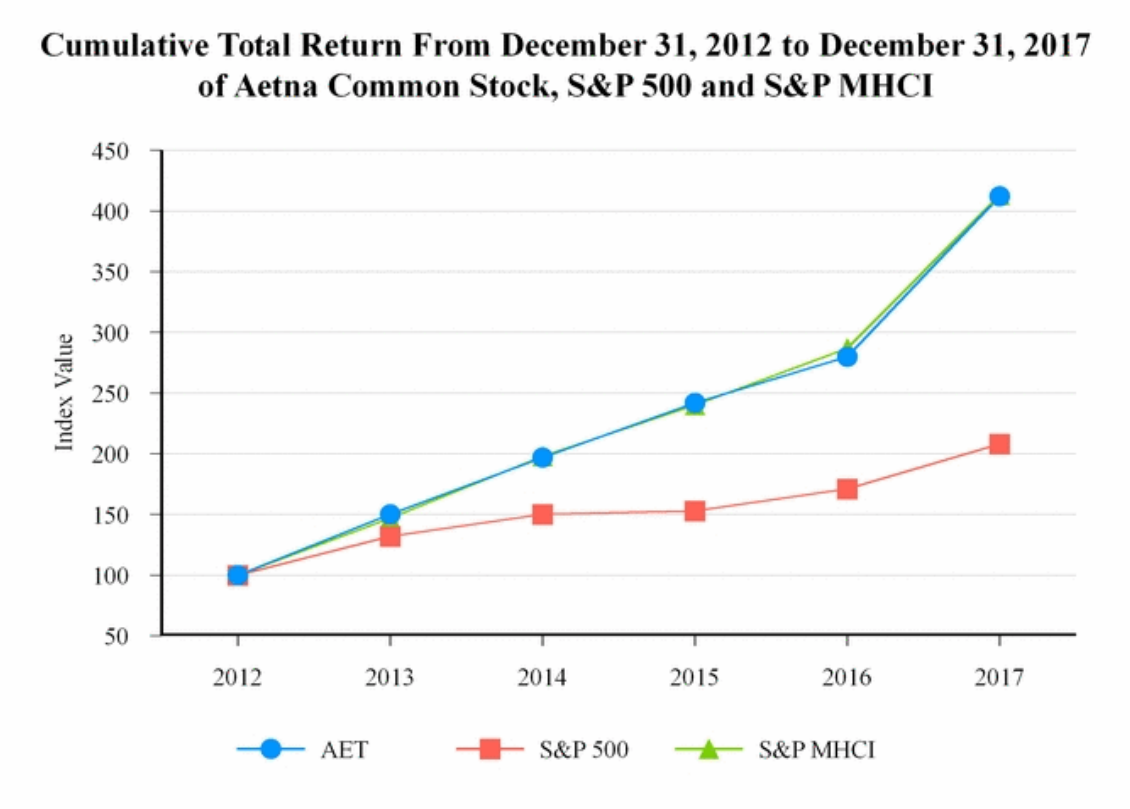
Issuer Purchases of Equity Securities

During the three months ended December 31, 2017, we did not repurchase any shares of common stock. At December 31, 2017, we had remaining authorization to repurchase an aggregate of up to approximately $1.2 billion of common stock under our February 17, 2017 program, however, as a result of the CVS Merger Agreement, our ability to repurchase shares of our common stock prior to the completion of the Merger is limited.

Refer to Note 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K for information regarding our share repurchases including Board authorizations, shares repurchased during 2017 and our remaining share repurchase authorization as of December 31, 2017.

Corporate Performance Graph

The following graph compares the cumulative total shareholder return on our common stock (assuming reinvestment of dividends) with the cumulative total return on the published Standard & Poor's 500 Stock Index ("S&P 500") and the cumulative total return on the published Standard & Poor's Supercomposite Managed Health Care Index ("S&P MHCI") from December 31, 2012 through December 31, 2017. The graph assumes a $100 investment in shares of our common stock on December 31, 2012.



	December 31,					
	2012	2013	2014	2015	2016	2017
AET	$ 100	$ 150	$ 197	$ 242	$ 280	$ 412
S&P 500	100	132	150	153	171	208
S&P MHCI [1]	100	147	198	240	287	413

[1] At December 31, 2017, the companies included in the S&P MHCI were: Aetna Inc., Anthem, Inc., Centene Corporation, Cigna Corporation, HealthEquity, Inc., Humana Inc., Magellan Health, Inc., Molina Healthcare, Inc., UnitedHealth Group Incorporated and WellCare Health Plans, Inc.

Shareholder returns over the period shown on the corporate performance graph should not be considered indicative of future shareholder returns.

Item 6. Selected Financial Data

The table below provides selected consolidated financial data of Aetna. The information has been derived from our consolidated financial statements for each of the years in the five year period ended December 31, 2017. You should read this selected consolidated financial data in conjunction with MD&A included in Part II, Item 7 of this Annual Report on Form 10-K and the audited consolidated financial statements and notes as of and for the year ended December 31, 2017 included in Part II, Item 8 of this Annual Report on Form 10-K.

	As of and for the Years Ended December 31,				
(Millions, except per common share data)	**2017**	**2016**	**2015**	**2014**	**2013** [1]
Income Statement Data					
Total revenue	**$ 60,535**	$ 63,155	$ 60,337	$ 58,003	$ 47,295
Net income attributable to Aetna	**1,904**	2,271	2,390	2,041	1,914
Net realized capital (losses) gains, net of tax	**(155)**	56	(42)	52	(7)
Per Common Share Data					
Cumulative annual dividends declared	**$ 2.00**	$ 1.00	$ 1.00	$ .925	$ .825
Net income attributable to Aetna:					
Basic	**5.71**	6.46	6.84	5.74	5.38
Diluted	**5.68**	6.41	6.78	5.68	5.33
Balance Sheet Data					
Total assets [2]	**$ 55,151**	$ 69,146	$ 53,509	$ 53,354	$ 49,723
Short-term debt	**—**	—	—	500	—
Long-term debt [2]	**9,159**	20,661	7,785	8,033	8,210
Total Aetna shareholders' equity	**15,580**	17,881	16,114	14,483	14,026

(1) We acquired Coventry Health Care, Inc. ("Coventry") in May 2013, which impacts the comparability of operating results for the year ended December 31, 2013 to the other periods presented.

(2) Amounts as of December 31, 2013 to 2015 have been retroactively restated to reflect the reclassification of debt issuance costs from other current and long-term assets to a reduction of long-term debt as a result of the adoption of new accounting guidance during the year ended December 31, 2016.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A")

OVERVIEW

We are one of the nation's leading diversified health care benefits companies, serving an estimated 37.9 million people. We have the information and resources to help our members, in consultation with their health care professionals, make better informed decisions about their health care. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, medical management capabilities, Medicaid health care management services, Medicare Advantage and Medicare Supplement plans, workers' compensation administrative services and health information technology ("HIT") products and services. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions.

On December 3, 2017, we entered into a definitive agreement to be acquired by CVS Health Corporation ("CVS Health"). See "Significant Transactions - Proposed Acquisition by CVS Health" below. On November 1, 2017, we sold our domestic group life insurance, group disability insurance and absence management businesses to Hartford Life and Accident Insurance Company ("HLAIC"). See "Significant Transactions - Divestiture of Domestic Group Life Insurance, Group Disability Insurance, and Absence Management Businesses" below.

Effective for the first quarter of 2018, we will realign our business segments to correspond with changes to our management structure and internal management reporting which reflect our evolving business strategy of helping our members live healthier lives. Refer to "Segment Results and Use of Non-GAAP Measures in this Document" for further discussion.

The following MD&A provides a review of our financial condition at December 31, 2017 and December 31, 2016 and operating results for the years ended December 31, 2017, 2016 and 2015. This Overview should be read in conjunction with the entire MD&A, which contains detailed information that is important to understanding our operating results and financial condition, the consolidated financial statements and other data presented in this Annual Report on Form 10-K. This Overview is qualified in its entirety by the full MD&A.

Summarized Results

				Change			
				2017 vs. 2016		2016 vs. 2015	
(Millions, except total medical membership)	2017	2016	2015	$	%	$	%
Total revenue	**$ 60,535**	$ 63,155	$ 60,337	$ (2,620)	(4)%	$ 2,818	5 %
Net income attributable to Aetna	**1,904**	2,271	2,390	(367)	(16)%	(119)	(5)%
Adjusted earnings [1]	**3,309**	2,917	2,717	392	13 %	200	7 %

A reconciliation of net income attributable to Aetna to adjusted earnings [1] for the years ended 2017, 2016, and 2015 follows:

(Millions)	2017	2016	2015
Net income attributable to Aetna (GAAP measure)	**$ 1,904**	$ 2,271	$ 2,390
Gain related to sale of certain domestic group insurance businesses	**(88)**	—	—
Loss on early extinguishment of long-term debt	**246**	—	—
Penn Treaty-related guaranty fund assessments	**231**	—	—
Transaction and integration-related costs	**1,240**	517	258
Restructuring costs	**60**	404	15
Reduction of reserve for anticipated future losses on discontinued products	**(109)**	(128)	—
Litigation related proceeds	**—**	—	(110)
Amortization of other acquired intangible assets	**272**	247	255
Net realized capital losses (gains)	**239**	(86)	65
Income tax benefit [2]	**(686)**	(308)	(156)
Adjusted earnings [1]	**$ 3,309**	$ 2,917	$ 2,717

(1) Adjusted earnings excludes from net income attributable to Aetna net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 " Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K. In addition, adjusted earnings excludes from net income attributable to Aetna the corresponding tax benefit or expense related to the items excluded from adjusted earnings discussed above. The tax benefit or expense was calculated utilizing the appropriate tax rate for each individual item excluded from adjusted earnings.

(2) In addition to the tax benefit or expense associated with each line item excluded from adjusted earnings, the year ended December 31, 2017 includes an incremental tax expense of $99 million which reflects the estimated impact of the enactment of the Tax Cuts and Jobs Act of 2017 (the "TCJA") on December 22, 2017. Among other things, the TCJA reduced the federal corporate income tax rate to 21 percent effective January 1, 2018. Accordingly, we remeasured our deferred tax assets and liabilities as of the enactment date to reflect the lower tax rate and recognized the resulting change in our income tax expense from continuing operations.

Effective March 31, 2017, to more clearly differentiate between the GAAP and non-GAAP financial measures used in our reports filed with or furnished to the Securities and Exchange Commission and our other disclosures, we changed the naming convention for our non-GAAP financial measures from "operating" measures to "adjusted" measures. The underlying calculations of our consolidated non-GAAP financial measures did not change. Our discussion of consolidated operating results is based on adjusted earnings, which is a non-GAAP measure of net income attributable to Aetna (the term "GAAP" refers to U.S. generally accepted accounting principles). Effective March 31, 2017, we began recording income taxes in our Corporate Financing segment and are no longer allocating income taxes to our business segments. Accordingly, our discussion of operating results for our reportable business segments is based on pre-tax adjusted earnings which is a non-GAAP measure of income before income taxes attributable to Aetna. Also effective March 31, 2017, transaction and integration-related costs and restructuring costs were reclassified to our Corporate Financing segment. Prior periods have been restated to reflect this presentation. Non-GAAP financial measures we disclose, such as adjusted earnings and pre-tax adjusted earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. Refer to "Segment Results and Use of Non-GAAP Measures in this Document" for a discussion of non-GAAP measures.

Commentary - Overview

Our results for the year ended December 31, 2017 include several items that impact comparability with results in prior periods, including:

- Costs associated with the termination of the Humana Merger Agreement (as defined below) during the first quarter of 2017. In addition, we incurred transaction and integration-related costs related to the Humana Transaction (as defined below) during the years ended December 31, 2015 and 2016 that did not recur during the year ended December 31, 2017 due to the termination of the Humana Merger Agreement in the first quarter of 2017.
- Reduced participation on the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") individual public health insurance exchanges in 2017.
- The temporary suspension of the ACA's health insurer fee (the "HIF") for 2017. Pricing actions designed to recover the HIF and other ACA-mandated fees represented approximately three percent of our Health Care premiums in 2016 and 2015.
- The Group Insurance sale (as defined below) on November 1, 2017.

Commentary - 2017 compared to 2016

- *Net income attributable to Aetna* decreased $367 million in 2017 compared to 2016 primarily due to costs associated with the termination of the Humana Merger Agreement during first-quarter 2017, partially offset by the increase in adjusted earnings described below.
- *Adjusted earnings* increased $392 million in 2017 compared to 2016, primarily due to strong performance in our Health Care segment.
- *Total revenue* decreased approximately $2.6 billion during 2017 compared to 2016, primarily due to lower premiums in our Health Care segment, including lower membership in our ACA compliant individual and small group products and the temporary suspension of the HIF for 2017. The Group Insurance sale on November 1, 2017 also contributed to the decrease in total revenue.
- *Our effective tax rate* was 36.3 percent in 2017 compared to 43.5 percent in 2016. Results for the year ended December 31, 2017 include an incremental tax expense of $99 million related to the estimated reduction in net deferred tax assets as a result of the enactment of the TCJA in December 2017. The decrease in our effective tax rate for 2017 was primarily due to the temporary suspension of the non-deductible HIF for 2017 and increased tax benefits for share-based compensation, largely offset by the unfavorable impact of the TCJA described above. Excluding the impact of the TCJA, our effective tax rate was 33.0 percent in 2017.

Commentary - 2016 compared to 2015

- *Net income attributable to Aetna* decreased $119 million in 2016 compared to 2015 primarily due to an increase in restructuring costs which include a $215 million ($330 million pre-tax) expense recorded during 2016 related to our previously announced voluntary early retirement program, higher transaction and integration-related costs and the favorable impact of litigation-related proceeds recorded during 2015. The decrease was partially offset by the increase in adjusted earnings described below, net realized capital gains during 2016 compared with net realized capital losses during 2015 and the favorable impact of the 2016 reduction of our reserve for anticipated future losses on discontinued products.
- *Adjusted earnings* increased $200 million in 2016 compared to 2015 primarily as a result of higher fees and other revenue in our Health Care segment.
- *Total revenue* increased $2.8 billion in 2016 compared to 2015 primarily due to higher premiums in our Health Care segment.
- *Our effective tax rate* was 43.5 percent in both 2016 and 2015.

Outlook for 2018

In 2018, we project the following challenges will impact our total revenue:

- The sale of our domestic group life insurance, group disability insurance and absence management businesses;
- Our previously disclosed Medicaid contract exits;
- Our exit from individual Commercial products;
- Our continued repositioning of our ACA-compliant small group Commercial products; and
- The suspension of the HIF for 2019 due to reduced premiums for 2018 medical customer renewals that have member months in 2019.

In addition to the total revenue challenges described above which we project will pressure our ability to grow net income and adjusted earnings in 2018, we project earnings growth also will be pressured by the timing of revenue and expense recognition related to the reintroduction of the industry wide, nondeductible HIF for 2018. We also expect that reintroduction to produce incremental experience rating pressure in our large group insured products.

We also see the following opportunities in 2018:

- The projected increase to our net income and adjusted earnings resulting from the reduced corporate income tax rate which became effective January 1, 2018 due to the TCJA;
- Our projected above-industry growth in individual Medicare Advantage products and strong growth in group Medicare Advantage products;
- The reduction of losses from exiting individual Commercial products in 2018; and
- Our ability to achieve expense efficiencies as we continue to simplify our processes and drive for best-in-class business performance.

Refer to "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K for information regarding other important risk factors that may cause our actual results to differ from those currently projected and/or otherwise materially affect us.

Significant Transactions

Proposed Acquisition by CVS Health

On December 3, 2017, we entered into a definitive agreement (the "CVS Merger Agreement") under which CVS Health will acquire all of our outstanding shares for a combination of cash and stock. Under terms of the agreement, our shareholders will receive $145 in cash and 0.8378 of a CVS Health common share for each of our common shares. The proposed transaction (the "CVS Health Transaction") is subject to customary closing conditions, including the approval and adoption of the CVS Merger Agreement by our shareholders, the approval of the issuance of CVS Health shares in the transaction by CVS Health stockholders, expiration of the federal Hart-Scott-Rodino anti-trust waiting period and approvals of certain state departments of insurance and other regulators. On February 1, 2018, Aetna and CVS Health each received a request for additional information (also known as a "second request") from the U.S. Department of Justice (the "DOJ") in connection with the DOJ's review of the transactions contemplated by the CVS Merger Agreement. The CVS Health Transaction is expected to close in the second half of 2018.

Divestiture of Domestic Group Life Insurance, Group Disability Insurance, and Absence Management Businesses

On November 1, 2017, we completed the sale of a substantial portion of our Group Insurance segment consisting of our domestic group life insurance, group disability insurance and absence management businesses (the "Group Insurance sale") to HLAIC for cash consideration of $1.45 billion. The transaction was accomplished through an indemnity reinsurance arrangement under which HLAIC contractually assumed certain of our policyholder liabilities and obligations, although we remain directly obligated to policyholders. Assets related to and supporting the reinsured life and disability insurance policies were transferred to a trust established by HLAIC for our benefit, and we recorded a reinsurance receivable from HLAIC. The sale is expected to result in an after-tax gain of approximately $710 million ($1.1 billion pre-tax), a significant portion of which has been deferred and will be amortized into earnings: (i) over the remaining contract period (estimated to be approximately 3 years) in proportion to the amount of insurance protection provided for the prospective reinsurance portion of the gain; and (ii) as we recover amounts due from HLAIC over a period estimated to be approximately 30 years for the retrospective reinsurance portion of the gain.

Terminated Acquisition of Humana and Terminated Divestiture to Molina

On July 2, 2015, we entered into a definitive agreement (the "Humana Merger Agreement") to acquire Humana Inc. ("Humana"). On July 21, 2016, the DOJ and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that our acquisition of Humana (the "Humana Transaction") would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Transaction.

On February 14, 2017, Aetna and Humana entered into a mutual termination agreement (the "Termination Agreement") pursuant to which the parties thereto (collectively, the "Parties") agreed to terminate the Humana Merger Agreement, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby, entered pursuant thereto or entered in connection therewith (other than certain confidentiality agreements) (collectively with the Humana Merger Agreement, the "Transaction Documents"), effective immediately as of February 14, 2017 (the "Termination Date"). Under the Termination Agreement, Aetna agreed to pay Humana the Regulatory Termination Fee (as defined in the Humana Merger Agreement) of $1.0 billion in cash in full satisfaction of any amounts required to be paid by Aetna under the Humana Merger Agreement. The Parties also agreed to release each other from any and all liability, claims, rights, actions, causes of action, suits, liens, obligations, accounts, debts, demands, agreements, promises, liabilities, controversies, costs, charges, damages, expenses and fees, however arising, in connection with, arising out of or related to the Transaction Documents, the transactions contemplated therein or thereby or certain related matters. We paid Humana the Regulatory Termination Fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes (as defined below).

In June 2016, we issued $13.0 billion of senior notes to partially fund the Humana Transaction (collectively, the "2016 senior notes"). In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for $10.2 billion aggregate principal amount of certain of the 2016 senior notes (collectively, the "Special Mandatory Redemption Notes") at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We redeemed the Special Mandatory Redemption Notes on March 16, 2017, and we funded the redemption with the proceeds of the 2016 senior notes. As a result of the redemption of the Special Mandatory Redemption Notes, we recognized on a pretax basis in our net income during the year ended December 31, 2017 a loss on early extinguishment of long-term debt of $192 million and a realized capital loss for the remaining unamortized effective portion of the related hedge loss of $323 million that was previously recorded in accumulated other comprehensive income.

In order to address the DOJ's perceived competitive concerns regarding Medicare Advantage relating to the Humana Transaction, on August 2, 2016, we entered into a definitive agreement (the "Aetna APA") to sell for cash to Molina Healthcare, Inc. ("Molina") certain of our Medicare Advantage assets. On February 14, 2017, Aetna and Molina entered into a Termination Agreement (the "APA Termination Agreement") pursuant to which Aetna terminated the Aetna APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, Aetna agreed to pay Molina in cash (a) a termination fee of $53 million and (b) approximately 70% of Molina's transaction costs. We paid Molina the termination fee on February 16, 2017 and the applicable transaction costs of $7 million on February 27, 2017 and recorded the expense in general and administrative expenses. The payments were funded with the proceeds of the 2016 senior notes.

Refer to Notes 3 "Acquisition, Divestiture, Terminated Acquisition and Terminated Divestiture" and 9 "Debt" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the Humana Transaction.

Health Care Reform

The ACA has made broad-based changes to the U.S. health care system. We anticipate continued efforts in 2018 and beyond to modify, repeal or replace the ACA, and the future of the ACA is uncertain. We expect aspects of the ACA and/or their implementation or enforcement, including the January 2018 suspension of the HIF for 2019, and uncertainty about the future of the ACA to continue to significantly impact our business operations and operating results, including our pricing and our medical benefit ratios ("MBRs").

During the years ended December 31, 2017, 2016 and 2015, we paid the following fees and contributions required by the ACA:

(Millions)	2017	2016	2015
Current year HIF	$ —	$ 837	$ 856
Estimated current year ACA reinsurance contribution	—	114	185
Remaining portion of prior year ACA reinsurance contribution	28	62	60

In December 2015, the Consolidated Appropriation Act was enacted, which included a one year suspension of the HIF for 2017. As 2016 was the last program year for the ACA's reinsurance program, we did not pay any reinsurance contribution fees in 2017. In January 2018, the HIF was suspended for 2019.

In October 2017, the federal government announced that the Centers for Medicare & Medicaid Services ("CMS") will curtail payments related to the Cost-Sharing Subsidy program. While the details regarding implementation of this new policy are not yet finalized, and it is the subject of pending litigation, we do not anticipate a material impact to our financial statements as a result of this action.

The federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system. We cannot predict whether pending or future federal or state legislative or regulatory activity or court proceedings, including Federal budget negotiations and future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or the ACA or the implementation and/or enforcement of the ACA or the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

For additional information on federal and state health care reform, including the ACA, refer to "Regulatory Environment" below in this MD&A and Notes 2 "Summary of Significant Accounting Policies" and 8 "The ACA's Reinsurance, Risk Adjustment and Risk Corridor Programs (the "3Rs")" included in Part II, Item 8 of this Annual Report on Form 10-K. For a discussion of certain factors that may cause our actual results to differ from currently anticipated results in connection with health care reform, refer to "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K.

Medicare Update
On April 3, 2017, CMS issued its final notice detailing final 2018 Medicare Advantage benchmark payment rates (the "Final Notice"). Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of coding trend, by less than one percent in 2018 compared to 2017.

The ACA ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Beginning in 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released our 2018 star ratings in October 2017. Our 2018 star ratings will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2019. Based on our membership at December 31, 2017, 87% of our Medicare Advantage members were in plans with 2018 star ratings of at least 4.0 stars, compared to 92% of our Medicare Advantage members being in plans with 2017 star ratings of at least 4.0 stars based on our membership at December 31, 2016.

During 2017, our star ratings resulted in additional revenue of approximately $760 million, inclusive of bonus payments and rebates.

Management Update
On January 25, 2018, Aetna announced that Gary W. Loveman, Ph.D., Aetna's Executive Vice President, Consumer Health and Services, would be leaving the Company. Mr. Loveman's last day of employment with the Company was February 20, 2018.

Effective November 1, 2017, Heather Dixon was appointed Vice President, Controller and Chief Accounting Officer of Aetna. Ms. Dixon succeeded Sharon A. Virag when Ms. Virag left the Company effective November 1, 2017.

Segment Results and Use of Non-GAAP Measures in this Document
The following discussion of operating results is presented based on our reportable segments in accordance with the accounting guidance for segment reporting and is consistent with our segment disclosure included in Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment; it is added to our business segments to reconcile our segment reporting to our consolidated results. The Corporate Financing segment includes transaction and integration-related costs, restructuring costs, income taxes, interest expense on our outstanding debt and the financing components of our pension and other postretirement employee benefit plans ("OPEB") expense (the service cost and prior service cost components of this expense are allocated to our business segments).

Effective for the first quarter of 2018, we will realign our business segments to correspond with changes to our management structure and internal management reporting which reflect our evolving business strategy of helping our members live healthier lives. As a result of this realignment, our operations will now be conducted in the Health Care reportable segment. Health Care offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services to large and small employers, public sector employers, and Medicaid and Medicare beneficiaries. Our Health Care products are offered on both an Insured basis and an employer-funded basis. Health Care also includes emerging business products and services that complement and enhance our medical products.

Effective for the first quarter of 2018, we will present the remainder of our financial results in the Corporate/Other category, which will consist of:

- Products for which we no longer solicit or accept new customers such as our large case pensions and long-term care products;
- Contracts we have divested through reinsurance or other contracts, such as our domestic group life insurance, group disability insurance and absence management businesses; and
- Corporate expenses not supporting business operations, including transaction and integration-related costs, income taxes, interest expense on our outstanding debt and the financing components of our pension and OPEB expense.

Pre-tax adjusted earnings and adjusted earnings discussed in this Annual Report on Form 10-K exclude from income before income taxes attributable to Aetna and net income attributable to Aetna reported in accordance with GAAP net realized capital gains or losses, amortization of other acquired intangible assets and other items, if any, that neither relate to the ordinary course of our business nor reflect our underlying business performance. Although the excluded items may recur, we believe excluding them from income before income taxes attributable to Aetna and net income attributable to Aetna to arrive at pre-tax adjusted earnings and adjusted earnings provides a more useful comparison of our underlying business performance from period to period. Net realized capital gains and losses arise from various types of transactions, primarily in the course of managing a

portfolio of assets that support the payment of liabilities. Amortization of other acquired intangible assets relates to our acquisition activities. These transactions and amortization do not directly relate to the underwriting or servicing of products for our customers and are not directly related to the core performance of our business operations. Pre-tax adjusted earnings is the measure reported to our chief executive officer for purposes of assessing business segment financial performance and making operating decisions, such as the allocation of resources among our business segments. In each business segment discussion in this MD&A, we provide a table that reconciles income before income taxes attributable to Aetna to pre-tax adjusted earnings. Each table details the net realized capital gains or losses, amortization of other acquired intangible assets and any other items excluded from income before income taxes attributable to Aetna, and the footnotes to each table describe the nature of each other item and the reason we believe it is appropriate to exclude that item from income before income taxes attributable to Aetna. Non-GAAP financial measures we disclose, such as pre-tax adjusted earnings and adjusted earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

HEALTH CARE

Health Care consists of medical, pharmacy benefit management services, dental, behavioral health and vision plans offered on both an Insured basis (where we assume all or a majority of the risk for medical and dental care costs) and an employer-funded basis (where the plan sponsor under an administrative services contract ("ASC") assumes all or a majority of this risk) and emerging businesses products and services that complement and enhance our medical products. We also offer Medicare and Medicaid products and services and other medical products, such as medical management and data analytics services, medical stop loss insurance, workers' compensation administrative services and products that provide access to our provider networks in select geographies. We separately track premiums and health care costs for Government businesses (which represent our combined Medicare and Medicaid products). All other medical, dental and other Health Care products are referred to as Commercial. We no longer sell individual Commercial products, and we exited the individual Public Exchanges in 2018.

Operating Summary

				Change			
				2017 vs. 2016		2016 vs. 2015	
(Millions)	**2017**	**2016**	**2015**	**$**	%	**$**	**%**
Premiums:							
Commercial	**$ 24,548**	$ 27,916	$ 28,709	$ (3,368)	(12)%	$ (793)	(3)%
Government	**27,474**	26,200	22,909	1,274	5 %	3,291	14 %
Total premiums	**52,022**	54,116	51,618	(2,094)	(4)%	2,498	5 %
Fees and other revenue	**5,749**	5,744	5,585	5	— %	159	3 %
Net investment income	**476**	435	408	41	9 %	27	7 %
Net realized capital gains (losses)	**55**	52	(50)	3	6 %	102	204 %
Total revenue	**58,302**	60,347	57,561	(2,045)	(3)%	2,786	5 %
Health care costs:							
Commercial	**19,952**	22,896	23,057	(2,944)	(13)%	(161)	(1)%
Government	**22,801**	21,359	18,655	1,442	7 %	2,704	14 %
Total health care costs	**42,753**	44,255	41,712	(1,502)	(3)%	2,543	6 %
Operating expenses:							
Selling expenses	**1,479**	1,545	1,490	(66)	(4)%	55	4 %
General and administrative expenses	**9,050**	9,442	9,543	(392)	(4)%	(101)	(1)%
Total operating expenses	**10,529**	10,987	11,033	(458)	(4)%	(46)	— %
Amortization of other acquired intangible assets	**272**	247	255	25	10 %	(8)	(3)%
Total benefits and expenses	**53,554**	55,489	53,000	(1,935)	(3)%	2,489	5 %
Income before income taxes including non-controlling interests	**4,748**	4,858	4,561	(110)	(2)%	297	7 %
Less: (Loss) income before income taxes attributable to non-controlling interests	**(11)**	(20)	5	9	45 %	(25)	(500)%
Income before income taxes attributable to Aetna for Health Care	**$ 4,759**	$ 4,878	$ 4,556	$ (119)	(2)%	$ 322	7 %

We calculate our MBRs by dividing health care costs by health care premiums. Our Commercial, Government and Total Health Care MBRs for the last three years were:

				Change (basis points)	
	2017	2016	2015	2017 vs. 2016	2016 vs. 2015
Commercial	**81.3%**	82.0%	80.3%	(70)	170
Government	**83.0%**	81.5%	81.4%	150	10
Total Health Care	**82.2%**	81.8%	80.8%	40	100

The table presented below reconciles income before income taxes to pre-tax adjusted earnings [1] for our Health Care segment:

(Millions)	2017	2016	2015
Income before income taxes for Health Care (GAAP measure)	4,748	4,858	4,561
Less: (Loss) income before income taxes attributable to non-controlling interests (GAAP measure)	(11)	(20)	5
Income before income taxes attributable to Aetna for Health Care (GAAP measure)	4,759	4,878	4,556
Penn Treaty-related guaranty fund assessments	231	—	—
Litigation-related proceeds	—	—	(110)
Amortization of other acquired intangible assets	272	247	255
Net realized capital (gains) losses	(55)	(52)	50
Pre-tax adjusted earnings for Health Care	5,207	5,073	4,751

[1] Pre-tax adjusted earnings excludes net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K.

Commentary - 2017 compared to 2016

- *Income before income taxes attributable to Aetna for Health Care* decreased $119 million in 2017 compared to 2016, primarily due to a $231 million pre-tax expense related to estimated future guaranty fund assessments as a result of Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") being placed in liquidation in 2017, partially offset by the increase in pre-tax adjusted earnings described below.
- *Pre-tax adjusted earnings for Health Care* increased by $134 million in 2017 compared to 2016, primarily due to continued strong performance across our core Health Care businesses and reduced losses in our individual Commercial products, partially offset by the negative impact of the temporary suspension of the HIF for 2017 and higher targeted investment spending on our growth initiatives.
- *Commercial premiums* decreased $3.4 billion in 2017 compared to 2016, primarily as a result of lower membership in our ACA compliant individual and small group products and the temporary suspension of the HIF for 2017, partially offset by higher premium yields.
- *Our Commercial MBR* decreased 70 basis points over the prior year. The decrease in our Commercial MBR is primarily due to reduced losses in our Individual Commercial products, partially offset by the unfavorable impact of the temporary suspension of the HIF for 2017.
- *Government premiums* increased $1.3 billion in 2017 compared to 2016 primarily due to membership growth in our Medicare products and higher premium yields, partially offset by the temporary suspension of the HIF for 2017 and membership declines in our Medicaid products.
- *Our Government MBR* increased 150 basis points year over year. The increase in our Government MBR is primarily due to the unfavorable impact of the temporary suspension of the HIF for 2017, partially offset by improved performance in our Medicaid products.
- *General and administrative expenses* decreased by $392 million during 2017 compared to 2016 primarily due to the temporary suspension of the HIF for 2017 and the continued execution of our expense management initiatives, largely offset by targeted investment spending on our growth initiatives and the expense recorded for estimated future guaranty fund assessments related to Penn Treaty.

Commentary - 2016 compared to 2015

- *Income before income taxes attributable to Aetna for Health Care* increased by $322 million in 2016 compared to 2015, primarily as a result of an increase in pre-tax adjusted earnings described below and net realized capital gains during 2016 compared with net realized capital losses during 2015, partially offset by the favorable impact of litigation-related proceeds recorded during 2015.
- *Pre-tax adjusted earnings* increased by $322 million in 2016 compared to 2015, primarily as a result of higher underwriting margins in our Government business, higher fees and other revenue primarily due to higher average fee yields and lower general and administrative expenses. The increase was partially offset by lower underwriting margins in Aetna's Commercial business.
- *Commercial premiums* were $793 million lower in 2016 than 2015, primarily as a result of membership losses in our Commercial Insured products, partially offset by higher premium yields.
- *Our Commercial MBR* increased 170 basis points over the prior year. The increase was primarily due to higher medical costs in our Individual Commercial products and performance in our Middle Market Commercial products.
- *Government premiums* were approximately $3.3 billion higher in 2016 compared to 2015 primarily due to membership growth in our Government business.
- Our *Government MBR* remained consistent in 2016 compared to 2015 reflecting higher MBRs in our Medicaid products and lower favorable development of prior-year health care cost estimates in 2016, offset by improved performance in our Medicare products.
- *Health Care fees and other revenue* for 2016 increased $159 million compared to 2015 primarily due to higher average fee yields in 2016, partially offset by the favorable impact of $110 million pretax of net litigation-related proceeds recorded in 2015.

Membership

Health Care's membership at December 31, 2017 and 2016 was:

	2017			2016			Change 2017 vs. 2016		
(Thousands)	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical:									
Commercial	**4,504**	**13,596**	**18,100**	5,457	13,132	18,589	(953)	464	(489)
Medicare Advantage	**1,473**	**—**	**1,473**	1,362	—	1,362	111	—	111
Medicare Supplement	**740**	**—**	**740**	685	—	685	55	—	55
Medicaid [1]	**1,316**	**608**	**1,924**	1,668	806	2,474	(352)	(198)	(550)
Total Medical Membership	**8,033**	**14,204**	**22,237**	9,172	13,938	23,110	(1,139)	266	(873)
Dental:									
Total Dental Membership	**5,421**	**8,006**	**13,427**	6,086	8,386	14,472	(665)	(380)	(1,045)
Pharmacy:									
Commercial			**8,034**			9,400			(1,366)
Medicare PDP (stand-alone)			**2,077**			2,067			10
Medicare Advantage PDP			**1,129**			953			176
Medicaid [1]			**2,525**			2,783			(258)
Total Pharmacy Benefit Management Services			**13,765**			15,203			(1,438)

[1] Medicaid membership includes members who are dually-eligible for both Medicare and Medicaid.

Commentary - 2017 compared to 2016

- *Total medical membership* at December 31, 2017 decreased 873 thousand members compared to December 31, 2016, primarily reflecting declines in our Insured ACA compliant individual and small group products and our Insured and ASC Medicaid products. The decrease was partially offset by increases in our Commercial ASC, International Commercial Insured and Medicare Insured products.

- *Total dental membership* at December 31, 2017 decreased 1.0 million members compared to December 31, 2016 due to declines in our Insured and ASC dental products.
- *Total pharmacy benefit management services membership* decreased 1.4 million at December 31, 2017 compared to December 31, 2016 primarily reflecting declines in our Commercial business, primarily attributable to our ACA compliant individual and small group products, and declines in our Medicaid products.

GROUP INSURANCE

Group Insurance primarily includes group life insurance and group disability products. Group life insurance products are offered on an Insured basis. Group disability products are offered to employers on both an Insured and an ASC basis. Group Insurance also includes long-term care products that were offered primarily on an Insured basis. We no longer solicit or accept new long-term care customers. On November 1, 2017, we sold a substantial portion of our Group Insurance business segment consisting of our domestic group life insurance, group disability insurance, and absence management business to HLAIC.

Operating Summary

				Change			
				2017 vs. 2016		2016 vs. 2015	
(Millions)	2017	2016	2015	$	%	$	%
Premiums:							
Life	**$ 977**	$ 1,142	$ 1,216	$ (165)	(14)%	$ (74)	(6)%
Disability	**799**	957	879	(158)	(17)%	78	9 %
Long-term care	**43**	44	44	(1)	(2)%	—	— %
Total premiums	**1,819**	2,143	2,139	(324)	(15)%	4	— %
Fees and other revenue	**173**	108	101	65	60 %	7	7 %
Net investment income	**210**	226	238	(16)	(7)%	(12)	(5)%
Net realized capital gains	**35**	24	—	11	46 %	24	100 %
Total revenue	**2,237**	2,501	2,478	(264)	(11)%	23	1 %
Current and future benefits	**1,588**	1,850	1,837	(262)	(14)%	13	1 %
Operating expenses:							
Selling expenses	**119**	133	121	(14)	(11)%	12	10 %
General and administrative expenses	**282**	353	346	(71)	(20)%	7	2 %
Total operating expenses	**401**	486	467	(85)	(17)%	19	4 %
Total benefits and expenses	**1,989**	2,336	2,304	(347)	(15)%	32	1 %
Income before income taxes attributable to Aetna for Group Insurance	**$ 248**	$ 165	$ 174	$ 83	50 %	$ (9)	(5)%

We calculate our group benefit ratio by dividing current and future benefits by total premiums. Our group benefit ratios for the last three years were:

				Change (basis points)	
				2017 vs. 2016	2016 vs. 2015
	2017	2016	2015		
Group benefit ratio	**87.3%**	86.3%	85.9%	100	40

The table presented below reconciles income before income taxes to pre-tax adjusted earnings [(1)] for our Group Insurance segment:

(Millions)	2017	2016	2015
Income before income taxes attributable to Aetna for Group Insurance (GAAP measure)	**$ 248**	$ 165	$ 174
Gain related to divestiture of domestic group insurance business	**(88)**	—	—
Net realized capital gains	**(35)**	(24)	—
Pre-tax adjusted earnings for Group Insurance	**$ 125**	$ 141	$ 174

(1) Pre-tax adjusted earnings excludes net realized capital gains and losses and the other items described in the reconciliation in Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K.

Commentary - 2017 compared to 2016

- *Income before income taxes attributable to Aetna for Group Insurance* for 2017 increased by $83 million compared to 2016, primarily due to the recognition of a portion of the gain related to the Group Insurance sale in 2017.
- P*re-tax adjusted earnings for Group Insurance* for 2017 declined by $16 million compared to 2016, primarily as a result of the Group Insurance sale during 2017.
- *Total revenue* for 2017 decreased $264 million compared to 2016 primarily due to lower premiums as a result of the Group Insurance sale during 2017, partially offset by the recognition of a portion of the gain related to the Group Insurance sale in 2017.
- *Our group benefit ratio* increased by 100 basis points in 2017 over the prior year, primarily due to lower underwriting margins in our life products.

Commentary - 2016 compared to 2015

- *Income before income taxes attributable to Aetna for Group Insurance* for 2016 declined by $9 million compared to 2015 primarily due to the decrease in pre-tax adjusted earnings described below, partially offset by higher net realized capital gains in 2016 compared to 2015.
- *Pre-tax adjusted earnings* for 2016 declined by $33 million compared to 2015, primarily due to lower underwriting margins (calculated as premiums less current and future benefits) in our disability products and higher operating expenses, partially offset by improved underwriting margins in our long-term care products.
- *Total revenue* for 2016 increased $23 million compared to 2015 primarily due to higher premiums in our disability products and higher net realized capital gains in 2016 compared to 2015, partially offset by lower premiums in our life products and lower net investment income in 2016 compared to 2015.
- *Our group benefit ratio* increased by 40 basis points in 2016 over the prior year, primarily due to lower underwriting margins in our disability products, partially offset by improved underwriting margins in our long-term care products.

LARGE CASE PENSIONS

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. These products provide a variety of funding and benefit payment distribution options and other services. The Large Case Pensions segment also includes certain discontinued products.

Operating Summary

				Change			
				2017 vs. 2016		2016 vs. 2015	
(Millions)	**2017**	**2016**	**2015**	**$**	%	**$**	**%**
Premiums	**$ 53**	$ 39	$ 32	$ 14	36 %	$ 7	22 %
Other revenue	**8**	9	10	(1)	(11)%	(1)	(10)%
Net investment income	**253**	226	271	27	12 %	(45)	(17)%
Net realized capital gains (losses)	**7**	10	(15)	(3)	(30)%	25	167 %
Total revenue	**321**	284	298	37	13 %	(14)	(5)%
Current and future benefits	**287**	251	284	36	14 %	(33)	(12)%
General and administrative expenses	**11**	13	13	(2)	(15)%	—	— %
Reduction of reserve for anticipated future losses on discontinued products	**(109)**	(128)	—	19	15 %	(128)	(100)%
Total benefits and expenses	**189**	136	297	53	39 %	(161)	(54)%
Income before income taxes including non-controlling interests	**$ 132**	$ 148	$ 1	(16)	(11)%	147	14,700 %
Less: Income before income taxes attributable to non-controlling interests	**$ 1**	$ —	$ 2	1	100 %	(2)	(100)%
Income (loss) before income taxes attributable to Aetna for Large Case Pensions	**$ 131**	$ 148	$ (1)	$ (17)	(11)%	$ 149	14,900 %

The table presented below reconciles income before income taxes to pre-tax adjusted earnings [1] for our Large Case Pensions segment:

(Millions)	2017	2016	2015
Income before income taxes for Large Case Pensions (GAAP measure)	**$ 132**	$ 148	$ 1
Less: Income before incomes taxes attributable to non-controlling interests (GAAP measure)	**1**	—	2
Income (loss) before income taxes attributable to Aetna for Large Case Pensions (GAAP measure)	**131**	148	(1)
Net realized capital (gains) losses	**(7)**	(10)	15
Reduction of reserve for anticipated future losses on discontinued products	**(109)**	(128)	—
Pre-tax adjusted earnings for Large Case Pensions	**$ 15**	$ 10	$ 14

[1] Pre-tax adjusted earnings excludes net realized capital gains and losses and the other items described in the reconciliation in Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K.

Commentary - 2017 compared to 2016

- *Income before income taxes attributable to Aetna for Large Case Pensions* for 2017 decreased by $17 million compared to 2016. The decrease was primarily due to a smaller reduction of our reserve for anticipated future losses on discontinued products in 2017 compared to 2016.
- *Pre-tax adjusted earnings for Large Case Pensions* increased by $5 million for 2017 compared to 2016, primarily due to improved results in our non-experience-rated products, including favorable mortality experience and higher net investment income.
- *Total revenue* increased by $37 million in 2017 compared to 2016, primarily as a result of higher net investment income and higher premiums in 2017.

Commentary - 2016 compared to 2015

- *Income before income taxes attributable to Aetna for Large Case Pensions* for 2016 increased by $149 million compared to 2015. The increase was primarily due to the 2016 reduction of our reserve for anticipated future losses on discontinued products, which was primarily due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve.
- *Pre-tax adjusted earnings for Large Case Pensions* decreased by $4 million for 2016 compared to 2015, primarily due to lower net investment income and lower fees in 2016 compared to 2015.
- *Total revenue* decreased by $14 million in 2016 compared to 2015, primarily as a result of lower net investment income, partially offset by net realized capital gains during 2016 compared with net realized capital losses during 2015.

Discontinued Products

Prior to 1993, we sold single-premium annuities ("SPAs") and guaranteed investment contracts ("GICs"), primarily to employer sponsored pension plans. In 1993, we discontinued selling these products to Large Case Pensions customers, and now we refer to these products as discontinued products. In November 2016, the last outstanding GIC matured. We discontinued selling these products because they were generating losses for us, and we projected that they would continue to generate losses over their life (which is currently greater than 30 years for SPAs); so we established a reserve for anticipated future losses at the time of discontinuance.

The operating summary for Large Case Pensions above includes revenues and expenses related to our discontinued products, with the exception of net realized capital gains and losses which are recorded as part of current and future benefits. Since we established a reserve for anticipated future losses on discontinued products, as long as our expected future losses remain consistent with prior projections, the results of our discontinued products are applied against the reserve and do not impact net income attributable to Aetna. If actual or expected future losses are greater than we currently estimate, we may increase the reserve, which could adversely impact net income attributable to Aetna. If actual or expected future losses are less than we currently estimate, we may decrease the reserve, which could favorably impact net income attributable to Aetna. In those cases, we disclose such adjustment separately in the operating summary. Management reviews the adequacy of the discontinued products reserve quarterly. As a result of this review, we released $71 million ($109 million pretax) and $84 million ($128 million pretax) of the reserve in the years ended December 31, 2017 and 2016, respectively. No releases were made to the reserve in 2015. The reserve release during the year ended December 31, 2017 was primarily due to favorable mortality experience compared to assumptions we previously made in estimating the reserve. The reserve release in the years

ended December 31, 2017 and 2016 also was due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve. The current reserve reflects management's best estimate of anticipated future losses and is included in future policy benefits on our Consolidated Balance Sheets.

Refer to Note 19 "Discontinued Products" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the activity in the reserve for anticipated future losses on discontinued products during 2017, 2016 and 2015.

LIQUIDITY AND CAPITAL RESOURCES

Cash Flows

We meet our operating cash requirements by maintaining liquidity in our investment portfolio, using overall cash flows from premiums, fees and other revenue, deposits and income received on investments, issuing commercial paper, entering into repurchase agreements and obtaining cash advances from the Federal Home Loan Bank of Boston (the "FHLBB") from time to time. We monitor the duration of our investment portfolio of highly marketable debt securities and mortgage loans, and execute purchases and sales of these investments with the objective of having adequate funds available to satisfy our maturing liabilities. Overall cash flows are used primarily for claim and benefit payments, operating expenses, share and debt repurchases, repayment of debt, acquisitions, contract withdrawals and shareholder dividends. We have committed short-term borrowing capacity of $2.0 billion through a revolving credit facility agreement that expires in March 2021.

Presented below is a condensed statement of cash flows for each of the last three years. We present net cash flows used for operating activities and net cash flows provided by investing activities separately for our Large Case Pensions segment because changes in the insurance reserves for the Large Case Pensions segment (which are reported as cash used for operating activities) are funded from the sale of investments (which are reported as cash provided by investing activities). Refer to the Consolidated Statements of Cash Flows included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

				Change			
				2017 vs. 2016		2016 vs. 2015	
(Millions)	2017	2016	2015	$	%	$	%
Cash flows from operating activities							
Health Care and Group Insurance	**$ (178)**	$ 3,988	$ 4,388	$ (4,166)	(104)%	$ (400)	(9)%
Large Case Pensions	**(286)**	(269)	(522)	(17)	(6)%	253	48 %
Net cash (used for) provided by operating activities	**(464)**	3,719	3,866	(4,183)	(112)%	(147)	(4)%
Cash flows from investing activities							
Health Care and Group Insurance	**2,436**	(628)	(1,663)	3,064	488 %	1,035	62 %
Large Case Pensions	**294**	247	636	47	19 %	(389)	(61)%
Net cash provided by (used for) investing activities	**2,730**	(381)	(1,027)	3,111	817 %	646	63 %
Net cash (used for) provided by financing activities	**(16,186)**	12,134	(1,735)	(28,320)	(233)%	13,869	799 %
Net (decrease) increase in cash and cash equivalents	**$ (13,920)**	$ 15,472	$ 1,104	$ (29,392)	(190)%	$ 14,368	1,301 %

Commentary - 2017 compared to 2016

- *Cash flows used for operating activities for Health Care and Group Insurance* were $178 million during 2017 compared to cash flow provided by operating activities of $4.0 billion 2016. The decrease was primarily due to cash payments associated with the termination of the Humana Merger Agreement, the timing of cash collections in our Medicare products and a tax payment associated with the Group Insurance sale.
- *Cash flows provided by investing activities* increased $3.1 billion in 2017 compared to 2016 primarily due to net sales and maturities of investments and proceeds received from the Group Insurance sale during 2017 compared with net purchases of investments during 2016.

- *Cash flows used for financing activities* were $16.2 billion for 2017 compared with cash flows provided by financing activities of $12.1 billion for 2016. The activity for 2017 reflects the repayment of long-term debt (including the $10.2 billion principal amount Special Mandatory Redemption Notes), share repurchases, the issuance of long-term debt and dividends paid to shareholders. The activity for 2016 reflects the issuance of long-term debt, net payment on interest rate derivatives and dividends paid to shareholders.

Commentary - 2016 compared to 2015

- *Cash flows provided by operating activities for Health Care and Group Insurance* decreased $400 million during 2016 compared to 2015 primarily due to a smaller increase in our health care costs payable liability in 2016 compared with 2015 and decreased operating performance primarily due to higher transaction and integration-related costs, partially offset by the timing of collections of premium receivables.
- *Cash flows used for investing activities* decreased $646 million in 2016 compared to 2015 primarily due to lower net purchases of investments in 2016.
- *Cash flows used for financing activities* increased approximately $13.9 billion in 2016 compared to 2015 primarily due to the issuance of the 2016 senior notes. The increase is also driven by the repayment of debt, settlement of repurchase agreements and repurchases of common shares that occurred in 2015 and did not recur in 2016, partially offset by higher net repayment on interest rate derivatives in 2016.

Refer to Notes 9 "Debt" and 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information about debt issuances, debt repayments, share repurchases and dividend payments.

Termination of Humana Merger Agreement and Aetna APA
As a result of the termination of the Humana Merger Agreement, we paid Humana the applicable $1.0 billion Regulatory Termination Fee on February 16, 2017. As a result of the APA Termination Agreement, we paid Molina the applicable termination fee of $53 million on February 16, 2017 and paid Molina the applicable transaction costs of $7 million on February 27, 2017. We funded these payments with the proceeds of the 2016 senior notes.

2016 Senior Notes
In June 2016, we issued $13 billion of 2016 senior notes. In accordance with the terms of the 2016 senior notes, on February 14, 2017, following the termination of the Humana Merger Agreement, we issued a notice of redemption for the entire $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We redeemed the Special Mandatory Redemption Notes on March 16, 2017, and we funded the redemption with the proceeds of the 2016 senior notes. As a result of the redemption of the Special Mandatory Redemption Notes, we recognized on a pretax basis in our net income during 2017 a loss on early extinguishment of long-term debt of $192 million and a realized capital loss for the remaining unamortized effective portion of the related hedge loss of $323 million that was previously recorded in accumulated other comprehensive income. Refer to Note 3 "Acquisition, Divestiture, Terminated Acquisition and Terminated Divestiture" and 9 "Debt" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on these transactions.

2017 Senior Notes
In August 2017, we issued $1.0 billion of 3.875% senior notes due 2047. We used the net proceeds of this offering to repay a portion of our 1.5% senior notes due in November 2017, repay a portion of our floating rate senior notes due in December 2017 and for general corporate purposes.

Other Liquidity Information
From time to time, we use short-term commercial paper borrowings, repurchase agreements and cash advances from the FHLBB to address timing differences between cash receipts and disbursements. At December 31, 2017 and 2016, we did not have any commercial paper outstanding or outstanding advances from the FHLBB. The maximum amount of commercial paper borrowings outstanding during the year ended December 31, 2017 was approximately $850 million.

Our consolidated debt to capitalization ratio (calculated by dividing total long-term debt and short-term debt ("Total Debt") by the sum of Total Debt and total Aetna shareholders' equity) was 37.0 percent and 53.6 percent at December 31, 2017 and 2016, respectively. Our consolidated debt to capitalization ratio at December 31, 2017 reflects financing activity during 2017 including the repayment of approximately $12.6 billion aggregate principal amount of our senior notes and the issuance of $1.0 billion aggregate principal amount of our senior notes. We continually monitor existing and alternative financing sources to support our capital and liquidity needs, including, but not limited to, debt issuance, preferred or common stock issuance, reinsurance and pledging or selling of assets.

Interest expense was $442 million, $604 million and $369 million for 2017, 2016 and 2015, respectively. The decrease in interest expense during 2017 compared to 2016 is primarily due to a lower long-term debt balance during 2017 compared to 2016. The increase in interest expense during 2016 compared to 2015 reflects financing activity associated with the Humana Transaction.

Refer to Notes 9 “Debt” and 13 “Shareholders’ Equity” for information on our FHLBB membership and our stock-based compensation awards granted during 2017, respectively.

The State of Illinois experienced budget difficulties which contributed to the state being delinquent in paying certain of our premiums and fees. As a result of the actions taken by the state to pay us, our premium receivable balance at December 31, 2017 from the State of Illinois was approximately $350 million. Given our significant cash collections during the fourth quarter of 2017 of approximately $960 million, the State of Illinois budget and bond issuance, a federal judge’s ruling that prioritized Medicaid payments and the federal government’s match of a percentage of payments made by the state to managed care organizations under the state’s Medicaid program, we continue to believe the amounts due to us are collectible.

Contractual Obligations

The following table summarizes certain estimated future obligations by period under our various contractual obligations at December 31, 2017. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2017 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements). We believe that funds from future operating cash flows, together with cash, investments and other funds available under our revolving credit facility; from the FHLBB; and from public or private financing sources, will be sufficient to meet our existing commitments as well as our liquidity needs associated with future operations, including our strategic growth initiatives.

(Millions)	2018	2019-2020	2021-2022	Thereafter	Total
Long-term debt obligations, including interest	$ 1,350	$ 1,043	$ 2,681	$ 9,233	$ 14,307
Operating lease obligations	142	194	116	243	695
Purchase obligations	239	442	250	24	955
Other liabilities reflected on our balance sheet: [1]					
Future policy benefits [2]	604	1,199	930	3,634	6,367
Unpaid claims [2]	850	633	415	874	2,772
Policyholders’ funds [2] [3]	807	87	91	425	1,410
Other liabilities [4]	4,523	346	81	194	5,144
Total	$ 8,515	$ 3,944	$ 4,564	$ 14,627	$ 31,650

(1) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $4.3 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of our business.

(2) Total payments of future policy benefits, unpaid claims and policyholders’ funds include $887 million, $2.7 billion and $355 million, respectively, of reserves for contracts subject to reinsurance. We expect the assuming reinsurance carrier to fund these obligations and have reflected these amounts as reinsurance recoverable assets on our Consolidated Balance Sheets.

(3) Customer funds associated with group life and health contracts of approximately $2.2 billion have been excluded from the table above because such funds may be used primarily at the customer’s discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt and equity securities supporting experience-rated products of $51 million, before tax, have been excluded from the table above.

(4) Other liabilities in the table above include general expense accruals and other related payables and exclude the following:

- Employee-related benefit obligations of $572 million, including our pension and other postretirement and post-employment benefit obligations and certain deferred compensation arrangements. These liabilities do not necessarily represent future cash payments we will be required to make, or such payment patterns cannot be determined. However, other long-term liabilities include expected benefit payments of $329 million over the next ten years for our non-qualified supplemental pension plan and our postretirement benefit plans, which we primarily fund when paid by the plans.
- Deferred gains of $1.1 billion which will be recognized in our earnings in the future in accordance with GAAP.
- Net unrealized capital gains of $143 million, before tax, supporting discontinued products.
- Other payables of $49 million.

Restrictions on Certain Payments
In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to Aetna as a holding company, since Aetna is not an HMO or an insurance company. The additional regulations applicable to our HMO and insurance company subsidiaries are not expected to affect our ability to service our debt, meet our other financing obligations or pay dividends, or the ability of any of our subsidiaries to service other financing obligations. Under applicable regulatory requirements, at December 31, 2017, the amount of dividends that may be paid by our insurance and HMO subsidiaries without prior approval by regulatory authorities was approximately $1.6 billion in the aggregate.

We maintain capital levels in our operating subsidiaries at or above targeted and/or required capital levels and dividend amounts in excess of these levels to meet our liquidity requirements, including the payment of interest on debt and shareholder dividends. In addition, at our discretion, we use these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes we consider advisable.

Under the terms of the CVS Merger Agreement, prior to the completion of the merger contemplated by the CVS Merger Agreement, our ability to repurchase shares of our common stock is limited, and we are not permitted to declare, set aside or pay any dividend or make any other distribution other than a regular quarterly cash dividend in the ordinary course of business, which cannot exceed $.50 per share.

At December 31, 2017 and 2016, we held investments of $616 million and $657 million, respectively, that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of our business. Refer to Note 4 "Investments" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Off-Balance Sheet Arrangements
We do not have any guarantees or other off-balance sheet arrangements that we believe, based on historical experience and current business plans, are reasonably likely to have a material impact on our current or future operating results, financial position or cash flows (other than the guarantees described in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K) at December 31, 2017. In addition, refer to Note 4 "Investments" included in Part II, Item 8 of this Annual Report on Form 10-K for additional detail of our variable interest entities at December 31, 2017.

Solvency Regulation
The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2017, the RBC Ratio of each of our primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2017, at that date, each of our active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

CRITICAL ACCOUNTING ESTIMATES

We prepare our consolidated financial statements in accordance with GAAP. The application of GAAP requires management to make estimates and assumptions that affect our consolidated financial statements and related notes. The accounting estimates described below are those we consider critical in preparing our consolidated financial statements. We use information available to us at the time the estimates are made; however, as described below, these estimates could change materially if different information or assumptions were used. Also, these estimates may not ultimately reflect the actual amounts that occur.

Health Care Costs Payable
At both December 31, 2017 and 2016, 86% of health care costs payable are estimates of the ultimate cost of (i) services rendered to our members but not yet reported to us and (ii) claims which have been reported to us but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if we are obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. We develop our estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Refer to Note 2 "Summary of Significant Accounting Policies - Health Care Costs Payable" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our reserving methodology.

During 2017 and 2016 we observed an increase in our completion factors relative to those assumed at the prior year end. After considering the claims paid in 2017 and 2016 with dates of service prior to the fourth quarter of the previous year, we observed the assumed incurred claim weighted average completion factors were each 28 basis points higher than previously estimated, resulting in a reduction of $244 million and $230 million in 2017 and 2016, respectively, in health care costs payable that related to the prior year. We have considered the pattern of changes in our completion factors when determining the completion factors used in our estimates of IBNR at December 31, 2017. However, based on our historical claim experience, it is reasonably possible that our estimated weighted average completion factors may vary by plus or minus 20 basis points from our assumed rates, which could impact health care costs payable by approximately plus or minus $241 million pretax.

Also during 2017 and 2016, we observed that our health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2017 and 2016 with claim incurred dates for the fourth quarter of the previous year, we observed health care costs that were 6.6% and 6.5% lower, respectively, for each fourth quarter than previously estimated, resulting in a reduction of $570 million in 2017 and $534 million in 2016 in health care costs payable that related to the prior year.

We consider historical health care cost trend rates together with our knowledge of recent events that may impact current trends when developing our estimates of current health care cost trend rates. When establishing our reserves at December 31, 2017, we increased our assumed health care cost trend rates for the most recent three months by 7.4% from health care cost trend rates recently observed. However, based on our historical claim experience, it is reasonably possible that our estimated health care cost trend rates may vary by plus or minus 3.5% from our assumed rates, which could impact health care costs payable by plus or minus $301 million pretax.

Health care costs payable as of December 31, 2017 and 2016 consisted of the following products:

(Millions)	2017	2016
Commercial	$ 2,632	$ 3,273
Government	3,183	3,285
Total health care costs payable	$ 5,815	$ 6,558

Other Insurance Liabilities
We establish insurance liabilities other than health care costs payable for benefit claims primarily related to our Group Insurance segment. We refer to these liabilities as other insurance liabilities. These liabilities primarily relate to our life, disability and long-term care products. Substantially all of our life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements, however we remain directly obligated to the policyholders.

Life and Disability
The liabilities for our life and disability products reflect estimates of the ultimate cost of benefit claims that have been reported to us but not yet paid, benefit claims that have been incurred but not yet reported to us, and future policy benefits earned under insurance contracts. We develop our estimate of these reserves and the related benefit expenses using actuarial principles and assumptions that consider, among other things, discount, resolution and mortality rates. Completion factors are also evaluated when estimating our reserves for claims incurred but not yet reported for life products. We also consider the benefit payments from the U.S. Social Security Administration for which our disability members may be eligible and which may offset our liability for disability claims (this is known as the Social Security offset). Each period, we estimate these factors, to the extent relevant, based primarily on historical data, and use these estimates to determine the assumptions underlying our reserve calculations. Given the extensive degree of judgment and uncertainty used in developing these estimates, it is possible that our estimates could develop either favorably or unfavorably.

The discount rate is the interest rate at which future benefit cash flows are discounted to determine the present value of those cash flows. The discount rate we select is a critical estimate, because higher discount rates result in lower reserves. We determine the discount rate based on the current and estimated future yield of the asset portfolio supporting our life and disability reserves. If the discount rate we select in estimating our reserves is lower (higher) than our actual future portfolio rate of return, our reserves may be higher (lower) than necessary. Following the Group Insurance sale, the discount rates selected for life insurance waiver of premiums and long-term disability reserves at December 31, 2017 were 250 basis points lower than the rates we selected at December 31, 2016, primarily due to the decrease in the projected yield of the asset portfolio supporting our reserves. The discount rates we selected for life insurance waiver of premiums and long-term disability reserves at December 31, 2016 were 40 basis points lower than the rates we selected at December 31, 2015, primarily due to the decrease in projected future portfolio rates of return. Based on our historical experience, it is reasonably possible that the assumed discount rates for our life and disability reserves may vary by plus or minus 50 basis points from year to year. A 50 basis point decrease in the discount rates selected for both our life insurance waiver of premium and disability reserves would have increased our life and disability liabilities by $54 million pretax for 2017.

For disability claims and a portion of our life claims, we must estimate the timing of benefit payments, which takes into consideration the maximum benefit period and the probabilities of recovery (i.e., recovery rate) or death (i.e., mortality rate) of the member. Benefit payments may also be affected by a change in employment status of a disabled member, for example, if the member returns to work on a part-time basis. Estimating the recovery and mortality rates of our members is complex. Our actuaries evaluate our current and historical claim patterns, the timing and amount of any Social Security offset (for disability only), as well as other factors including the relative ages of covered members and the duration of each member's disability when developing these assumptions. For disability reserves, if our actual recovery and mortality rates are lower (higher) than our estimates, our reserves will be lower (higher) than required to cover future disability benefit payments. For certain life insurance premium waiver reserves, if the actual recovery rates are lower (higher) than our estimates or the actual mortality rates are higher (lower) than our estimates, our reserves will be lower (higher) than required to cover future life benefit payments. We use standard industry tables and our historical claim experience to develop our estimated recovery and mortality rates. Claim reserves for our disability and life products are sensitive to these assumptions. Our historical experience has been that our recovery or mortality rates for our life and disability reserves vary by less than ten percent during the course of a year. A ten percent less (more) favorable assumption for our recovery or mortality rates would have increased (decreased) current and future life and disability benefit costs by $89 million pretax for 2017. When establishing our reserves at December 31, 2017, we set our estimates of recovery and mortality rates based on recent experience. Refer to Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our reserving methodology.

Long-term Care
We established reserves for future policy benefits for the long-term care products we issued based on the present value of estimated future benefit payments less the present value of estimated future net premiums. In establishing this reserve, we evaluated assumptions about mortality, morbidity, lapse rates and the rate at which new claims would be submitted to us. We estimated the future policy benefits reserve for long-term care products using these assumptions and actuarial principles. For long-term care insurance contracts, we use our original assumptions throughout the life of the policy and do not subsequently modify them unless we deem the reserves to be inadequate. A portion of our reserves for long-term care products also reflect our estimates relating to future payments to members currently receiving benefits. These reserves are estimated primarily using recovery and mortality rates, as described above.

Premium Deficiency Reserves on our Health Care and Group Insurance products
We recognize a premium deficiency loss when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. Any such reserves established would normally cover expected losses until the next policy renewal dates for the related policies. We established a premium deficiency reserve of $16 million related to our Medicaid products at December 31, 2017 for the 2018 coverage year. We did not have any material premium deficiency reserves for our Health Care or Group Insurance business at December 31, 2016.

Large Case Pensions Discontinued Products Reserve
We discontinued certain Large Case Pensions products in 1993 and established a reserve to cover losses expected during the run-off period. Since 1993, we have made several adjustments resulting in a reduction to this reserve that have increased net income attributable to Aetna. These adjustments occurred primarily because our investment experience as well as our mortality and retirement experience have been better than the experience we projected at the time we discontinued the products. We released $71 million ($109 million pretax) and $84 million ($128 million pretax) of the reserve in the years ended December 31, 2017 and 2016, respectively. No releases were made to the reserve in 2015. The reserve release during the year ended December 31, 2017 was primarily due to favorable mortality experience compared to assumptions we previously made in estimating the reserve. The reserve release in the years ended December 31, 2017 and 2016 also was due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve. There can be no assurance that adjustments to the discontinued products reserve will occur in the future. Future adjustments could positively or negatively impact net income attributable to Aetna.

Recoverability of Goodwill and Other Acquired Intangible Assets
We have made acquisitions that included a significant amount of goodwill and other intangible assets. When we complete an acquisition, we apply the acquisition method of accounting, which among other things, requires the recognition of goodwill (which represents the excess cost of the acquisition over the fair value of net assets acquired and identified intangible assets). Goodwill is subject to an annual (or under certain circumstances more frequent) impairment test based on its estimated fair value. Other intangible assets that meet certain criteria are amortized over their useful lives, except for the valuation of business acquired which amortizes in proportion to estimated premiums over the expected life of the acquired contracts, and are also subject to a periodic impairment test. Historically, for these impairment evaluations, we have used an implied fair value approach, which used a discounted cash flow analysis and other valuation methodologies. Effective January 1, 2017, we adopted, on a prospective basis, new accounting guidance which simplifies the accounting for goodwill impairment. The new guidance eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. A goodwill impairment charge would be recognized if the carrying amount of a reporting unit exceeds the estimated fair value of the reporting unit. The adoption of this new guidance did not have a material impact on our financial position or operating results. Our impairment evaluations use many assumptions and estimates to determine estimated fair value of the reporting unit, including certain assumptions and estimates related to future earnings. If we do not achieve our earnings objectives, the assumptions and estimates underlying these impairment evaluations could be adversely affected, which could result in an asset impairment charge that would negatively impact our operating results. There were no material impairment losses recognized in any of the three years ended December 31, 2017, 2016 or 2015. In conjunction with the Group Insurance sale, which included a substantial portion of our Group Insurance business, the goodwill allocated to our Group Insurance segment of $113 million was included in the calculation of the total gain on sale, with a corresponding reduction of the goodwill balance.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans
We sponsor defined benefit pension plans (“pension plans”) and OPEB plans for our employees and retirees. Effective December 31, 2010, our employees no longer earn future pension service credits in the Aetna Pension Plan, although the Aetna Pension Plan will continue to operate and account balances will continue to earn annual interest credits. Employees covered by our non-qualified supplemental pension plan stopped accruing benefits effective January 1, 2007, although interest credits continue to be credited on these cash balance accounts.

Major assumptions used in the accounting for our pension plans include the expected return on plan assets, if applicable, mortality rates and the discount rate. We select our assumptions based on our information and market indicators, and we evaluate our assumptions at each annual measurement date (December 31, for each year presented). A change in any of our assumptions would have an effect on our pension and OPEB plan costs. A discussion of our assumptions used to determine the expected return on plan assets and mortality rates can be found in Note 10 “Pension and Other Postretirement Plans” included in Part II, Item 8 of this Annual Report on Form 10-K.

The discount rates we used in accounting for our pension and OPEB plans were calculated using a yield curve as of our annual measurement date. Each yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds (that is, bonds with an average rating of AA based on ratings from Standard & Poor’s, Fitch, and the equivalent ratings from Moody’s). We project the benefits expected to be paid from each plan at each point in the future based on each participant’s current service (but reflecting expected future pay increases). These projected benefit payments are then discounted to the measurement date using the corresponding rate from the yield curve. A lower discount rate increases the present value of benefit obligations. In 2017, we decreased our weighted average discount rate to 3.68% for our pension plans from the 4.22% used at the measurement date in 2016. In 2017, we decreased our weighted average discount rate on OPEB plans to 3.63% from the 4.12% used at the measurement date in 2016. A one-percentage point decrease in the assumed discount rate would decrease our annual pension costs by $10 million after-tax and would have a negligible effect on our annual OPEB costs.

Effective as of the beginning of 2017, we refined the approach used to estimate the interest cost component of net periodic benefit cost for pension and OPEB plans that utilize a yield curve approach. Historically, we estimated the interest cost using a single weighted average discount rate derived from the yield curve used to measure the projected benefit obligation. We have now elected to measure interest cost by applying the specific spot rates along that yield curve to the relevant projected cash flows for each component. We believe the new approach provides a more precise estimate of such interest cost. We have accounted for this refinement as a change in accounting estimate and, accordingly, have accounted for it on a prospective basis beginning in 2017. The reduction in net periodic benefit cost associated with this refinement for the year ended December 31, 2017 was $26 million ($41 million pre-tax). For our pension benefits, the 2017 weighted-average discount rate for interest costs under the refined approach adopted as of the beginning of 2017 was 3.51%. Under the prior methodology, the 2017 weighted-average discount rate would have been 4.22%.

At December 31, 2017, our pension and OPEB plans had aggregate pretax accumulated actuarial losses of approximately $2.4 billion. Accumulated actuarial losses are primarily due to an increase in the present value of future plan obligations driven by lower interest rates and improving mortality trends as well as investment results below the returns assumed in 2008. The accumulated actuarial loss is amortized over the weighted-average expected life of pension plan participants (estimated to be up to 27 years at December 31, 2017 for the pension plans) and the expected life of OPEB plan participants (estimated to be up to 17 years at December 31, 2017) to the extent the loss is outside of a corridor established in accordance with GAAP. The corridor is established based on the greater of 10% of the plan assets or 10% of the projected benefit obligation. At December 31, 2017, approximately $1.7 billion of the actuarial loss was outside of the corridor, which will result in amortization of $43 million after-tax in our 2017 pension and OPEB expense.

The expected return on plan assets and discount rate assumptions discussed above impacted the reported net periodic benefit costs and benefit obligations of our pension and OPEB plans, but did not impact the required contributions to these plans, if any. Refer to Note 10 “Pension and Other Postretirement Plans” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our defined benefit pension and other postretirement employee benefit plans, including our current funding strategy.

Other-Than-Temporary Impairment of Debt Securities
We regularly review our debt securities to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in our operating results, and the amount of the non-credit related component is included in other comprehensive income, unless we intend to sell the security or it is more likely than not that we will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. We analyze all facts and circumstances we believe are relevant for each investment when performing this analysis, in accordance with applicable accounting guidance promulgated by the Financial Accounting Standards Board and the U.S. Securities and Exchange Commission (the “SEC”).

Among the factors we consider in evaluating whether a decline is other-than-temporary are whether the decline in fair value results from a change in the quality of the debt security itself, whether the decline results from a downward movement in the market as a whole, and the prospects for realizing the carrying value of the debt security based on the investment’s current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, we determine whether we intend to sell the debt security or if it is more likely than not that we will be required to sell the debt security before recovery of its amortized cost basis. If either case is true, we recognize an other-than-temporary impairment (“OTTI”), and the cost basis/carrying amount of the debt security is written down to fair value.

Debt securities in an unrealized loss position for which we believe we will not recover the amortized cost due to the quality of the debt security or the creditworthiness of the issuer are categorized as credit-related OTTI.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from our projections and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Revenue Recognition and Allowance for Estimated Terminations and Uncollectible Accounts
Our revenue is principally derived from premiums and fees billed to customers in the Health Care and Group Insurance segments. In Health Care, revenue is recognized based on customer billings, which reflect contracted rates per employee and

the number of covered employees recorded in our records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. In Group Insurance, premium for group life and disability products is recognized as revenue, net of allowances for uncollectible accounts, over the term of coverage. Amounts received before the period of coverage begins are recorded as unearned premiums. On November 1, 2017, we completed the sale of a substantial portion of our Group Insurance segment.

Health Care billings may be subsequently adjusted to reflect enrollment changes due to terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, we estimate the amount of future retroactivity and adjust the recorded revenue accordingly. In each period, we also estimate the amount of uncollectible receivables and establish an allowance for uncollectible amounts. We base such estimates on historical trends, premiums billed, the amount of contract renewal activity during the period and other relevant information. As information regarding actual retroactivity and uncollectible amounts becomes known, we refine our estimates and record any required adjustments to revenues in the period they arise. A significant difference in the actual level of retroactivity or uncollectible amounts compared to our estimated levels would have a significant effect on our operating results.

Additionally, premium revenue subject to the ACA's minimum MLR rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. We estimate the minimum MLR rebates by projecting MLRs for certain markets, as defined by the ACA, for each state in which each of our insurance entities operate. The claims and premiums used in estimating such rebates are modified for certain adjustments allowed by the ACA and include a statistical credibility adjustment for those states with a number of members that is not statistically credible.

Furthermore, premium revenue subject to the ACA's permanent risk adjustment program transfers funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of our qualified plan members relative to the average risk of members of other qualified plans in comparable markets, we estimate our ultimate risk adjustment receivable or payable for the current calendar year and reflect the pro-rata year-to-date impact as an adjustment to our premium revenue. In this analysis, we consider the estimate of the average risk of members of other qualified plans in comparable markets the most critical assumption. We estimate this assumption using management's best estimates, which are based on various data sources, including but not limited to market risk data compiled by third party sources as well as pricing and other regulatory inputs. Refer to Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on each of the ACA's risk adjustment, risk corridor and reinsurance programs.

NEW ACCOUNTING STANDARDS

Refer to Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for a discussion of recently issued accounting standards.

REGULATORY ENVIRONMENT

General

Our operations are subject to comprehensive United States federal, state and local and comparable multiple levels of international regulation in the jurisdictions in which we do business. The laws and rules governing our business and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The current U.S. presidential administration and the control of the U.S. Congress by a single political party increase the likelihood of significant changes in those laws and rules, including the ACA. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices.

We must obtain and maintain regulatory approvals to price, market and administer many of our products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight ("CCIIO") and the Department of Labor ("DOL"), as well as state health, insurance, managed care and Medicaid agencies and state boards of pharmacy have broad authority to take one or more of the following actions:

- Grant, suspend and revoke our licenses to transact business;
- Suspend or exclude us from participation in government programs;
- Suspend or limit our authority to market products;
- Regulate many aspects of the products and services we offer, including the pricing and underwriting of many of our products and services;
- Audit us and our performance of our contracts, which can, among other things, affect our Medicare Advantage plans' and Medicare Part D Prescription Drug plans' ("PDPs"") star ratings;
- Assess damages, fines and/or penalties;

- Terminate our contract with the government agency and/or withhold payments from the government agency to us;
- Impose retroactive adjustments to premiums and require us to pay refunds to the government, customers and/or members;
- Restrict our ability to conduct acquisitions or dispositions;
- Require us to maintain minimum capital levels in our companies and monitor our solvency and reserve adequacy;
- Regulate our investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude our plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by the U.S. Department of Health and Human Services ("HHS") or the applicable state.

Our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators. See "Audits and Investigations" below in this MD&A - Regulatory Environment for additional information on these matters.

The ACA made broad-based changes to the U.S. health care system. On January 20, 2017, the President signed an executive order that gives the regulatory agencies that enforce the ACA the authority to interpret regulations issued under the ACA in a way that limits fiscal burdens on states and financial or regulatory burdens on individuals, providers, health insurers and others. The practical implications of that order are unclear, and the future of the ACA is uncertain. While we anticipate continued efforts in 2018 and beyond to modify, repeal or replace the ACA, we expect aspects of the ACA to continue to significantly impact our business operations and operating results, including our pricing, our MBRs and the geographies in which our products are available. The ACA has presented us with business opportunities, but also with financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, including Public Exchanges, required minimum MLRs in Commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's CMS quality performance ratings or "star ratings." The effects of these changes are reflected in our operating results. If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2022.

We expect to continue to dedicate significant resources and incur significant expenses during 2018 to comply with the ACA as currently enacted and implement and comply with changes to the ACA as well as state level health care reform. While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, regulations and guidance. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing state and federal budgetary pressures make it more likely that any changes, including changes at the state level in response changes to, or repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, we cannot predict the impact on us of future changes to the ACA. It is reasonably possible that repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on our business operations and operating results.

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of congressional and state level elections, pending litigation challenging aspects of the law or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Examples of recent administrative policy, legislative and regulatory changes include: the January 2018 suspension of the HIF for 2019 and delay of the "Cadillac" tax on high-cost employer sponsored health coverage until 2022; the December 2017 TCJA, which repealed the ACA's individual mandate and related penalties; the January 20, 2017 and October 12, 2017 executive orders relating to the ACA; the federal government's October 2017 curtailment of payments related to the Cost-Sharing Subsidy Program; the November 2016 HHS announcement that risk corridor collections for the 2015 program year would be applied first to amounts owed to plans for the 2014 program year; and the May 2016 final regulations relating to the ACA's non-discrimination requirements. The pending litigation challenging the ACA includes challenges by various states of the federal government's decision to curtail payments related to the Cost-Sharing Subsidy Program. The time frame for conclusion and final outcome and ultimate impact of this litigation are uncertain.

As described above, the availability of funding for the ACA's temporary risk corridor program is an example of this uncertainty. We continue to believe that receipt of any risk corridor payment from HHS for the 2016 or 2015 program year and receipt of such payments in excess of the announced prorated amount for the 2014 program year are uncertain. At December 31, 2017, we had an immaterial receivable for the remaining 2014 program year prorated amount that had not been collected from HHS and

no receivable for either of the 2015 or 2016 program years. 2016 was the last program year for the ACA's risk corridor program. On-going uncertainty regarding the funding of ACA-related programs and subsidies can be expected to create additional instability in the marketplace.

In addition to efforts to amend, repeal or replace the ACA and the related regulations, the federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and our business. We cannot predict whether pending or future federal or state legislation or court proceedings, including future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or the ACA or the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements we and other health plans are paid by the federal government for our Medicare members, among other sources. While not all-inclusive, the following are some of the key provisions of the ACA (assuming it continues to be implemented in its current form) that become effective on or after January 1, 2018. We continue to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on our business operations and operating results:

- Closure of the gap in coverage for Medicare Part D prescription drug coverage (the so-called "donut hole") which began to close in 2010 and will incrementally close until the coverage gap is eliminated in 2019.
- The imposition on us and other health insurers, health plans and other market participants of significant fees, assessments and taxes, including the industry-wide reinsurance assessment of $5 billion in 2016 and an annual non-tax deductible industry-wide $14.3 billion HIF for 2018, which was zero in 2017. On January 22, 2018, the HIF was suspended for 2019. As currently enacted, the HIF will increase in 2020 and annually thereafter. As a result of the 2018 reinstatement of the HIF, we expect our share of the applicable 2018 ACA fees, assessments and taxes to be approximately $930 million.
- A non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold beginning in 2022.
- Reduced funding for Medicaid expansion, which began in 2017.

The ACA also specifies minimum MLRs for our Commercial and Medicare Insured products, specifies features required to be included in Commercial benefit designs, limits Commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and significantly increases federal and state oversight of health plans, including regulations and processes that could delay or limit our ability to appropriately increase our health plan premium rates. This in turn could adversely affect our ability to continue to participate in certain product lines and/or geographies we serve today.

In addition, the ACA ties a portion of each Medicare Advantage plan's reimbursement to the achievement of favorable CMS quality performance measures ("star ratings"). Since 2015, only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, our Medicare Advantage plans' operating results in 2018 and going forward will be significantly affected by their star ratings. For additional information on CMS's stars program and our related performance, see "Medicare" below in this MD&A - Regulatory Environment.

In 2017, state legislatures focused on state budgets and taxes (including new assessments on health care premiums), stabilizing the health insurance marketplace, provider network composition and provider directory accuracy requirements, pharmacy benefit and drug coverage requirements, Medicaid reforms, "surprise" billing of members and health care delivery system transformation. At the state level, all 50 U.S. states and the District of Columbia will hold regular legislative sessions in 2018. We expect additional state level legislation and regulatory activity that impacts our businesses to be enacted in 2018, including potentially significant changes in small group and Medicaid products and/or programs in response to or in anticipation of reduced federal funding and other state budgetary pressures and/or the adverse impact of actual and/or expected changes to the ACA and other federal programs on state citizens, programs, and budgets. In addition, independent of federal efforts, we expect many states to continue to consider legislation or regulations that affect privately-financed health insurance arrangements and/or public programs, including changes to Medicaid program eligibility rules and/or benefits, imposing requirements on the composition of our provider networks and the accuracy of our provider directories, mandating specific benefit coverages, and enhancing consumer transparency on provider network composition as well as cost and quality of care. For example, regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards or procedures for reviewing proposed premium rate changes, as well as imposing taxes on insurers and other health plans to finance Public Exchanges, Medicaid and other state programs. If any elements of the ACA are repealed at the federal level, we expect that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage,

requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

We cannot predict what provisions legislation or regulation will contain in any state or what effect legislation or regulation will have on our business operations or operating results, but the effect could be materially adverse.

Health Care Regulation

General
Federal, state, local and foreign governments have adopted comprehensive laws and regulations that govern our business activities in various ways. Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. These laws and regulations, including the ACA, restrict how we conduct our business and result in additional burdens and costs to us.

In addition to the expanded regulation created by the ACA discussed above, significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, health care provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks, pharmacy and pharmacy benefit management operations and financial position (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of our regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In addition, some of our business and related activities may be subject to preferred provider organization ("PPO"), managed care organization, utilization review or third-party administrator-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain health care provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for our delivery of services, payment of claims, fraud prevention, protection of consumer health information, payment for covered benefits and services and escheatment of funds to states. Our pharmacy benefit management ("PBM") services suppliers, including CaremarkPCS Health, L.L.C. (and its predecessors, collectively "Caremark", a wholly-owned subsidiary of CVS Health), also are subject to extensive federal and state regulation, including many of the items described above.

Pricing and Underwriting Restrictions
Pricing and underwriting regulation by states limits our underwriting and rating practices and those of other health insurers, particularly for small employer groups. Since 2014, as a result of the ACA, health insurers cannot vary small group premium rates based on individual members' characteristics except for geography and limited variation for age and tobacco use. Since 2016, as a result of the ACA, states have the ability to expand the small group rating category to cover groups of up to 100 employees. Pricing and underwriting laws and regulations vary by state. In general, they apply to certain customer segments and limit our ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict our ability to price for the risk we assume and/or reflect reasonable costs in our pricing.

The ACA expanded the premium rate review process by, among other things, requiring our rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding 10% (or a state specified threshold). HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect our ability to price for the risk we assume, which could adversely affect our medical benefit ratios and operating results, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds our projections.

The ACA also specifies minimum MLRs of 85% for large group commercial products, 80% for individual and small group commercial products and 85% for Medicare Advantage and Medicare Part D plans. Since 2017, Medicaid managed care products, including those we offer, also are subject to a minimum MLR of 85% under a final rule issued by CMS in 2016. Because the ACA and the Medicaid minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing its various restrictions. For Medicaid managed care and commercial products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings for commercial products, require prior approval of premium

rates for commercial products, or impose other requirements related to minimum MLR. For example, Texas has expanded from 50 to 100 the maximum size of "small groups" that are subject to its minimum MLR requirements, and New York, New Jersey and California all have established state-specific minimum MLR requirements. Minimum MLR requirements and similar actions further limit the level of margin we can earn in our Insured business while leaving us exposed to medical costs that are higher than those reflected in our pricing. We also may be subject to significant fines, penalties, premium refunds and litigation if we fail to comply with minimum MLR laws and regulations. In addition, if a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

In addition, we requested significant increases in our premium rates in our small group Health Care business for 2018 and expect to continue to request significant increases in those rates for 2019 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect adverse selection in our products, particularly in small group products, which we expect to continue and potentially worsen in 2018 with the expiration of the ACA's risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of these laws and regulations also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage. In addition, HHS' rules on rates impose additional public disclosure requirements on any rate filings that exceed the "reasonableness" threshold and require additional review of those rates.

In addition, a number of states provide for a voluntary reinsurance mechanism to spread small group risk among participating insurers and other carriers. In a small number of states, participation in this pooling mechanism is mandatory for all small group carriers. In general, we have elected not to participate in voluntary pools. However, even in the voluntary pool states, we may be subject to certain supplemental assessments related to the state's small group experience. Core elements of the ACA were designed to reduce or eliminate reliance on these state pooling mechanisms. If those elements of the ACA are modified, repealed or replaced, states may reinstate or expand their pooling requirements, including mandatory participation.

HIPAA Administrative Simplification, GLBA and Other Privacy, Security and Confidentiality Requirements

Federal, state and international privacy and security requirements change periodically because of legislation, regulations and judicial or administrative interpretation. The regulations under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") and the ACA, also impose a number of additional obligations on issuers of health insurance coverage and health benefit plan sponsors.

HIPAA's administrative simplification requirements apply to self-funded group health plans, health insurers and HMOs, health care clearinghouses and health care providers who transmit health information electronically ("Covered Entities"). Regulations adopted to implement administrative simplification also require that "business associates" (e.g., entities that provide services to health plans, such as electronic claims clearinghouses, print and fulfillment vendors, consultants, and us for the administrative services we provide to our ASC customers) acting for or on behalf of these Covered Entities be contractually obligated to meet HIPAA standards. The administrative simplification regulations establish significant criminal penalties and civil sanctions for noncompliance.

The HIPAA privacy regulations adopted by HHS establish limits on the use and disclosure of medical records and other individually identifiable health information (protected health information or "PHI") by Covered Entities. Further, ARRA requires us and other Covered Entities to report any breaches of PHI to impacted individuals and to HHS and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Business associates must also comply with certain HIPAA provisions. In addition, ARRA establishes greater civil and criminal penalties for Covered Entities and business associates who fail to comply with HIPAA's provisions and gives new enforcement rights to state attorneys general.

The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may apply to us and other Covered Entities, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. Complying with additional state requirements requires us to make additional investments beyond those we have made to comply with the HIPAA

regulations. HHS also has adopted security regulations designed to protect member health information from unauthorized use or disclosure. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

The HIPAA privacy regulations provide patients with rights to understand and control how their health information is used. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. The GLBA regulations apply to health, life and disability insurance. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection.

The Cybersecurity Information Sharing Act of 2015 ("CISA") encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency. States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. Widely-reported large scale U.S. commercial data breaches increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of our businesses, including our Consumer Health and Services businesses, our privacy and security strategy and our web-based and mobile assets.

Other Legislative Initiatives and Regulatory Initiatives

In addition to the ACA, HIPAA and ARRA measures discussed above, the U.S. federal and state governments, as well as governments in other countries where we do business, continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system. For example:

- Under the Budget Control Act of 2011 (the "BCA") and the American Taxpayer Relief Act of 2012 (the "ATRA") significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. CMS issued its final notice detailing final Medicare Advantage benchmark payment rates for 2018 (the "Final Notice") in April 2017. Overall, we project the benchmark payment rates in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of coding trend, by less than 1 percent in 2018 compared to 2017. This 2018 rate increase only slightly offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications), the HIF and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids. Significant uncertainty remains as to whether and how the U.S. Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. We cannot predict future Medicare or Medicaid funding levels or the impact that future federal budget actions or entitlement program reform, if it occurs, will have on our business, operations or operating results, but the effects could be materially adverse, particularly on our Medicare and/or Medicaid revenues, medical benefit ratios and operating results.
- The European Union's ("EU's") General Data Protection Regulation will apply across the EU effective May 2018.

Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:

- Restricting our ability to limit providers' participation in our networks and/or remove providers from our networks by imposing network adequacy requirements or otherwise (including in our Medicare, Public Exchange and other Commercial products).
- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
- Reducing federal and/or state government funding of government-sponsored health programs in which we participate, including Medicare and Medicaid programs.
- Restricting or mandating health plan claim processing, review, payment and/or related procedures.
- Mandating coverage for additional conditions and/or specified procedures, drugs or devices (for example, high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).

- Imposing requirements and restrictions on the administration of pharmacy benefits, including restricting or eliminating the use of formularies for prescription drugs; restricting our ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting our ability to place certain specialty or other drugs in the higher cost tiers of our pharmacy formularies; restricting our ability to make changes to drug formularies and/or our clinical programs; limiting or eliminating rebates on pharmaceuticals; restricting our ability to configure our pharmacy networks; and restricting or eliminating the use of certain drug pricing methodologies.
- Regulating electronic connectivity.
- Mandating or regulating the disclosure of health care provider fee schedules and other data about our payments to providers.
- Mandating or regulating disclosure of health care provider outcome and/or efficiency information.
- Prescribing or limiting members' financial responsibility for health care or other covered services they utilize.
- Assessing the medical device status of HIT products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with U.S. Food and Drug Administration ("FDA") requirements in relation to some of these products, solutions and/or tools.
- Imposing payment levels for services rendered to our members by health care providers who do not have contracts with us.
- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
- Amending or supplementing the Employee Retirement Income Security Act of 1974 ("ERISA") to impose greater requirements on the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

Some of the changes, if enacted, could provide us with business opportunities. However, it is uncertain whether we can counter the potential adverse effects of such potential legislation or regulation, including whether we can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying our systems to implement any enacted legislation or regulations.

Our business also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA").

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the U.S. Department of the Treasury and the Internal Revenue Service (the "IRS").

We also may be adversely impacted by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Medicare

Our Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. Our Medicare PDP and Medicare Supplement products are complementary products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

We continue to expand the number of counties in which we offer Medicare products and the Medicare products we offer. We expect to further expand our Medicare service area and products in 2018 and are seeking to substantially grow our Medicare membership, revenue and operating results over the next several years, including through growth in our Medicare Supplement products, which products are regulated at the state level. The organic expansion of our Medicare service area and Medicare products we offer and the Medicare-related provisions of the ACA significantly increase our exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which we participate, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, sequestration began in 2013 and resulted in an automatic reduction in Medicare reimbursements to health plans of not more than 2% of total program costs per year through 2024. In addition, the ACA as currently enacted contains further significant reductions in the reimbursements we receive for our Medicare Advantage

members which were fully phased-in for 2017. Since the 2014 contract year, the ACA also has required minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to participate in open enrollment. If a Medicare Advantage contract pays rebates for five consecutive years, it will be terminated by CMS.

Overall, we project the benchmark payment rates for 2018 in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of coding trend, by less than 1 percent in 2018 compared to 2017. This 2018 rate increase only slightly offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications), the HIF and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids.

Our Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to us and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. We have invested significant resources to comply with Medicare standards, and our Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit us from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of our Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against us if we fail to comply with CMS regulations or our Medicare contractual requirements.

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare Advantage and PDP beneficiaries. For example, CMS currently conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. The OIG also is auditing risk adjustment data of us and other companies, and we expect CMS and the OIG to continue auditing risk adjustment data. We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. In December 2015, CMS released a request for information ("RFI") for a significant expansion of the RADV audit program. As described in the RFI, CMS would use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. Refer to "CMS Actions" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K for information on certain pending CMS audits.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Our star ratings and past performance scores are adversely affected by compliance issues that arise in our Medicare operations, such as our distribution of inaccurate information regarding which pharmacies were part of our Medicare network and related $1 million civil monetary penalty in 2015, notices of non-compliance and warning letters in 2016 and notices of non-compliance in 2017.

Beginning in 2015, Medicare Advantage plans must have an overall star rating of four stars or higher (out of five stars) to qualify for a quality bonus in their basic premium rates. CMS released our 2018 star ratings in October 2017. Our 2018 star ratings will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2019. Based on our membership at December 31, 2017, 87% of our Medicare Advantage members were in plans with 2018 star ratings of at least 4.0 stars, compared to 92% of our Medicare Advantage members being in plans with star ratings of at least 4.0 stars based on our membership at December 31. 2016. CMS will release updated stars ratings in October 2018 that will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. In 2018 and going forward, our Medicare Advantage plans' operating results will continue to be significantly affected by their star ratings. CMS continues to revise the star ratings system to make it harder to achieve four stars or more. Despite our success in maintaining high star ratings and other quality measures for 2018 and the continuation of our improvement efforts, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

We cannot predict future Medicare funding levels or the impact that future federal budget actions or entitlement program reform, if it occurs, will have on our business, operations or operating results, but the effects could be materially adverse, particularly on our Medicare and/or Medicaid revenues, medical benefit ratios and operating results. For example, the Federal

government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. We currently believe that the payments we receive and will receive in the near term are adequate to justify our continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

Going forward, we expect CMS, the OIG, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDP, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' role. It is not possible to predict the outcome of this Congressional or regulatory activity, any of which could adversely affect us.

Medicaid

We are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, we also are increasing our exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which we participate, including changes in the amounts payable to us under those programs.

In April 2016, CMS issued a final rule that overhauls the entire Medicaid managed care delivery system. The final rule represents the first update to Medicaid managed care regulations since 2002. Among other things the final rule requires Medicaid products to have a minimum MLR of 85%; establishes a Medicaid managed care quality rating system; and establishes provider network adequacy requirements. The minimum MLR requirements were effective beginning in 2017.

The impact of Medicaid expansion under the ACA is uncertain. The future of the ACA is uncertain, and states may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, a number of states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. In 2017, federal funding for expanded Medicaid coverage began to decrease, and proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2018 and beyond, including the possibility of converting federal Medicaid support to block grants and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation may adversely affect Medicaid payment rates, our revenues and our Medicaid membership in those states.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in our networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for us to continue program participation due to state and federal budgetary constraints and continuing efforts to reduce health care costs. In addition, our Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (for example, when a state discontinues a managed care program) or in the event of insufficient state funding.

Our Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit our performance to determine compliance with CMS contracts and regulations. Our Medicaid products, dual eligible products and Children's Health Insurance Program ("CHIP") contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services we provide to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to us and other participants in Medicaid and dual eligible programs, including requirements that we submit encounter data to the applicable state agency, are extensive, complex and subject to change. We have invested significant resources to comply with these standards, and our Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine us, withhold payments to us, seek premium and other refunds, terminate our existing contracts, elect not to award us new contracts or not to renew our existing contracts, prohibit us from continuing to market and/or enroll members in or refuse

to automatically assign members to one or more of our Medicaid or dual eligible products, exclude us from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against us if we fail to comply with CMS or state regulations or contractual requirements.

We cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can we predict the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

Federal Employees Health Benefits Program ("FEHB")
Our subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. We also manage certain FEHB plans on a "cost-plus" basis. The OPM conducts periodic audits of its contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against us if we fail to comply with the FEHB program requirements.

The Employee Retirement Income Security Act of 1974
The provision of services to certain employee benefit plans, including certain Health Care, Group Insurance and Large Case Pensions benefit plans, is subject to ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the IRS and the U.S. Department of Labor (the "DOL"). ERISA regulates certain aspects of the relationships between us and employers who maintain employee benefit plans subject to ERISA. Some of our administrative services and other activities also are subject to regulation and/or review by the DOL under ERISA. ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts.

Some of our Health Care, Group Insurance and Large Case Pensions products and services and related fees we charge also are subject to potential issues raised by certain judicial interpretations relating to ERISA. Under those interpretations, together with DOL regulations, we may have ERISA fiduciary duties with respect to certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those assets are subject to conflict of interest and other restrictions, and we must provide certain disclosures to policyholders annually. We must comply with these restrictions or face substantial penalties.

HMO, Insurance Holding Company and Other State Laws
A number of states, including Pennsylvania and Connecticut, regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require us and our subsidiaries to maintain certain levels of equity and require prior regulatory approval of material intercompany transfers of assets as well as transactions between the regulated companies and their affiliates, including their parent holding companies. We expect the states in which our insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of our insurance companies and HMOs.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or "RBC", requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2017, the RBC level of each of our insurance and HMO subsidiaries was above the level that would require regulatory action.

In addition, changes to regulations or the interpretation of those regulations due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to recent and expected payor insolvencies, could negatively impact our business in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

For information regarding restrictions on certain payments of dividends or other distributions by our HMO and insurance company subsidiaries, refer to Note 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K.

The holding company laws for the states of domicile of Aetna and certain of its subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as our parent company, Aetna Inc.) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Our workers' compensation business includes the comparison of medical claims data against the applicable state's fee schedule pricing, including applicable regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. Our workers' compensation business also includes PBM and care management services, both of which are regulated at the state level. Our workers' compensation customers include insurance carriers and TPA's who also are regulated at the state level. The laws and regulations applicable to us and other participants in the workers' compensation business are extensive, complex and subject to change. We have invested significant resources to comply with these standards, and our workers' compensation compliance efforts will continue to require significant resources. We may be subject to significant fines, penalties and litigation if we fail to comply with those laws and regulations.

Audits and Investigations

We and our vendors and other downstream entities typically have been, are currently and may in the future be involved in various governmental investigations, audits, examinations, reviews, subpoenas and other requests for information, the intensity and scope of which continue to increase. These include routine, regular and special investigations, audits, examinations and reviews by, as well as subpoenas and other requests for information from, CMS, HHS (including the Office of Civil Rights), various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the CCIIO, the Office of the Inspector General (the "OIG"), the OPM, the DOL, the Treasury, the FDA, committees, subcommittees and members of the U.S. Congress, the DOJ, the U.S. Federal Trade Commission (the "FTC"), the Office of Foreign Assets Control ("OFAC") of the Treasury, U.S. attorneys and other state, federal and international governmental authorities.

For example, certain of our Medicare Advantage plans are currently under audit for, among other things, compliance with coding and other requirements under the Medicare risk adjustment model; we have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program; federal and state auditors are challenging our Commercial business compliance with the ACA's minimum MLR requirements; federal auditors are challenging our FEHB plans' compliance with the OPM's FEHB program specific minimum MLR requirements; and our Commercial business is subject to audits related to the ACA's risk adjustment and reinsurance data since those programs were implemented in 2014. HHS also has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security. Such government actions may, among other things, prevent or delay us from implementing planned premium rate increases and have resulted and may result in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds to members or the government, withholding of premium payments to us by government agencies, payments under insurance policies prior to those payments being due under the terms of the policy, assessments of damages, civil or criminal fines or penalties (including under the federal false claims act (the "False Claims Act")), or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

A significant number of states are investigating life insurers' and health insurers' claims payment and related escheat practices. For additional information on these life insurance matters, refer to "Life and Disability Insurance" below in this MD&A - Regulatory Environment.

Refer to "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K for more information regarding pending audits and investigations.

Federal and State Reporting

We are subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the state and federal level. Our ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. We are and will continue to be required to modify our information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, we cannot eliminate the risks of unavailability of or errors in our reports.

Fraud, Waste and Abuse Laws
Federal and state governments have made investigating and prosecuting health care fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a health care provider, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to us and other participants in these public-sector programs are complex and subject to change. Although our compliance program is designed to meet all statutory and regulatory requirements, our policies and procedures are frequently under review and subject to updates, and our training and education programs continue to evolve. We have invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

Federal and State Laws and Regulations Governing Submission of Information and Claims to Agencies
We are subject to federal and state laws and regulations that apply to the submission of information and claims to various government agencies. For example, the False Claims Act provides, in part, that the federal government may bring a lawsuit against any person or entity who the government believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. There also is False Claims Act liability for knowingly or improperly avoiding repayment of an overpayment received from the government and/or failing to promptly report and return any such overpayment. The federal government, whistleblowers and some courts have taken the position that claims presented in violation of other statutes, such as the federal anti-kickback statute, may be considered a violation of the False Claims Act. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products that are sold on Public Exchanges or otherwise subject to the ACA. Violations of the False Claims Act are punishable by treble damages and penalties of up to a specified dollar amount per false claim. In addition, a special provision under the False Claims Act allows a private person (for example, a "whistleblower" such as a disgruntled current or former competitor, member or employee) to bring an action under the False Claims Act on behalf of the government alleging that a company has defrauded the federal government and permits the private person to share in any settlement of, or judgment entered in, the lawsuit.

A number of states, including states in which we operate, have adopted their own false claims acts and whistleblower provisions that are similar to the False Claims Act. Companies in the health and related benefits industry, including ours, frequently are subject to actions under the False Claims Act or similar state laws.

Product Design and Administration and Sales Practices
State and/or federal regulatory scrutiny of health care benefit and life insurance product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. Refer to "Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K for more information on the liquidation of Penn Treaty and certain assessments to which our HMOs are subject. Penn Treaty was placed in liquidation in March, 2017, as a result of which we recorded an estimated liability and expense of $231 million pretax in the first quarter of 2017. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

Regulation of Pharmacy Operations
Caremark has provided certain PBM services to us and certain of our customers and members since January 1, 2011. As amended, our PBM agreement with Caremark has a term ending in December 2022, although we have certain termination rights beginning in January 2020. Express Scripts also provides certain PBM services to a portion of our Commercial and Medicaid customers and members under an agreement with a term ending in 2018 with an option to extend thereafter. Express Scripts also provided PBM services to a portion of our Medicare members in 2015.

Notwithstanding our contracting with our PBM services suppliers, we remain responsible to regulators and members for the delivery of PBM services. In addition, we continue to operate two home delivery pharmacy facilities and one specialty pharmacy facility (our "Pharmacies") and utilize certain pharmacies of our PBM services suppliers. Our Pharmacies dispense pharmaceuticals throughout the U.S. and are participating providers in Medicare, Medicare Part D and various Medicaid programs. The pharmacy practice is generally regulated at the state level by state boards of pharmacy. Our Pharmacies are required to be licensed in the state where they are located, as well as the states that require registration or licensure of home delivery pharmacies with the state's board of pharmacy or similar regulatory body. Our Pharmacies also must register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances and must comply with applicable Medicare, Medicaid and other provider rules and regulations, including the False Claims Act, state false claims acts and federal and state anti-kickback laws. Our PBM services suppliers' owned and contracted pharmacies are subject to these same licensing requirements and other laws and regulations. The loss or suspension of any such licenses or registrations could have a material adverse effect on our ability to meet our contractual obligations to our customers, which could, in turn, have a material adverse effect on our pharmacy business and/or operating results.

Regulation of Pharmacy Benefit Management Operations
Our PBM services are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and federal and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of, and/or changes to drug formularies, maximum allowable cost list pricing, average wholesale prices and/or clinical programs; disclosure of data to third parties; drug utilization management practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of our Pharmacies (including audits of our Pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by us or one of our PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on our operating results.

Life and Disability Insurance
Our life and disability insurance operations are subject to extensive regulation. Changes in these regulations, such as expanding the definition of disability or mandating changes to claim payment, determination and/or settlement practices, could have a material adverse impact on our life insurance and/or disability insurance operations and/or operating results. Legislation has been enacted or introduced in a number of states requiring life insurers to take additional steps to identify unreported deceased policy holders, and make other changes to their claim payment and related escheat practices, including consultation of certain databases. A significant number of states are investigating life insurers' claims payment and related escheat practices, and these investigations have resulted in significant charges to earnings by other life insurers in connection with related settlement agreements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

Consumer Protection Laws
Our Consumer Health and Services businesses and certain of our other businesses participate in direct-to-consumer activities, and we increasingly offer mobile and web-based solutions to our members and to other consumers. We are therefore subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. In particular, the FTC is aggressively exercising its enforcement authority in the areas of consumer privacy and data security with a focus on web-based, mobile products and "big data." As a result of the widely-reported large scale U.S. commercial data breaches during 2017 and prior years, the FTC and state regulators have increased their enforcement activity in these regimes. These enforcement developments will impact the design, management and operation of our businesses, including our Consumer Health and Services businesses, our privacy and security strategy and our web-based and mobile assets.

International Regulation
We expect to continue to expand our Health Care operations in foreign countries through both organic growth and acquisitions. We currently have insurance licenses in several foreign jurisdictions and do business directly or through local affiliations in numerous countries around the world. The impact on our international operations and results of the United Kingdom's pending exit from the EU is uncertain.

Our international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which will apply across the EU effective May 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of our operations into foreign countries increases our exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. We also are subject to applicable anti-corruption laws of the jurisdictions in which we operate. In many countries outside the U.S., health care professionals are employed by the government. Therefore, our dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the SEC and the DOJ have increased their enforcement activities with respect to the FCPA. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. We have internal control policies and procedures and conduct training and compliance programs for our employees to deter prohibited practices. However, if our employees or agents fail to comply with applicable laws governing our international operations, we may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions. See *"As we expand our international operations, we will increasingly face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations. Our exposure to these risks is expected to increase"* in "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K for a discussion of the risks related to operating globally.

Anti-Money Laundering Regulations
Certain of our lines of business are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their compliance with the regulations. We also may be subject to anti-money laundering laws in non-U.S. jurisdictions where we operate.

Office of Foreign Assets Control
We also are subject to regulation by OFAC. OFAC administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, we may be subject to similar regulations in the non-U.S. jurisdictions in which we operate.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Our earnings and financial position are exposed to interest rate risk, credit quality risk and market valuation risk.

Evaluation of Interest Rate and Credit Quality Risk
We manage interest rate risk by seeking to maintain a tight match between the durations of our assets and liabilities when appropriate. We manage credit risk by seeking to maintain high average credit quality ratings and diversified sector exposure within our debt securities portfolio. In connection with our investment and risk management objectives, we also use derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. Our use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject us to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, we expect these instruments to reduce overall risk.

Investments
Our investment portfolio supported the following products at December 31, 2017 and 2016:

(Millions)		**2017**		**2016**
Experience-rated products	**$**	**1,112**	$	1,154
Discontinued products		**2,754**		2,929
Remaining products		**16,207**		20,796
Total investments	**$**	**20,073**	$	24,879

Investment risks associated with our experience-rated and discontinued products generally do not impact our operating results. The risks associated with investments supporting experience-rated pension and annuity products in our Large Case Pensions business are assumed by the contract holders and not by us (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals. The distributions on our experience-rated products consisted of scheduled contract maturities and benefit payments and contract holder withdrawals of $98 million, $90 million and $285 million, respectively, in the years ended December 31, 2017, 2016 and 2015. Participant-directed withdrawals were not material in the years ended December 31, 2017, 2016 or 2015. Refer to Note 19 “Discontinued Products” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information related to our discontinued products.

Debt and Equity Securities
The debt securities in our investment portfolio had an average credit quality rating of A at both December 31, 2017 and 2016, with approximately $3.6 billion and $5.2 billion rated AAA at December 31, 2017 and 2016, respectively. The debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) were $1.4 billion and $1.6 billion at December 31, 2017 and 2016, respectively (of which 14% and 12% at December 31, 2017 and 2016, respectively, supported our experience-rated and discontinued products).

At December 31, 2017 and 2016, we held $551 million and $812 million, respectively, of municipal debt securities that were guaranteed by third parties, representing 3% of our total investments at both December 31, 2017 and 2016. These securities had an average credit quality rating of AA at both December 31, 2017 and 2016 with the guarantee. These securities had an average credit quality rating of A+ and A at December 31, 2017 and 2016, respectively, without the guarantee. We do not have any significant concentration of investments with third party guarantors (either direct or indirect).

We generally classify our debt and equity securities as available for sale, and carry them at fair value on our Consolidated Balance Sheets. At both December 31, 2017 and 2016, 1% of our debt and equity securities were valued using inputs that reflect our own assumptions (categorized as Level 3 inputs in accordance with GAAP). Refer to Note 5 “Fair Value” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the methodologies and key assumptions we use to determine the fair value of investments.

For additional information related to our investments, see Note 4 “Investments” included in Part II, Item 8 of this Annual Report on Form 10-K.

We regularly review our debt securities to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in our operating results, and the amount of the non-credit related component is included in other comprehensive income, unless we intend to sell the debt security or it is more likely than not that we will be required to

sell the debt security prior to its anticipated recovery of its amortized cost basis. Accounting for other-than-temporary impairment ("OTTI") of our debt securities is considered a critical accounting estimate. Refer to "Critical Accounting Estimates - Other-Than-Temporary Impairment of Debt Securities" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K for additional information.

Evaluation of Market Risks
We regularly evaluate our risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. We also regularly evaluate the appropriateness of investments relative to our management-approved investment guidelines (and operate within those guidelines) and the business objectives of our portfolios.

On a quarterly basis, we review the impact of hypothetical net losses in our investment portfolio on our consolidated near-term financial position, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for us. We have estimated the impact on the fair value of our market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which we believe represents a moderately adverse scenario and is approximately equal to the historical annual volatility of interest rate movements for our intermediate-term available-for-sale debt securities) and an immediate decrease of 15% in prices for domestic equity securities.

Assuming an immediate 100 basis point increase in interest rates and immediate decrease of 15% in the prices for domestic equity securities, the theoretical decline in the fair values of our market sensitive instruments at December 31, 2017 is as follows:

- The fair value of our long-term debt would decline by $519 million ($799 million pretax). Changes in the fair value of our long-term debt do not impact our financial position or operating results.
- The theoretical reduction in the fair value of our investment securities partially offset by the theoretical reduction in the fair value of our interest rate sensitive liabilities would result in a net decline in fair value of $395 million ($608 million pretax) related to our continuing non-experience-rated products. Reductions in the fair value of our investment securities would be reflected as an unrealized loss in equity, as we classify these securities as available for sale. We do not record our liabilities at fair value.

Based on our overall exposure to interest rate risk and equity price risk, we believe that these changes in market rates and prices would not materially affect our consolidated near-term financial position, operating results or cash flows as of December 31, 2017.

Evaluation of Operational Risks
We also face certain operational risks, including risks related to information security, including cybersecurity. We and our vendors have experienced a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. We are dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis our systems and processes that are designed to mitigate the information security risks we face and protect the security of our computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, destroy data, disrupt or degrade service, sabotage systems or cause other damage. The impact of the cyber attacks we have experienced through December 31, 2017 has not been material to our operations or operating results. Our Board and Audit Committee are regularly informed regarding our information security policies, practices and status.

Item 8. Financial Statements and Supplementary Data

Index to Consolidated Financial Statements

Consolidated Balance Sheets

(Millions)	At December 31, 2017	2016
Assets:		
Current assets:		
Cash and cash equivalents	**$ 4,076**	$ 17,996
Investments	**2,280**	3,046
Premiums receivable, net	**2,240**	2,356
Other receivables, net	**2,831**	2,224
Reinsurance recoverables	**1,050**	292
Accrued investment income	**193**	232
Income taxes receivable	**365**	44
Other current assets	**2,488**	2,259
Total current assets	**15,523**	28,449
Long-term investments	**17,793**	21,833
Reinsurance recoverables	**3,323**	727
Goodwill	**10,571**	10,637
Other acquired intangible assets, net	**1,180**	1,442
Property and equipment, net	**586**	587
Deferred income taxes	**195**	—
Other long-term assets	**1,684**	1,480
Separate Accounts assets	**4,296**	3,991
Total assets	**$ 55,151**	$ 69,146
Liabilities and shareholders' equity:		
Current liabilities:		
Health care costs payable	**$ 5,815**	$ 6,558
Future policy benefits	**604**	645
Unpaid claims	**850**	801
Unearned premiums	**654**	556
Policyholders' funds	**2,918**	2,772
Current portion of long-term debt	**999**	1,634
Accrued expenses and other current liabilities	**4,997**	5,728
Total current liabilities	**16,837**	18,694
Future policy benefits	**5,763**	5,929
Unpaid claims	**1,922**	1,703
Policyholders' funds	**739**	812
Long-term debt, less current portion	**8,160**	19,027
Deferred income taxes	**—**	4
Other long-term liabilities	**1,597**	1,043
Separate Accounts liabilities	**4,296**	3,991
Total liabilities	**39,314**	51,203
Commitments and contingencies (Note 17)		
Shareholders' equity:		
Common stock ($.01 par value; 2.5 billion shares authorized and 326.8 million shares issued and outstanding in 2017; 2.5 billion shares authorized and 351.7 million shares issued and outstanding in 2016) and additional paid-in capital	**4,706**	4,716
Retained earnings	**12,118**	14,717
Accumulated other comprehensive loss	**(1,244)**	(1,552)
Total Aetna shareholders' equity	**15,580**	17,881
Non-controlling interests	**257**	62
Total equity	**15,837**	17,943
Total liabilities and equity	**$ 55,151**	$ 69,146

Refer to accompanying Notes to Consolidated Financial Statements.

Consolidated Statements of Income

(Millions, except per common share data)	For the Years Ended December 31, 2017	2016	2015
Revenue:			
Health care premiums	**$ 52,022**	$ 54,116	$ 51,618
Other premiums	**1,872**	2,182	2,171
Fees and other revenue [1]	**5,930**	5,861	5,696
Net investment income	**950**	910	917
Net realized capital (losses) gains	**(239)**	86	(65)
Total revenue	**60,535**	63,155	60,337
Benefits and expenses:			
Health care costs [2]	**42,753**	44,255	41,712
Current and future benefits	**1,875**	2,101	2,121
Operating expenses:			
Selling expenses	**1,598**	1,678	1,611
General and administrative expenses	**10,466**	10,407	10,033
Total operating expenses	**12,064**	12,085	11,644
Interest expense	**442**	604	369
Amortization of other acquired intangible assets	**272**	247	255
Loss on early extinguishment of long-term debt	**246**	—	—
Reduction of reserve for anticipated future losses on discontinued products	**(109)**	(128)	—
Total benefits and expenses	**57,543**	59,164	56,101
Income before income taxes	**2,992**	3,991	4,236
Income tax expense	**1,087**	1,735	1,841
Net income including non-controlling interests	**1,905**	2,256	2,395
Less: Net income (loss) attributable to non-controlling interests	**1**	(15)	5
Net income attributable to Aetna	**$ 1,904**	$ 2,271	$ 2,390
Earnings per common share:			
Basic	**$ 5.71**	$ 6.46	$ 6.84
Diluted	**$ 5.68**	$ 6.41	$ 6.78

[1] Fees and other revenue include administrative services contract member co-payments and plan sponsor reimbursements related to our home delivery and specialty pharmacy operations of $130 million, $128 million and $112 million for 2017, 2016 and 2015, respectively (net of pharmaceutical and processing costs of $1.4 billion for 2017 and 1.3 billion for each of 2016 and 2015).

[2] Health care costs have been reduced by Insured member co-payments related to our home delivery and specialty pharmacy operations of $115 million, $115 million and $117 million for 2017, 2016 and 2015, respectively.

Refer to accompanying Notes to Consolidated Financial Statements.

Consolidated Statements of Comprehensive Income

	For the Years Ended December 31,		
(Millions)	**2017**	**2016**	**2015**
Net income including non-controlling interests	**$ 1,905**	$ 2,256	$ 2,395
Other comprehensive income (loss), net of tax:			
Previously impaired debt securities	**(11)**	(3)	(16)
All other securities	**29**	(15)	(256)
Derivatives and foreign currency	**231**	(161)	(13)
Pension and OPEB plans	**59**	(43)	66
Other comprehensive income (loss)	**308**	(222)	(219)
Comprehensive income including non-controlling interests	**2,213**	2,034	2,176
Less: Comprehensive income (loss) attributable to non-controlling interests	**1**	(15)	5
Comprehensive income attributable to Aetna	**$ 2,212**	$ 2,049	$ 2,171

Refer to accompanying Notes to Consolidated Financial Statements, including Note 14 for further information about other comprehensive income (loss).

Consolidated Statements of Shareholders' Equity

(Millions)	Number of Common Shares Outstanding	Attributable to Aetna: Common Stock and Additional Paid-in Capital	Attributable to Aetna: Retained Earnings	Attributable to Aetna: Accumulated Other Comprehensive Loss	Attributable to Aetna: Total Aetna Shareholders' Equity	Non-Controlling Interests	Total Equity
Balance at December 31, 2014	349.8	$ 4,542	$ 11,052	$ (1,111)	$ 14,483	$ 69	$ 14,552
Net income	—	—	2,390	—	2,390	5	2,395
Other decreases in non-controlling interest	—	—	—	—	—	(9)	(9)
Other comprehensive loss (Note 14)	—	—	—	(219)	(219)	—	(219)
Common shares issued for benefit plans, including tax benefits, net of employee tax withholdings	2.7	105	—	—	105	—	105
Repurchases of common shares	(3.0)	—	(296)	—	(296)	—	(296)
Dividends declared	—	—	(349)	—	(349)	—	(349)
Balance at December 31, 2015	349.5	4,647	12,797	(1,330)	16,114	65	16,179
Net income (loss)	—	—	2,271	—	2,271	(15)	2,256
Other increases in non-controlling interest	—	—	—	—	—	12	12
Other comprehensive loss (Note 14)	—	—	—	(222)	(222)	—	(222)
Common shares issued for benefit plans, including tax benefits, net of employee tax withholdings	2.2	69	—	—	69	—	69
Dividends declared	—	—	(351)	—	(351)	—	(351)
Balance at December 31, 2016	**351.7**	**4,716**	**14,717**	**(1,552)**	**17,881**	**62**	**17,943**
Net income	**—**	**—**	**1,904**	**—**	**1,904**	**1**	**1,905**
Other increases in non-controlling interest	**—**	**—**	**—**	**—**	**—**	**194**	**194**
Other comprehensive income (Note 14)	**—**	**—**	**—**	**308**	**308**	**—**	**308**
Common shares issued for benefit plans, net of employee tax withholdings	**2.1**	**(10)**	**—**	**—**	**(10)**	**—**	**(10)**
Repurchases of common shares	**(27.0)**	**—**	**(3,845)**	**—**	**(3,845)**	**—**	**(3,845)**
Dividends declared	**—**	**—**	**(658)**	**—**	**(658)**	**—**	**(658)**
Balance at December 31, 2017	**326.8**	**$ 4,706**	**$ 12,118**	**$ (1,244)**	**$ 15,580**	**$ 257**	**$ 15,837**

Refer to accompanying Notes to Consolidated Financial Statements.

Consolidated Statements of Cash Flows

(Millions)	For the Years Ended December 31, 2017	2016	2015
Cash flows from operating activities:			
Net income including non-controlling interests	**$ 1,905**	$ 2,256	$ 2,395
Adjustments to reconcile net income to net cash (used for) provided by operating activities:			
Net realized capital losses (gains)	**239**	(86)	65
Depreciation and amortization	**705**	681	671
Debt fair value amortization	**(17)**	(30)	(30)
Equity in earnings of affiliates, net	**(105)**	(6)	(31)
Stock-based compensation expense	**187**	191	181
Reduction of reserve for anticipated future losses on discontinued products	**(109)**	(128)	—
Amortization of net investment premium	**69**	79	84
Loss on early extinguishment of long-term debt	**246**	—	—
Gain on sale of businesses	**(88)**	—	—
Changes in assets and liabilities:			
Premiums due and other receivables	**(809)**	(153)	(616)
Income taxes	**(672)**	155	31
Other assets and other liabilities	**(1,445)**	669	646
Health care and insurance liabilities	**(624)**	91	470
Distributions from partnership investments	**54**	—	—
Net cash (used for) provided by operating activities	**(464)**	3,719	3,866
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	**12,144**	14,741	12,299
Cost of investments	**(10,370)**	(14,852)	(12,943)
Additions to property, equipment and software	**(410)**	(270)	(363)
Proceeds from sale of businesses, net of cash transferred	**1,390**	—	—
Cash used for acquisitions, net of cash acquired	**(24)**	—	(20)
Net cash provided by (used for) investing activities	**2,730**	(381)	(1,027)
Cash flows from financing activities:			
Issuance of long-term debt	**988**	12,886	—
Repayment of long-term debt	**(12,734)**	—	(229)
Repayment of short-term debt	**—**	—	(500)
Deposits and interest credited to investment contracts net of (withdrawals)	**1**	1	(35)
Common shares issued under benefit plans, net	**(180)**	(139)	(143)
Stock-based compensation tax benefits	**—**	—	53
Settlements from repurchase agreements	**—**	—	(202)
Common shares repurchased	**(3,845)**	—	(296)
Dividends paid to shareholders	**(583)**	(351)	(349)
Net payment on interest rate derivatives	**—**	(274)	(25)
Contributions (distributions), non-controlling interests	**167**	11	(9)
Net cash (used for) provided by financing activities	**(16,186)**	12,134	(1,735)
Net (decrease) increase in cash and cash equivalents	**(13,920)**	15,472	1,104
Cash and cash equivalents, beginning of period	**17,996**	2,524	1,420
Cash and cash equivalents, end of period	**$ 4,076**	$ 17,996	$ 2,524
Supplemental cash flow information:			
Interest paid	**$ 453**	$ 541	$ 338
Income taxes paid	**1,759**	1,580	1,755

Refer to accompanying Notes to Consolidated Financial Statements.

Notes to Consolidated Financial Statements

1. Organization

We conduct our operations in three business segments:

- **Health Care** consists of medical, pharmacy benefit management services, dental, behavioral health and vision plans offered on both an Insured basis (where we assume all or a majority of the risk for medical and dental care costs) and an employer-funded basis (where the plan sponsor under an administrative services contract ("ASC") assumes all or a majority of this risk) and emerging business products and services that complement and enhance our medical products. We also offer Medicare and Medicaid products and services and other medical products, such as medical management and data analytics services, medical stop loss insurance, workers' compensation administrative services and products that provide access to our provider networks in select geographies. We no longer sell individual Commercial products, and we exited the individual Public Exchanges in 2018.

- **Group Insurance** primarily includes group life insurance and group disability products. Group life insurance products are offered on an Insured basis. Group disability products are offered to employers on both an Insured and an ASC basis. Group Insurance also includes long-term care products that were offered primarily on an Insured basis. We no longer solicit or accept new long-term care customers. During the fourth quarter of 2017, we sold a substantial portion of our Group Insurance business to Hartford Life and Accident Insurance Company ("HLAIC") (refer to Note 3 for additional information).

- **Large Case Pensions** manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. These products provide a variety of funding and benefit payment distribution options and other services. Large Case Pensions also includes certain discontinued products (refer to Note 19 for additional information).

Our three business segments are distinct businesses that offer different products and services. Our Chief Executive Officer evaluates financial performance and makes resource allocation decisions at these segment levels. The accounting policies of the segments are the same as those described in the summary of significant accounting policies in Note 2. We evaluate the performance of these business segments based on pre-tax adjusted earnings (income before income taxes attributable to Aetna, excluding net realized capital gains or losses, amortization of other acquired intangible assets and other items, if any, that neither relate to the ordinary course of our business nor reflect our underlying business performance).

Effective for the first quarter of 2018, we will realign our business segments to correspond with changes to our management structure and internal management reporting which reflect our evolving business strategy of helping our members live healthier lives. As a result of this realignment, our operations will now be conducted in the Health Care reportable segment. Health Care offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services to large and small employers, public sector employers, and Medicaid and Medicare beneficiaries. Our Health Care products are offered on both an Insured basis and an employer-funded basis. Health Care also includes emerging business products and services that complement and enhance our medical products.

Effective for the first quarter of 2018, we will present the remainder of our financial results in the Corporate/Other category, which will consist of:

- Products for which we no longer solicit or accept new customers such as our large case pensions and long-term care products;
- Contracts we have divested through reinsurance or other contracts, such as our domestic group life insurance, group disability insurance and absence management businesses; and
- Corporate expenses not supporting business operations, including transaction and integration-related costs, income taxes, interest expense on our outstanding debt and the financing components of our pension and other postretirement employee benefit plans ("OPEB") expense.

Refer to Note 18 for segment financial information.

2. Summary of Significant Accounting Policies

Basis of Presentation
The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP") and include the accounts of Aetna and the subsidiaries that we control. All significant

intercompany balances have been eliminated in consolidation. The Company has evaluated subsequent events from the financial statement date through the date the financial statements were issued and determined there were no subsequent events to disclose other than as disclosed in Notes 1, 13, 16 and 18.

Reclassifications
Certain prior year amounts have been reclassified to conform to the current year presentation.

Use of Estimates
The preparation of the accompanying consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the amounts reported in these consolidated financial statements and notes. We consider the following accounting estimates critical in the preparation of the accompanying consolidated financial statements: health care costs payable, other insurance liabilities, recoverability of goodwill and other acquired intangible assets, measurement of defined benefit pension and other postretirement employee benefit plans, other-than-temporary impairment of debt securities, revenue recognition, allowance for estimated terminations and uncollectible accounts and accounting for certain provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA"). We use information available to us at the time estimates are made; however, these estimates could change materially if different information or assumptions were used. Additionally, these estimates may not ultimately reflect the actual amounts of the final transactions that occur.

Cash and Cash Equivalents
Cash and cash equivalents include cash on-hand and debt securities with an original maturity of three months or less when purchased. The carrying value of cash equivalents approximates fair value due to the short-term nature of these investments. Cash and cash equivalents at December 31, 2016 included approximately $13 billion of highly-rated money market fund investments related to the net proceeds received from the 2016 senior notes we issued in June 2016 to partially fund our then pending acquisition of Humana Inc. (the "Humana Transaction"). These money market funds had average maturities of 60 days or less and were redeemable daily at par value plus accrued dividends with specified yield rates.

Investments
Debt and Equity Securities
Debt and equity securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt and equity securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless we intend to sell an investment within the next twelve months, in which case it is classified as current on our Consolidated Balance Sheets. We have classified our debt and equity securities as available for sale and carry them at fair value. Refer to Note 5 for additional information on how we estimate the fair value of these investments.

The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments.

We regularly review our debt and equity securities to determine whether a decline in fair value below the carrying value is other-than-temporary. When a debt or equity security is in an unrealized capital loss position, we monitor the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in the fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in our operating results, and the amount of the non-credit related component is included in other comprehensive income, unless we intend to sell the debt security or it is more likely than not that we will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. We do not accrue interest on debt securities when management believes the collection of interest is unlikely. If we intend to sell an equity security, we will recognize the unrealized capital gain or loss in our operating results.

Mortgage Loans
We value our mortgage loan investments on our balance sheet at the unpaid principal balance, net of impairment reserves. A mortgage loan may be impaired when it is a problem loan (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure), a potential problem loan (i.e., high probability of default) or a restructured loan. For impaired loans, a specific impairment reserve is established for the difference between the recorded investment in the loan and the estimated fair value of the collateral. We apply our loan impairment policy individually to all loans in our portfolio.

The impairment evaluation described above also considers characteristics and risk factors attributable to the aggregate portfolio. We establish an additional allowance for loan losses if it is probable that there will be a credit loss on a group of similar mortgage loans. We consider the following characteristics and risk factors when evaluating if a credit loss is probable

on a group of similar mortgage loans: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition. As a result of that evaluation, we determined that a credit loss was not probable and did not record any additional allowance for groups of similar mortgage loans in 2017, 2016 or 2015.

We record full or partial impairments of loans at the time an event occurs affecting the legal status of the loan, typically at the time of foreclosure or upon a loan modification giving rise to forgiveness of debt. Interest income on a potential problem loan or restructured loan is accrued to the extent we deem it collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on our Consolidated Balance Sheets.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships, which are carried at fair value on our Consolidated Balance Sheets. The fair values of private equity limited partnerships are estimated based on the fair value of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. We typically do not have a controlling ownership in our private equity limited partnership investments, and therefore we apply the equity method of accounting for these investments. Hedge fund limited partnerships are carried at fair value which is estimated using the net asset value ("NAV") per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. We review our investments for impairment at least quarterly and monitor their performance throughout the year through discussions with the administrators, managers and/or general partners. If we become aware of an impairment of a limited partnership's investments through our review or prior to receiving the limited partnership's financial statements at the financial statement date, we will recognize an impairment by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.
- Investment real estate, which is carried on our Consolidated Balance Sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any of our real estate investments is considered held-for-sale, we carry it at the lower of its carrying value or fair value less estimated selling costs. We generally estimate fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, we record the difference between the sales price and the carrying value as a realized capital gain or loss.
- Privately-placed equity securities, which are carried at cost on our Consolidated Balance Sheets. We do not estimate the fair value of these securities if there are no identified events or changes in circumstances that may have a significant adverse effect on the fair value of the investment. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), we are required to purchase and hold shares of the FHLBB. These shares are restricted and also carried at cost.
- Bank loans, which are carried on our Consolidated Balance Sheets at amortized cost, net of any allowance for impairments. If any of our bank loans are considered held-for-sale, we carry those loans at the lower of cost or fair value.
- Derivatives, which we make limited use of in order to manage interest rate, foreign exchange and price risk and credit exposure. The derivatives we use consist primarily of interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options, and credit default swaps. Derivative assets are recorded in investments and derivative liabilities are recorded in accrued expenses and other current liabilities on our Consolidated Balance Sheets and reflected at fair value. When we enter into a derivative contract, if certain criteria are met, we may designate it as one of the following: a hedge of the fair value of a recognized asset or liability or of an unrecognized firm commitment; a hedge of a forecasted transaction or of the variability of cash flows to be received or paid related to a recognized asset or liability; or a foreign currency fair value or cash flow hedge.

Net Investment Income
Net investment income on investments supporting Health Care and Group Insurance liabilities and Large Case Pensions products (other than experience-rated and discontinued products) is reflected in our operating results.

Experience-rated products are products in the Large Case Pensions business where the contract holder, not us, assumes investment and other risks, subject to, among other things, minimum guarantees provided by us. The effect of investment

performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact our operating results (as long as our minimum guarantees are not triggered).

When we discontinued the sale of our fully-guaranteed Large Case Pensions products, we established a reserve for anticipated future losses from these discontinued products and segregated the related investments. Investment performance on this separate portfolio is ultimately credited/charged to the reserve and, generally, does not impact our operating results.

Net investment income supporting Large Case Pensions' experience-rated and discontinued products is included in net investment income in our Consolidated Statements of Income and is credited to contract holders' accounts or the reserve for anticipated future losses through a charge to current and future benefits.

Realized/Unrealized Capital Gains and Losses
Realized capital gains and losses on investments supporting Health Care and Group Insurance liabilities and Large Case Pensions products (other than experience-rated and discontinued products) are reflected in our operating results. Realized capital gains and losses are determined on a specific identification basis. We reflect purchases and sales of debt and equity securities and alternative investments on the trade date. We reflect purchases and sales of mortgage loans and investment real estate on the closing date.

Realized capital gains and losses on investments supporting Large Case Pensions' experience-rated and discontinued products are not included in realized capital gains and losses in our Consolidated Statements of Income and instead are credited directly to contract holders' accounts, in the case of experience-rated products, or allocated to the reserve for anticipated future losses, in the case of discontinued products. The contract holders' accounts are reflected in policyholders' funds, and the reserve for anticipated future losses is reflected in future policy benefits on our Consolidated Balance Sheets.

Unrealized capital gains and losses on investments supporting Health Care and Group Insurance liabilities and Large Case Pensions products (other than experience-rated and discontinued products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive loss.

Unrealized capital gains and losses on investments supporting Large Case Pensions' experience-rated products are credited directly to contract holders' accounts, which are reflected in policyholders' funds on our Consolidated Balance Sheets. Unrealized capital gains and losses on discontinued products are reflected in other long-term liabilities on our Consolidated Balance Sheets.

Refer to Note 19 for additional information on our discontinued products.

Premium Receivables
Premium receivables include the uncollected amounts from fully-insured groups, individuals and government programs and are reported net of an allowance for estimated terminations and uncollectible accounts of $381 million and $139 million at December 31, 2017 and 2016, respectively. We estimate the allowance for estimated terminations and uncollectible accounts using management's best estimate of collectability, taking into consideration the age of the outstanding amount, historical collection patterns and other economic factors. For details on our Medicare Part D Prescription Drug Program Plans ("Medicare Part D") receivables at December 31, 2017 and 2016, refer to the "*Accounting for Medicare Part D"* section below.

Our premium receivable balance at December 31, 2017 from the State of Illinois was approximately $350 million. The State of Illinois experienced budget difficulties which contributed to the state being delinquent in paying certain of our premiums and fees. Given our significant cash collections during the fourth quarter of 2017 of approximately $960 million, the State of Illinois budget and bond issuance, a federal judge's ruling that prioritized Medicaid payments and the federal government's match of a percentage of payments made by the state to managed care organizations under the state's Medicaid program, we continue to believe the amounts due to us are collectible.

Other Receivables
Other receivables include uncollected amounts from self-funded groups, pharmacy rebates, other government receivables, proceeds due from brokers on investment trades, provider advances and other miscellaneous amounts due to us. These receivables are reported net of an allowance for uncollectible accounts of $74 million and $37 million at December 31, 2017 and 2016, respectively. We estimate the allowance for uncollectible accounts using management's best estimate of collectability, taking into consideration the age of the outstanding amount, historical collection patterns and other economic factors. Pharmacy rebate receivables were $1.0 billion and $916 million at December 31, 2017 and 2016, respectively. For

details on our Medicare Part D receivables at December 31, 2017 and 2016, refer to the "*Accounting for Medicare Part D"* section below.

Reinsurance Recoverables
We utilize reinsurance agreements primarily to reduce our required capital and to facilitate the acquisition or disposition of certain insurance contracts (including the Group Insurance sale (as defined in Note 3)). Ceded reinsurance agreements permit us to recover a portion of our losses from reinsurers, although they do not discharge our primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify us could result in losses; however, we do not expect charges for unrecoverable reinsurance to have a material effect on our operating results or financial position. We evaluate the financial condition of our reinsurers and monitor concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of our reinsurers. At December 31, 2017, our reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations.

Health Care Contract Acquisition Costs
Health care benefits products included in our Health Care segment are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to our prepaid health care and health indemnity contracts are generally expensed as incurred. At December 31, 2017 and 2016, the balance of our deferred acquisition costs was $521 million and $412 million, respectively, comprised primarily of commissions paid on our Medicare Supplement products. Deferred acquisition costs are recorded as other current assets or other long-term assets on our Consolidated Balance Sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in general and administrative expenses in our Consolidated Statements of Income.

Goodwill and Other Acquired Intangible Assets
When we complete an acquisition, we apply the acquisition method of accounting, which requires the recognition of goodwill (which represents the excess cost of the acquisition over the fair value of net assets acquired and identified intangible assets). We evaluate goodwill for impairment (at the reporting unit level) annually, or more frequently if circumstances indicate a possible impairment, by comparing an estimate of the fair value of the applicable reporting unit to its carrying value, including goodwill. If the carrying value exceeds fair value, we have historically compared the implied fair value of the applicable goodwill to its carrying amount to measure the amount of goodwill impairment, if any. Effective January 1, 2017, we adopted, on a prospective basis, new accounting guidance which simplifies the accounting for goodwill impairment. The new guidance eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. A goodwill impairment charge would be recognized if the carrying amount of a reporting unit exceeds the estimated fair value of the reporting unit. The fair value of each reporting unit substantially exceeded its carrying value in each of the three years ended December 31, 2017, 2016, or 2015, and no goodwill impairment loss was recognized in any of those years. In conjunction with the Group Insurance sale, which included a substantial portion of our Group Insurance business, the goodwill allocated to our Group Insurance segment of $113 million was included in the calculation of the total gain on the sale, with a corresponding reduction of the goodwill balance.

Our annual impairment tests were based on an evaluation of future discounted cash flows. These evaluations utilized the best information available to us at the time, including supportable assumptions and projections we believe are reasonable. Collectively, these evaluations were our best estimates of projected future cash flows. Our discounted cash flow evaluations used discount rates that correspond to a weighted-average cost of capital consistent with a market-participant view. The discount rates are consistent with those used for investment decisions and take into account the operating plans and strategies of our reporting units. Certain other key assumptions utilized, including changes in membership, revenue, health care costs, operating expenses, impacts of health care reform fees, assessments and taxes, and effective tax rates, are based on estimates consistent with those utilized in our annual planning process that we believe are reasonable. If we do not achieve our earnings objectives, the assumptions and estimates underlying these goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment.

We report other acquired intangible assets at historical cost, net of accumulated amortization. Other acquired intangible assets primarily relate to provider networks, customer lists, value of business acquired ("VOBA"), technology and trademarks and are amortized over the useful-life based upon the pattern of future cash flows attributable to the asset. Other than VOBA and indefinite lived trademarks, other acquired intangible assets generally are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. Other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually.

We regularly evaluate whether events or changes in circumstances indicate that the carrying value of other acquired intangible assets may not be recoverable. If we determine that the carrying value of an asset may not be recoverable, we group the asset

with other assets and liabilities at the lowest level for which independent identifiable cash flows are available and estimate the future undiscounted cash flows expected to result from future use of the asset group and its eventual disposition. If the sum of the expected undiscounted future cash flows is less than the carrying value of the asset group, we recognize an impairment loss for the amount by which the carrying value of the asset group exceeds its fair value. There were no material impairment losses on other acquired intangible assets recognized in any of the three years ended December 31, 2017, 2016 or 2015.

Property and Equipment
We report property and equipment at historical cost, net of accumulated depreciation. At December 31, 2017 and 2016, the historical cost of property and equipment was approximately $1.5 billion and $1.4 billion, respectively, and the related accumulated depreciation was $893 million and $851 million, respectively. We calculate depreciation primarily using the straight-line method over the estimated useful lives of the respective assets, which range from 10 to 40 years for buildings and 3 to 10 years for equipment. Depreciation expense was $118 million, $125 million and $131 million for the years ended December 31, 2017, 2016 and 2015, respectively. If we determine the carrying value of our property and equipment is not recoverable, an impairment charge is recorded. There were no material impairment losses on property and equipment recognized in any of the three years ended December 31, 2017, 2016 or 2015.

Separate Accounts
Separate Accounts assets and liabilities in the Large Case Pensions segment represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income and net realized capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from our other businesses. Deposits, withdrawals, net investment income and net realized and net unrealized capital gains and losses on Separate Accounts assets are not reflected in our Consolidated Statements of Income or Cash Flows. Management fees charged to contract holders are included in fees and other revenue and recognized over the period earned.

Health Care Costs Payable
Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements related to the Health Care segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include our estimate of payments we will make for (i) services rendered to our members but not yet reported to us and (ii) claims which have been reported to us but not yet paid, each as of the financial statement date (collectively, "IBNR") in our Health Care segment. Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if we are obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors. We reflect changes in these estimates in health care costs in our operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the member. Approximately 3% of our health care costs related to capitated arrangements in 2017 and approximately 4% of our health care costs related to capitated arrangements in both 2016 and 2015. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

We develop our estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, we consider the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing our estimate of IBNR, we consistently apply these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop our estimate of IBNR in 2017.

We analyze historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." We use completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. We estimate completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents our estimate of claims

remaining to be paid as of the financial statement date and is included in our health care costs payable. We use completion factors predominantly to estimate the ultimate cost of claims with claim incurred dates greater than three months prior to the financial statement date. The completion factors we use reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, we use a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. We apply our actuarial judgment and place a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

Our health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including our ability to manage health care costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of our business. The health status of our members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and our health care cost trend rate.

For each reporting period, we use an extensive degree of judgment in the process of estimating our health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period we recognize the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. We believe our estimate of health care costs payable is reasonable and adequate to cover our obligations at December 31, 2017; however, actual claim payments may differ from our estimates. A worsening (or improvement) of our health care cost trend rates or changes in completion factors from those that we assumed in estimating health care costs payable at December 31, 2017 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, we re-examine previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that our estimates of health care costs payable could develop either favorably (that is, our actual health care costs for the period were less than we estimated) or unfavorably. The changes in our estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For our roll forward of our health care costs payable, refer to Note 7. Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for health care costs payable.

Unpaid claims

Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts in the Group Insurance segment, including an estimate for IBNR in our Group Insurance segment as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon our estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. We develop our estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. We discount certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect our expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. Our estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in our Consolidated Statements of Income in the period they are determined. Substantially all of our life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements, however we remain directly obligated to the policyholders.

We estimate our reserve for claims IBNR for life products largely based on completion factors. The completion factors we use are based on our historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. At December 31, 2017, we held $239 million in reserves for life claims incurred but not yet reported to us.

There have been no significant changes to the methodologies or assumptions used to develop our estimate of IBNR in 2017.

Future policy benefits

Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts in the Large Case Pensions segment and long-duration group life and long-term care insurance contracts in the Group Insurance segment. Reserves for limited payment contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from .8% to 11.3% in both 2017 and 2016. We periodically review mortality assumptions against both industry standards and our experience. Reserves for long-duration group life and long-term care contracts represent our estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. Assumed interest rates on such contracts ranged from 2.5% to 6.0% in 2017. Assumed interest rates on such contracts ranged from 2.5% to 8.8% in 2016. Our estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions.

Policyholders' funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts in the Large Case Pensions segment and customer funds associated with group life and health contracts in the Health Care and Group Insurance segments. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus credited interest thereon, net of experience-rated adjustments. In 2017, interest rates for pension and annuity investment contracts ranged from 3.5% to 15.4%, and interest rates for group life and health contracts ranged from 0% to 2.3%. In 2016, interest rates for pension and annuity investment contracts ranged from 3.5% to 15.9%, and interest rates for group life and health contracts ranged from 0% to 2.4%. Reserves for contracts subject to experience rating reflect our rights as well as the rights of policyholders and plan participants.

We also hold funds for health savings accounts ("HSAs") on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $1.9 billion and $1.7 billion at December 31, 2017 and 2016, respectively, and are reflected in other current assets with a corresponding liability in policyholder funds.

We review health care and other insurance liabilities periodically. We reflect any necessary adjustments during the current period in operating results. While the ultimate amount of claims and related expenses are dependent on future developments, it is management's opinion that the liabilities that have been established are adequate to cover such costs. The health care and other insurance liabilities that are expected to be paid within twelve months are classified as current on our Consolidated Balance Sheets.

Premium Deficiency Reserves

We evaluate our insurance contracts to determine if it is probable that a loss will be incurred. We recognize a premium deficiency loss when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with our method of acquiring, servicing and measuring the profitability of such contracts. We established a premium deficiency reserve of $16 million at December 31, 2017 for the 2018 coverage year related to our Medicaid products. We did not have any material premium deficiency reserves for our Health Care or Group Insurance business at December 31, 2016.

Revenue Recognition

Premium Revenue

Health care premiums are recognized as income in the month in which the enrollee is entitled to receive health care services. Health care premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the ACA's minimum Medical Loss Ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. Other premium revenue for group life, long-term care and disability products is recognized as income, net of allowances for termination and uncollectible accounts, over the term of the

coverage. Other premium revenue for Large Case Pensions' limited payment pension and annuity contracts is recognized as revenue in the period received. Premiums related to unexpired contractual coverage periods are reported as unearned premiums in our Consolidated Balance Sheets and recognized as revenue when earned.

Some of our contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Administrative Service Contract ("ASC") Fees
Fees and other revenue consists primarily of ASC fees which are received in exchange for performing certain claim processing and member services for health and disability members and are recognized as revenue over the period the service is provided. Fees and other revenue also includes fees related to our pharmacy benefit management and workers' compensation administrative services products and services. Some of our contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, we are financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to us by the customer involved. Each period we estimate our obligations under the terms of these guarantees and record it as an offset to our ASC fees.

In addition, fees and other revenue also include charges assessed against contract holders' funds for contract fees, participant fees and asset charges related to pension and annuity products in the Large Case Pensions segment. Other amounts received on pension and annuity investment-type contracts are reflected as deposits and are not recorded as revenue. Some of our Large Case Pensions contract holders have the contractual right to purchase annuities with life contingencies using the funds they maintain on deposit with us. Since these products are considered an insurance contract, when the contract holder makes this election, we treat the accumulated investment balance as a single premium and reflect it as both premiums and current and future benefits in our Consolidated Statements of Income.

Accounting for Medicare Part D
We offer Medicare Part D prescription drug insurance coverage under contracts with the Centers for Medicare & Medicaid Services ("CMS"). Under these annual contracts, we receive monthly payments from CMS and members which include:

- *Premiums:* CMS pays us a fixed monthly per member premium over the term of our annual contract. In addition, certain members pay us a fixed monthly premium over the term of our annual contract. For qualifying low-income Medicare beneficiaries, CMS pays us all or a portion of the member's monthly premiums. The payments we receive monthly from CMS and members, which are determined from our annual bid, represent amounts we are paid for providing Medicare Part D prescription drug insurance coverage. We recognize premium revenue for providing this insurance coverage ratably over the term of our annual contract.
- *Risk-Sharing Arrangement:* Our risk-sharing arrangement with CMS provides a risk corridor whereby the amount we received in premiums from members and CMS, based on our annual bid, is compared to our actual drug costs incurred during the contract year. Based on the risk corridor provision and Medicare Part D actual experience, we record an estimated risk-sharing receivable or payable as an adjustment to premium revenue. A final reconciliation and settlement of this risk sharing arrangement is made with CMS based on actual experience after the end of each contract year.
- *Catastrophic Reinsurance and Low-Income Cost Sharing Subsidies*: CMS pays us a cost reimbursement estimate monthly to fund the CMS obligation to pay its portion of prescription drug costs which exceed the member's out-of-pocket threshold. A final reconciliation and settlement is made with CMS based on actual experience after the end of each contract year. In addition, for qualifying low-income Medicare beneficiaries, CMS pays to us monthly, on the member's behalf, all or a portion of a member's cost sharing amounts (deductibles, coinsurance, etc.). We administer and pay the subsidized portion of the claims on behalf of CMS, and a final reconciliation and settlement of this cost sharing subsidy is made with CMS based on actual experience after the end of each contract year. These subsidies represent cost reimbursements under the Medicare Part D plans for which we are not at risk. Accordingly, the amounts received for these subsidies are not reflected as premium revenues, but rather are accounted for as receivables and liabilities.
- *Coverage Gap Drug Discount:* The ACA mandated a consumer discount on brand name prescription drugs for Medicare Part D participants in the coverage gap (the so-called "donut hole"). This discount is funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. Accordingly, amounts received are not reflected as premium revenues, but rather are accounted for as deposits. We record a liability when amounts are received from CMS and a receivable when we bill the pharmaceutical manufacturers.

We expense the cost of Medicare Part D covered prescription drugs as incurred in medical costs in our Consolidated Statements of Income.

The Consolidated Balance Sheets include the following amounts associated with Medicare Part D at December 31, 2017 and 2016. CMS subsidies and discounts in the table below include the catastrophic reinsurance and low-income cost sharing subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Medicare Part D participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	December 31, 2017		December 31, 2016	
(Millions)	Risk Share	CMS Subsidies/Discounts	Risk Share	CMS Subsidies/Discounts
Premium receivables, net	$ 148	$ —	$ 209	$ —
Other receivables, net	—	791	—	206
Other long-term assets	6	74	14	175
Total assets	154	865	223	381
Accrued expenses and other current liabilities	(1)	(20)	—	(656)
Other long-term liabilities	(8)	(39)	(22)	(33)
Total liabilities	(9)	(59)	(22)	(689)
Total net assets (liabilities)	$ 145	$ 806	$ 201	$ (308)

Health Care Reform

Health Insurer Fee

Since January 1, 2014, the ACA imposes an annual premium-based health insurer fee ("HIF") for each calendar year payable in September which is not deductible for tax purposes. We are required to estimate a liability for the HIF at the beginning of the calendar year in which the fee is payable with a corresponding deferred asset that is amortized ratably to general and administrative expense over the calendar year. We record the liability for the health insurer fee in accrued expenses and other current liabilities and record the deferred asset in other current assets in our consolidated financial statements. In December 2015, the Consolidated Appropriation Act was enacted, which included a one year suspension of the HIF for 2017. Accordingly, there was no expense related to the HIF in 2017. In 2016 and 2015, general and administrative expense includes $837 million and $857 million, respectively, related to our share of the HIF. In January 2018 the HIF was suspended for 2019.

Public Exchanges

Through December 31, 2017, we participated in certain public health insurance exchanges ("Public Exchanges") established pursuant to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA"). Under regulations established by the U.S. Department of Health and Human Services ("HHS"), HHS pays us a portion of the premium ("Premium Subsidy") and through September 30, 2017, paid a portion of the health care costs ("Cost Sharing Subsidy") for low-income individual Public Exchange members. In addition, HHS administers the 3Rs risk management programs. The ACA's temporary reinsurance and risk corridor programs expired at the end of 2016.

We recognize monthly premiums received from Public Exchange members and the Premium Subsidy as premium revenue ratably over the contract period. The Cost Sharing Subsidy offsets health care costs based on our estimate of the portion of claim costs incurred by our low income individual Public Exchange members that qualify for reimbursement by HHS. We record a liability or a receivable depending on whether qualifying health care costs incurred are less than or greater than the Cost Sharing Subsidy received to date.

Reinsurance

The ACA established a temporary reinsurance program that expired at the end of 2016. Under this program, all issuers of major medical commercial insurance products and self-insured plan sponsors were required to contribute funding in amounts set by HHS. Funds collected were utilized to reimburse issuers' high claims costs incurred for qualified individual members. The expense related to this required funding was reflected in general and administrative expenses for all of our insurance products with the exception of products associated with qualified individual members; this expense for qualified individual members was reflected as a reduction of premium revenue.

There was no expense recorded in 2017 related to our estimated contribution for the funding of the ACA's reinsurance program as the program expired at the end of 2016. In 2016 and 2015, our contribution to the funding of the ACA's reinsurance program

was $118 million and $210 million, respectively, which was recorded in general and administrative expenses. When annual claim costs incurred by our qualified individual members exceeded a specified attachment point, we were entitled to certain reimbursements from this program. We recorded a receivable and offset health care costs to reflect our estimate of these recoveries.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of our qualified plan members relative to the average risk of members of other qualified plans in comparable markets, we estimate our ultimate risk adjustment receivable or payable for the current calendar year and reflect the pro-rata year-to-date impact as an adjustment to our premium revenue.

Risk Corridor
The ACA established a temporary risk sharing program that expired at the end of 2016 for qualified individual and small group insurance plans. Under this program we made (or received) a payment to (or from) HHS based on the ratio of allowable costs to target costs (as defined by the ACA). We recorded a risk corridor receivable or payable as an adjustment to premium revenue on a pro-rata year-to-date basis based on our estimate of the ultimate risk sharing amount for the current calendar year. At December 31, 2017 and 2016, we did not record any ACA risk corridor receivables related to the 2016 or 2015 program years or any amount in excess of HHS's announced pro-rated funding amount for the 2014 program year because payments from HHS are uncertain.

We expect to perform an annual final reconciliation and settlement with HHS of the 3Rs in each subsequent year. The final reconciliation and settlement with HHS of the 2014 and 2015 Cost Sharing Subsidies occurred in 2016 and 2017, respectively. The final reconciliation and settlement of the 2016 Cost Sharing Subsidy is scheduled to occur in 2018.

Refer to Note 8 for additional information related to the 3Rs.

Selling Expenses
Selling expenses include broker commissions, the variable component of our internal sales force compensation and premium taxes.

Stock-Based Compensation
We record compensation expense for stock-based awards over their vesting periods primarily based on the estimated fair value at the grant date. For stock appreciation rights ("SARs"), the fair value is estimated using the Black-Scholes option-pricing model. For restricted stock units ("RSUs") and performance stock units ("PSUs"), the fair value is equal to the market price of the Company's common stock on the date of grant. For market stock units ("MSUs") and performance stock appreciation rights ("PSARs"), the fair value is estimated using Monte Carlo simulations. Stock-based compensation expense is recorded in general and administrative expenses in our Consolidated Statements of Income. Refer to Note 12 for additional information related to our stock-based employee incentive plans.

Income Taxes
We are taxed at the statutory corporate income tax rates after adjusting income reported for financial statement purposes for certain items. We recognize deferred income tax assets and liabilities for the differences between the financial and income tax reporting basis of assets and liabilities based on enacted tax rates and laws. Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. Deferred income tax expense or benefit primarily reflects the net change in deferred income tax assets and liabilities during the year.

Our current income tax provision reflects the tax results of revenues and expenses currently taxable or deductible. Penalties and interest on our tax positions are classified as a component of our income tax provision.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "TCJA") was enacted. Among other things, the TCJA reduced the federal corporate income tax rate to 21 percent effective January 1, 2018. Accordingly, we remeasured our deferred tax assets and liabilities as of the enactment date to reflect the lower tax rate and recognized an incremental tax expense of $99 million related to the reduction in our net deferred tax assets during the year ended December 31, 2017. The accounting for certain income tax effects of the TCJA was considered provisional at December 31, 2017, including the assessment of the mandatory repatriation of foreign earnings, the minimum tax on global intangible low-taxed income and the assertion of permanent reinvestment of foreign earnings. Accordingly, the items were recorded at a reasonable estimate at December 31, 2017. Measurement period adjustments will be recorded, as necessary, as adjustments to income tax expense from continuing operations.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit ("OPEB") Plans
We sponsor defined benefit pension plans ("pension plans") and OPEB plans for our employees and retirees. We recognize the funded status of our pension plans and OPEB plans on our Consolidated Balance Sheets based on our year-end measurements of plan assets and benefit obligations. Prepaid pension and OPEB benefits represent prepaid costs related to our pension plans and are reported with other current and long-term assets. Liabilities associated with pension plans and OPEB plans are reported within current and other long-term liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets.

Earnings Per Share
We calculate basic earnings per share based on the weighted average number of common shares outstanding for the period. Diluted earnings per common share is calculated based on the weighted average number of common shares outstanding plus the dilutive effect of outstanding SARs, MSUs, PSUs, RSUs and PSARs using the treasury stock method. Refer to Notes 12 and 15 for additional information.

New Accounting Standards
Accounting for Financial Instruments - Hedge Accounting
During the third quarter of 2017, we elected to early adopt new accounting guidance which simplifies the application of hedge accounting. The new guidance expands our ability to hedge non-financial and financial risk components, eliminates the requirement to separately measure and report hedge ineffectiveness, requires the entire change in the fair value of a hedging instrument to be presented in the same income statement line as the hedged item and simplifies certain documentation and assessment requirements. The adoption of this new guidance did not have a material impact on our financial position or operating results.

Simplifying the Test for Goodwill Impairment
Effective January 1, 2017, we adopted, on a prospective basis, new accounting guidance which simplifies the accounting for goodwill impairment. The new guidance eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. A goodwill impairment charge would be recognized if the carrying amount of a reporting unit exceeds the estimated fair value of the reporting unit. The adoption of this new guidance did not have a material impact on our financial position or operating results.

Classification of Certain Cash Receipts and Cash Payments in the Consolidated Statements of Cash Flows
Effective January 1, 2017, we adopted, on a retrospective basis, new accounting guidance which clarifies the classification of certain cash receipts and cash payments in our Consolidated Statements of Cash Flows. As a result, we classified $54 million of cash distributions received from our partnership investments as cash inflows from operating activities for the year ended December 31, 2017, that previously would have been classified as cash inflows from investing activities. There were no material reclassifications in our Consolidated Statements of Cash Flows for the years ended December 31, 2016 and 2015 as a result of the adoption of this new guidance.

Future Application of Accounting Standards
Revenue from Contracts with Customers
Effective January 1, 2018, we adopted new accounting guidance related to revenue recognition from contracts with customers. While industry-specific guidance related to contracts with customers within the scope of *Accounting Standards Codification ("ASC") 944 Financial Services - Insurance* remains unchanged, most other industry-specific revenue recognition requirements have been removed. The new guidance requires that an entity recognize revenue for the transfer of goods or services to a customer at an amount that reflects the consideration to which an entity expects to be entitled in exchange for those goods or services. The new guidance also requires additional disclosures regarding the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts. We adopted the new guidance using the modified retrospective approach. The new guidance only impacted contracts with customers outside of the scope of ASC Topic 944. We expect an increase to revenue and expenses within an expected range of approximately $1.5 billion to $2.0 billion for 2018 related to modifications to principal versus agent guidance for our home delivery and specialty pharmacy operations. We do not anticipate any material changes in the timing of our recognition of revenue or net income.

Recognition and Measurement of Financial Assets and Financial Liabilities
Effective January 1, 2018, we adopted new accounting guidance related to the recognition and measurement of financial assets and financial liabilities. Under the new guidance, all equity investments in unconsolidated entities will be measured at fair value with changes in fair value recognized in net income. We may elect to report equity investments without a readily determinable fair value at cost less impairment, plus or minus subsequent adjustments for observable price changes. The new

guidance also revises certain disclosures regarding financial assets and liabilities. The adoption of this new guidance did not have a material impact on our financial position or operating results.

Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost
Effective January 1, 2018, we adopted, on a retrospective basis, new accounting guidance related to the presentation of net periodic pension costs and net periodic postretirement benefit costs. Under the new guidance, the service cost component is required to be reported in the same income statement line item as other employee compensation costs for services rendered during the period. The other components of net periodic benefit cost are required to be presented in the income statement separately from the service cost component and outside of a subtotal of income from operations. The net periodic benefit costs for the Company's pension and other postretirement employee benefit plans do not contain a service cost component as these defined benefit plans have been frozen for an extended period of time. The adoption of this new guidance did not have a material impact on our financial position or operating results.

Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income
New accounting guidance was issued related to the reclassification of certain tax effects from accumulated other comprehensive income to retained earnings. The new guidance allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the TCJA. The new guidance is effective January 1, 2019, with early adoption permitted. We are still evaluating whether we will adopt the new guidance as well as the impact of the adoption of this new guidance on our financial position and operating results.

Leases
Effective January 1, 2019, we will adopt new accounting guidance related to the recognition, measurement and disclosure requirements for leases. Under the new guidance, lessees will be required to recognize a right-of-use asset and corresponding lease liability on their Consolidated Balance Sheets for all leases other than those that meet the definition of a short-term lease. The new guidance also revises certain disclosure requirements regarding leases. While we are still evaluating the impact of adoption of this new guidance, we anticipate that we will be required to record an asset and corresponding liability related to our operating leases (as described in Note 17) on our Consolidated Balance Sheets. The adoption of this new guidance is not expected to have a material impact on our operating results.

Accounting for Interest Associated with the Purchase of Callable Debt Securities
Effective January 1, 2019, we will adopt new accounting guidance related to the amortization of purchased callable debt securities held at a premium. Under the new guidance, premiums on callable debt securities are amortized to the earliest call date rather than to the contractual maturity date. Callable debt securities held at a discount will continue to be amortized to the contractual maturity date. We are still evaluating the impact of the adoption of this new guidance on our financial position and operating results.

Measurement of Credit Losses on Financial Instruments
Effective January 1, 2020, we will adopt new accounting guidance related to the measurement of credit losses on financial assets and certain other instruments. The new guidance requires the use of a new forward-looking expected loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. The new guidance also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. We are still evaluating the impact of the adoption of this new guidance on our financial position and operating results.

3. Acquisition, Divestiture, Terminated Acquisition and Terminated Divestiture

Proposed Acquisition by CVS Health
On December 3, 2017, we entered into a definitive agreement (the "CVS Merger Agreement") under which CVS Health Corporation ("CVS Health") will acquire all of our outstanding shares for a combination of cash and stock. Under terms of the agreement, our shareholders will receive $145 in cash and 0.8378 of a CVS Health common share for each of our common shares. The proposed transaction (the "CVS Health Transaction") is subject to customary closing conditions, including the approval and adoption of the CVS Merger Agreement by our shareholders, the approval of the issuance of CVS Health shares in the transaction by CVS Health stockholders, expiration of the federal Hart-Scott-Rodino anti-trust waiting period and approvals of certain state departments of insurance and other regulators. On February 1, 2018, Aetna and CVS Health each received a request for additional information (also known as a "second request") from the U.S. Department of Justice (the "DOJ") in connection with the DOJ's review of the transactions contemplated by the CVS Merger Agreement. The CVS Health Transaction is expected to close in the second half of 2018.

Divestiture of Group Life Insurance, Group Disability Insurance, and Absence Management Businesses
On November 1, 2017, we completed the sale of a substantial portion of our Group Insurance segment consisting of our domestic group life insurance, group disability insurance and absence management businesses (the "Group Insurance sale") to HLAIC for cash consideration of $1.45 billion. The transaction was accomplished through an indemnity reinsurance arrangement, under which HLAIC contractually assumed certain of our policyholder liabilities and obligations, although we remain directly obligated to policyholders. Assets related to and supporting the reinsured life and disability insurance policies were transferred to a trust established by HLAIC for our benefit, and we recorded a reinsurance receivable from HLAIC. The sale is expected to result in an after-tax gain of approximately $710 million ($1.1 billion pre-tax), a significant portion of which has been deferred and will be amortized into earnings: (i) over the remaining contract period (estimated to be approximately 3 years) in proportion to the amount of insurance protection provided for the prospective reinsurance portion of the gain; and (ii) as we recover amounts due from HLAIC over a period estimated to be approximately 30 years for the retrospective reinsurance portion of the gain. The deferred gain liability was recorded in accrued expenses and other current liabilities and in other long-term liabilities on our Consolidated Balance Sheets, and the gain recognition is being recorded in fees and other revenue in our Consolidated Statements of Income.

Revenues for the businesses sold were $1.9 billion, $2.3 billion and $2.3 billion for the for the years ended December 31, 2017, 2016, and 2015, respectively. Income before income taxes for the businesses being sold were $104 million, $127 million and $187 million for the years ended December 31, 2017, 2016, and 2015, respectively.

Terminated Acquisition of Humana
On July 2, 2015, we entered into a definitive agreement (the "Humana Merger Agreement") to acquire Humana Inc. ("Humana"). On July 21, 2016, the DOJ and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that our acquisition of Humana (the "Humana Transaction") would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Transaction.

On February 14, 2017, Aetna and Humana entered into a mutual termination agreement (the "Termination Agreement") pursuant to which the parties thereto (collectively the "Parties") agreed to terminate the Humana Merger Agreement, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby, entered pursuant thereto or entered in connection therewith (other than certain confidentiality agreements) (collectively with the Humana Merger Agreement, the "Transaction Documents"), effective immediately as of February 14, 2017 (the "Termination Date"). Under the Termination Agreement, Aetna agreed to pay Humana the Regulatory Termination Fee (as defined in the Humana Merger Agreement) of $1.0 billion in cash in full satisfaction of any amounts required to be paid by Aetna under the Humana Merger Agreement. The Parties also agreed to release each other from any and all liability, claims, rights, actions, causes of action, suits, liens, obligations, accounts, debts, demands, agreements, promises, liabilities, controversies, costs, charges, damages, expenses and fees, however arising, in connection with, arising out of or related to the Transaction Documents, the transactions contemplated therein or thereby or certain related matters. We paid Humana the Regulatory Termination Fee on February 16, 2017 and recorded the expense in general and administrative expenses. We funded that payment with the proceeds of the 2016 senior notes (as defined below).

In June 2016, we issued $13.0 billion of senior notes to partially fund the Humana Transaction (collectively, the "2016 senior notes"). In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for $10.2 billion aggregate principal amount of certain of the 2016 senior notes (collectively, the "Special Mandatory Redemption Notes") at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We redeemed the Special Mandatory Redemption Notes on March 16, 2017, and we funded the redemption with the proceeds of the 2016 senior notes. As a result of the redemption of the Special Mandatory Redemption Notes, we recognized certain costs in our net income during the year ended December 31, 2017. Refer to Note 9 for additional information.

Terminated Divestiture to Molina
In order to address the DOJ's perceived competitive concerns regarding Medicare Advantage relating to the Humana Transaction, on August 2, 2016, we entered into a definitive agreement (the "Aetna APA") to sell for cash to Molina Healthcare, Inc. ("Molina") certain of our Medicare Advantage assets. On February 14, 2017, Aetna and Molina entered into a Termination Agreement (the "APA Termination Agreement") pursuant to which Aetna terminated the Aetna APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, Aetna agreed to pay Molina in cash (a) a termination fee of $53 million and (b) approximately 70% of Molina's transaction costs. We paid Molina the termination fee on February 16, 2017 and the applicable transaction costs of $7 million on February 27, 2017 and recorded the expense in general and administrative expenses. The payments were funded with the proceeds of the 2016 senior notes.

4. Investments

Total investments at December 31, 2017 and 2016 were as follows:

	2017			2016		
(Millions)	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt and equity securities available for sale	**$ 2,114**	**$ 14,906**	**$ 17,020**	$ 2,876	$ 18,866	$ 21,742
Mortgage loans	**166**	**1,330**	**1,496**	170	1,341	1,511
Other investments	**—**	**1,557**	**1,557**	—	1,626	1,626
Total investments	**$ 2,280**	**$ 17,793**	**$ 20,073**	$ 3,046	$ 21,833	$ 24,879

At December 31, 2017 and 2016, we held investments of $616 million and $657 million, respectively, related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. These investments are included in the total investments of our Large Case Pensions segment supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of our business and only support our future policy benefits obligations under that group annuity contract. Refer to Note 2 for additional information.

Debt and Equity Securities

Debt and equity securities available for sale at December 31, 2017 and 2016 were as follows:

(Millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2017				
Debt securities:				
U.S. government securities	**$ 1,319**	**$ 44**	**$ (1)**	**$ 1,362**
States, municipalities and political subdivisions	**3,287**	**116**	**(12)**	**3,391**
U.S. corporate securities	**6,886**	**388**	**(22)**	**7,252**
Foreign securities	**2,498**	**187**	**(7)**	**2,678**
Residential mortgage-backed securities	**570**	**5**	**(4)**	**571**
Commercial mortgage-backed securities	**641**	**3**	**(9)**	**635**
Other asset-backed securities	**1,031**	**8**	**(4)**	**1,035**
Redeemable preferred securities	**22**	**4**	**—**	**26**
Total debt securities	**16,254**	**755**	**(59)**	**16,950**
Equity securities	**60**	**12**	**(2)**	**70**
Total debt and equity securities [1] [2]	**$ 16,314**	**$ 767**	**$ (61)**	**$ 17,020**
December 31, 2016				
Debt securities:				
U.S. government securities	$ 1,643	$ 51	$ —	$ 1,694
States, municipalities and political subdivisions	5,047	152	(61)	5,138
U.S. corporate securities	8,145	385	(55)	8,475
Foreign securities	2,958	163	(33)	3,088
Residential mortgage-backed securities	793	11	(9)	795
Commercial mortgage-backed securities	1,382	5	(39)	1,348
Other asset-backed securities	1,077	7	(9)	1,075
Redeemable preferred securities	22	5	—	27
Total debt securities	21,067	779	(206)	21,640
Equity securities	84	20	(2)	102
Total debt and equity securities [1] [2]	$ 21,151	$ 799	$ (208)	$ 21,742

[1] At both December 31, 2017 and 2016, we held securities for which we previously recognized an immaterial amount of non-credit related impairments in accumulated other comprehensive loss. These securities each had an immaterial amount of net unrealized capital gains at both December 31, 2017 and 2016.

[2] Investment risks associated with our experience-rated and discontinued products generally do not impact our operating results (refer to Note 19 for additional information on our accounting for discontinued products). At December 31, 2017, debt and equity securities with a fair value of approximately $2.6 billion, gross unrealized capital gains of $202 million and gross unrealized capital losses of $9 million and, at December 31, 2016, debt and equity securities with a fair value of approximately $2.9 billion, gross unrealized capital gains of $195 million and gross unrealized capital losses of $35 million were included in total debt and equity securities, but support our experience-rated and discontinued products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income.

The fair value of debt securities at December 31, 2017 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or we intend to sell a security prior to maturity.

(Millions)	Amortized Cost	Fair Value
Due to mature:		
Less than one year	$ 1,048	$ 1,055
One year through five years	5,559	5,665
After five years through ten years	3,503	3,614
Greater than ten years	3,902	4,375
Residential mortgage-backed securities	570	571
Commercial mortgage-backed securities	641	635
Other asset-backed securities	1,031	1,035
Total	$ 16,254	$ 16,950

Mortgage-Backed and Other Asset-Backed Securities
All of our residential mortgage-backed securities at December 31, 2017 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2017, our residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 4.5 years.

Our commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2017, these securities had an average credit quality rating of AAA and a weighted average duration of 6.8 years.

Our other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2017, these securities had an average credit quality rating of AA- and a weighted average duration of 1.0 years.

Summarized below are the debt and equity securities we held at December 31, 2017 and 2016 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

(Millions, except number of securities)	Less than 12 months			Greater than 12 months			Total [1]		
	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses
December 31, 2017									
Debt securities:									
U.S. government securities	**77**	**$ 200**	**$ 1**	**14**	**$ 22**	**$ —**	**91**	**$ 222**	**$ 1**
States, municipalities and political subdivisions	**318**	**616**	**4**	**111**	**308**	**8**	**429**	**924**	**12**
U.S. corporate securities	**989**	**1,469**	**6**	**284**	**494**	**16**	**1,273**	**1,963**	**22**
Foreign securities	**262**	**419**	**3**	**91**	**194**	**4**	**353**	**613**	**7**
Residential mortgage-backed securities	**111**	**179**	**1**	**98**	**134**	**3**	**209**	**313**	**4**
Commercial mortgage-backed securities	**38**	**135**	**1**	**79**	**241**	**8**	**117**	**376**	**9**
Other asset-backed securities	**150**	**304**	**2**	**79**	**151**	**2**	**229**	**455**	**4**
Total debt securities	**1,945**	**3,322**	**18**	**756**	**1,544**	**41**	**2,701**	**4,866**	**59**
Equity securities	**2**	**2**	**—**	**7**	**7**	**2**	**9**	**9**	**2**
Total debt and equity securities [1]	**1,947**	**$ 3,324**	**$ 18**	**763**	**$ 1,551**	**$ 43**	**2,710**	**$ 4,875**	**$ 61**
December 31, 2016									
Debt securities:									
U.S. government securities	26	$ 39	$ —	1	$ 1	$ —	27	$ 40	$ —
States, municipalities and political subdivisions	865	2,228	58	37	75	3	902	2,303	61
U.S. corporate securities	1,428	2,277	44	114	101	11	1,542	2,378	55
Foreign securities	649	970	27	62	76	6	711	1,046	33
Residential mortgage-backed securities	188	455	8	104	17	1	292	472	9
Commercial mortgage-backed securities	285	1,038	39	3	3	—	288	1,041	39
Other asset-backed securities	226	403	4	208	177	5	434	580	9
Total debt securities	3,667	7,410	180	529	450	26	4,196	7,860	206
Equity securities	2	3	—	8	3	2	10	6	2
Total debt and equity securities [1]	3,669	$ 7,413	$ 180	537	$ 453	$ 28	4,206	$ 7,866	$ 208

[1] At December 31, 2017 and 2016, debt and equity securities in an unrealized capital loss position of $9 million and $35 million, respectively, and with related fair value of $517 million and $890 million, respectively, related to experience-rated and discontinued products.

We reviewed the securities in the tables above and concluded that they are performing assets generating investment income to support the needs of our business. In performing this review, we considered factors such as the quality of the investment security based on research performed by our internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. At December 31, 2017, we did not intend to sell these securities, and we did not believe it was more likely than not that we would be required to sell these securities prior to anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2017 were as follows:

	Supporting discontinued and experience-rated products		Supporting remaining products		Total	
(Millions)	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Due to mature:						
Less than one year	$ 2	$ —	$ 415	$ 1	$ 417	$ 1
One year through five years	119	—	1,890	18	2,009	18
After five years through ten years	170	3	675	10	845	13
Greater than ten years	97	3	354	7	451	10
Residential mortgage-backed securities	12	—	301	4	313	4
Commercial mortgage-backed securities	109	2	267	7	376	9
Other asset-backed securities	6	—	449	4	455	4
Total	$ 515	$ 8	$ 4,351	$ 51	$ 4,866	$ 59

Mortgage Loans

Our mortgage loans are collateralized by commercial real estate. During 2017 and 2016 we had the following activity in our mortgage loan portfolio:

(Millions)	2017	2016
New mortgage loans	$ 279	$ 190
Mortgage loans fully-repaid	248	173
Mortgage loans foreclosed	—	8

We assess our mortgage loans on a regular basis for credit impairments, and annually assign a credit quality indicator to each loan. Our credit quality indicator is internally developed and categorizes our portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, property condition, market trends, creditworthiness of the borrower and deal structure. The vast majority of our mortgage loans fall into categories 2 to 4.

- *Category 1* - Represents loans of superior quality
- *Categories 2 to 4* - Represents loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represents loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon our most recent assessments at December 31, 2017 and 2016, our mortgage loans were given the following credit quality indicators:

(In Millions, except credit ratings indicator)	2017	2016
1	$ 40	$ 45
2 to 4	1,447	1,449
5 and 6	9	17
7	—	—
Total	$ 1,496	$ 1,511

At December 31, 2017 scheduled mortgage loan principal repayments were as follows:

(Millions)	
2018	**$ 166**
2019	**124**
2020	**141**
2021	**273**
2022	**244**
Thereafter	**548**

Net Investment Income

Sources of net investment income for 2017, 2016 and 2015 were as follows:

(Millions)	2017	2016	2015
Debt securities	**$ 727**	$ 772	$ 794
Mortgage loans	**86**	95	91
Other investments	**185**	82	78
Gross investment income	**998**	949	963
Investment expenses	**(48)**	(39)	(46)
Net investment income [1]	**$ 950**	$ 910	$ 917

[1] Net investment income includes $233 million, $208 million and $248 million for 2017, 2016 and 2015, respectively, related to investments supporting our experience-rated and discontinued products.

Realized Capital Gains/Losses

Net realized capital (losses) gains for the three years ended December 31, 2017, 2016 and 2015, excluding amounts related to experience-rated contract holders and discontinued products, were as follows:

(Millions)	2017	2016	2015
Other-than-temporary impairment ("OTTI") losses on debt securities recognized in earnings	**$ (8)**	$ (30)	$ (64)
Other net realized capital (losses) gains	**(231)**	116	(1)
Net realized capital (losses) gains	**$ (239)**	$ 86	$ (65)

The net realized capital losses in 2017 were primarily attributable to the recognition into earnings of the entire unamortized effective portion of the related hedge losses upon the mandatory redemption of $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes and the redemption of $750 million aggregate principal amount of senior notes due 2020, partially offset by gains from the sale of debt securities and gains from other investments. The net realized capital gains in 2016 were primarily attributable to gains from the sales of debt securities and other investments, partially offset by yield-related OTTI on debt securities. The net realized capital losses in 2015 were primarily attributable to yield-related OTTI on U.S. corporate debt securities.

Yield-related impairments are recognized in other comprehensive income unless we have the intention to sell the security in an unrealized capital loss position, in which case the yield-related OTTI is recognized in earnings. In 2017, 2016 and 2015, we recognized yield-related OTTI losses of $6 million, $24 million and $63 million, respectively, related to our debt securities. We had no other individually material realized capital losses on debt or equity securities that impacted our operating results during 2017, 2016 or 2015.

Excluding amounts related to experience-rated and discontinued products, proceeds from the sale of available for sale debt and equity securities and the related gross realized capital gains and losses for 2017, 2016 and 2015 were as follows [1]:

(Millions)	2017	2016	2015
Proceeds on sales	**$ 5,753**	$ 6,725	$ 4,987
Gross realized capital gains	**114**	155	83
Gross realized capital losses	**47**	61	76

(1) The proceeds on sales and gross realized capital gains and losses exclude the impact of the sales of short-term debt securities which primarily relate to our investments in mutual funds. These investments were excluded from the disclosed amounts because they represent an immaterial amount of aggregate gross realized capital gains or losses and have a high volume of sales activity.

Variable Interest Entities

We have investments in certain hedge fund and private equity investments and real estate partnerships that are considered Variable Interest Entities ("VIE's"). We do not have a future obligation to fund losses or debts on behalf of these investments; however, we may voluntarily contribute funds. In evaluating whether we are the primary beneficiary of a VIE, we considered several factors, including whether we (a) have the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary

During the fourth quarter of 2017, we redeemed the entire minority shareholder interest related to our majority owned hedge fund investment where we were the investment manager and had the power to direct the activities that most significantly impact the VIE's economic performance, including determining the hedge fund's investment strategy. Prior to the fourth quarter of 2017, we were the primary beneficiary and consolidated the investment in our operating results. As of December 31, 2017, we will continue to consolidate the hedge fund in our operating results; however, the investment is no longer considered a VIE as the hedge fund is a wholly-owned subsidiary.

Substantially all of the assets of the VIE hedge fund were comprised of hedge fund investments reported as long-term investments on our Consolidated Balance Sheets. The VIE hedge fund had no material liabilities at December 31, 2016. The total amount of the VIE hedge fund's assets included in long-term investments on our Consolidated Balance Sheets at December 31, 2016 was $472 million.

Variable Interest Entities - Other Variable Interest Holder

Our involvement with VIEs where we are not determined to be the primary beneficiary consists of the following:

- *Hedge fund and private equity investments* - We invest in hedge fund and private equity investments in order to generate investment returns for our investment portfolio supporting our businesses.
- *Real estate partnerships* - We invest in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to us are from tax credits and other tax benefits.

We are not the primary beneficiary of these investments because the nature of our involvement with the activities of these VIEs does not give us the power to direct the activities that most significantly impact their economic performance. We record the amount of our investment in these VIEs as long-term investments on our Consolidated Balance Sheets and recognize our share of each VIE's income or losses in earnings. Our maximum exposure to loss from these VIEs is limited to our investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which we do not consider significant.

The total amount of other variable interest holder VIE assets included in long-term investments on our Consolidated Balance Sheets at December 31, 2017 and 2016 were as follows:

(Millions)	**December 31, 2017**	**December 31, 2016**
Hedge fund investments	**$ 351**	$ 384
Private equity investments	**453**	454
Real estate partnerships	**247**	278
Total	**$ 1,051**	$ 1,116

The carrying value of the total assets and liabilities of our other variable interest holder VIE investments at December 31, 2017 and 2016 were as follows:

(Millions)	December 31, 2017	December 31, 2016
Assets:		
Hedge fund investments	**$ 54,789**	$ 32,926
Private equity investments	**27,342**	25,368
Real estate partnerships	**6,451**	6,743
Total	**$ 88,582**	$ 65,037
Liabilities:		
Hedge fund investments	**$ 12,073**	$ 2,819
Private equity investments	**2,461**	2,354
Real estate partnerships	**4,691**	4,938
Total	**$ 19,225**	$ 10,111

5. Fair Value

The preparation of our consolidated financial statements in accordance with GAAP requires certain of our assets and liabilities to be reflected at their fair value, and others on another basis, such as an adjusted historical cost basis. In this note, we provide details on the fair value of financial assets and liabilities and how we determine those fair values. We present this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income attributable to Aetna or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value in our Consolidated Balance Sheets
Certain of our financial instruments are measured at fair value in our Consolidated Balance Sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified in Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for our financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Debt Securities – Where quoted prices are available in an active market, our debt securities are classified in Level 1 of the fair value hierarchy. Our Level 1 debt securities consist primarily of U.S. Treasury securities.

The fair values of our Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics, or discounted cash flows to estimate fair value. We review these prices to ensure they are based on observable market inputs that include, but are not limited to, quoted

prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable but not prices (for example, interest rates and credit risks). We also review the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, we select a sample of our Level 2 debt securities' prices and compare them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, our internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. We obtained one price for each of our Level 2 debt securities and did not adjust any of these prices at December 31, 2017 or 2016.

We also value certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. We obtained one non-binding broker quote for each of these Level 3 debt securities and did not adjust any of these quotes at December 31, 2017 or 2016. The total fair value of our broker quoted debt securities was $67 million and $80 million at December 31, 2017 and 2016, respectively. Examples of these broker quoted Level 3 debt securities include certain U.S. and foreign corporate securities and certain of our commercial mortgage-backed securities as well as other asset-backed securities. For some of our private placement securities, our internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

Equity Securities – We currently have two classifications of equity securities: those that are publicly traded and those that are privately placed. Our publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, we classify these securities in Level 3 because we price these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would result in a change in the fair value measurement, which may be significant.

Derivatives – Where quoted prices are available in an active market, our derivatives are classified in Level 1. Certain of our derivative instruments are valued using models that primarily use market observable inputs and therefore are classified in Level 2 because they are traded in markets where quoted market prices are not readily available.

Financial assets and liabilities measured at fair value on a recurring basis in our Consolidated Balance Sheets at December 31, 2017 and 2016 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total
December 31, 2017				
Assets:				
Debt securities:				
U.S. government securities	**$ 1,313**	**$ 49**	**$ —**	**$ 1,362**
States, municipalities and political subdivisions	**—**	**3,390**	**1**	**3,391**
U.S. corporate securities	**—**	**7,167**	**85**	**7,252**
Foreign securities	**—**	**2,675**	**3**	**2,678**
Residential mortgage-backed securities	**—**	**571**	**—**	**571**
Commercial mortgage-backed securities	**—**	**635**	**—**	**635**
Other asset-backed securities	**—**	**1,035**	**—**	**1,035**
Redeemable preferred securities	**—**	**19**	**7**	**26**
Total debt securities	**1,313**	**15,541**	**96**	**16,950**
Equity securities	**43**	**—**	**27**	**70**
Total	**$ 1,356**	**$ 15,541**	**$ 123**	**$ 17,020**
December 31, 2016				
Assets:				
Debt securities:				
U.S. government securities	$ 1,514	$ 180	$ —	$ 1,694
States, municipalities and political subdivisions	—	5,137	1	5,138
U.S. corporate securities	—	8,395	80	8,475
Foreign securities	—	3,067	21	3,088
Residential mortgage-backed securities	—	795	—	795
Commercial mortgage-backed securities	—	1,348	—	1,348
Other asset-backed securities	—	1,075	—	1,075
Redeemable preferred securities	—	26	1	27
Total debt securities	1,514	20,023	103	21,640
Equity securities	59	—	43	102
Total	$ 1,573	$ 20,023	$ 146	$ 21,742

There were no transfers between Levels 1 and 2 during the years ended December 31, 2017 and 2016.

The changes in the balances of Level 3 financial assets during 2017 were as follows:

(Millions)	Foreign securities	U.S. corporate securities	Equity securities	Other	Total
Beginning balance	**$ 21**	**$ 80**	**$ 43**	**$ 2**	**$ 146**
Net realized and unrealized capital gains (losses):					
Included in earnings	**—**	**4**	**42**	**—**	**46**
Included in other comprehensive income	**—**	**—**	**(38)**	**—**	**(38)**
Purchases	**—**	**18**	**9**	**42**	**69**
Sales	**—**	**—**	**(29)**	**—**	**(29)**
Settlements	**—**	**(17)**	**—**	**—**	**(17)**
Transfers out of Level 3, net	**(18)**	**—**	**—**	**(36)**	**(54)**
Ending balance	**$ 3**	**$ 85**	**$ 27**	**$ 8**	**$ 123**

The changes in the balances of Level 3 financial assets during 2016 were as follows:

(Millions)	Foreign securities	U.S. corporate securities	Equity securities	Other	Total
Beginning balance	$ 25	$ 64	$ 19	$ 6	$ 114
Net realized and unrealized capital (losses) gains:					
Included in earnings	—	(15)	—	—	(15)
Included in other comprehensive income	—	(4)	11	(3)	4
Other [1]	—	—	3	—	3
Purchases	16	41	10	33	100
Sales	(8)	(3)	—	(5)	(16)
Settlements	(2)	(3)	—	—	(5)
Transfers out of Level 3, net	(10)	—	—	(29)	(39)
Ending balance	$ 21	$ 80	$ 43	$ 2	$ 146

[1] Reflects realized and unrealized capital gains and losses on investments supporting our experience-rated and discontinued products, which do not impact our operating results.

The total gross transfers into (out of) Level 3 during the years ended December 31, 2017 and 2016 were as follows:

(Millions)	2017	2016
Gross transfers into Level 3	**$ —**	$ —
Gross transfers out of Level 3	**(54)**	(39)
Net transfers out of Level 3	**$ (54)**	$ (39)

Gross transfers out of Level 3 during 2017 primarily related to commercial mortgage-backed securities, other asset-backed securities and foreign debt securities for which observable market data was subsequently received. Gross transfers out of Level 3 during 2016 primarily related to commercial mortgage-backed securities for which observable market data was subsequently received.

Financial Instruments Not Measured at Fair Value in our Consolidated Balance Sheets

The following is a description of the valuation methodologies used for estimating the fair value of our financial assets and liabilities that are carried on our Consolidated Balance Sheets at adjusted cost or contract value.

Mortgage loans: Fair values are estimated by discounting expected mortgage loan cash flows at market rates that reflect the rates at which similar loans would be made to similar borrowers. These rates reflect our assessment of the creditworthiness of the borrower and the remaining duration of the loans. The fair value estimates of mortgage loans of lower credit quality, including problem and restructured loans, are based on the estimated fair value of the underlying collateral.

Bank loans: Where fair value is determined by quoted market prices of bank loans with similar characteristics, our bank loans are classified in Level 2. For bank loans classified in Level 3, fair value is determined by outside brokers using their internal analyses through a combination of their knowledge of the current pricing environment and market flows.

Equity securities: Certain of our equity securities are carried at cost. The fair values of our cost-method investments are not estimated if there are no identified events or changes in circumstances that may have a significant adverse effect on the fair value of the investment.

Investment contract liabilities:

- *With a fixed maturity*: Fair value is estimated by discounting cash flows at interest rates currently being offered by, or available to, us for similar contracts.
- *Without a fixed maturity*: Fair value is estimated as the amount payable to the contract holder upon demand. However, we have the right under such contracts to delay payment of withdrawals that may ultimately result in paying an amount different than that determined to be payable on demand.

Long-term debt: Fair values are based on quoted market prices for the same or similar issued debt or, if no quoted market prices are available, on the current rates estimated to be available to us for debt of similar terms and remaining maturities.

The carrying value and estimated fair value classified by level of fair value hierarchy for our financial instruments carried on our Consolidated Balance Sheets at adjusted cost or contract value at December 31, 2017 and 2016 were as follows:

(Millions)	Carrying Value	Estimated Fair Value			
		Level 1	Level 2	Level 3	Total
December 31, 2017					
Assets:					
Mortgage loans	**$ 1,496**	**$ —**	**$ —**	**$ 1,524**	**$ 1,524**
Bank loans	**7**	**—**	**—**	**7**	**7**
Equity securities [1]	**45**	**N/A**	**N/A**	**N/A**	**N/A**
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	**7**	**—**	**—**	**7**	**7**
Without a fixed maturity	**363**	**—**	**—**	**354**	**354**
Long-term debt	**9,159**	**—**	**9,815**	**—**	**9,815**

(Millions)	Carrying Value	Estimated Fair Value			
		Level 1	Level 2	Level 3	Total
December 31, 2016					
Assets:					
Mortgage loans	$ 1,511	$ —	$ —	$ 1,540	$ 1,540
Bank loans	8	—	—	8	8
Equity securities [1]	35	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	8	—	—	8	8
Without a fixed maturity	378	—	—	364	364
Long-term debt	20,661	—	21,468	—	21,468

[1] It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies.

Separate Accounts Measured at Fair Value in our Consolidated Balance Sheets

Separate Accounts assets in our Large Case Pensions segment represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from our other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in our Consolidated Statements of Income, Shareholders' Equity or Cash Flows.

Separate Accounts assets include debt and equity securities and derivative instruments. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 5. Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts' interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value per share/unit on the valuation date.

Separate Accounts financial assets at December 31, 2017 and 2016 were as follows:

	2017				2016			
(Millions)	**Level 1**	**Level 2**	**Level 3**	**Total**	**Level 1**	**Level 2**	**Level 3**	**Total**
Debt securities	**$ 1,085**	**$ 2,611**	**$ 2**	**$ 3,698**	$ 766	$ 2,378	$ —	$ 3,144
Equity securities	**—**	**6**	**—**	**6**	166	6	—	172
Common/collective trusts	**—**	**448**	**—**	**448**	—	582	—	582
Total [1]	**$ 1,085**	**$ 3,065**	**$ 2**	**$ 4,152**	$ 932	$ 2,966	$ —	$ 3,898

[1] Excludes $144 million and $93 million of cash and cash equivalents and other receivables at December 31, 2017 and 2016, respectively.

During 2017 and 2016, we had an immaterial amount of Level 3 Separate Accounts financial assets and an immaterial amount of gross transfers of Separate Accounts financial assets into or out of Level 3. During 2017 and 2016, there were no transfers of Separate Accounts financial assets between Levels 1 and 2.

Offsetting Financial Assets and Liabilities

Certain financial assets and liabilities are offset in our Consolidated Balance Sheets or are subject to master netting arrangements or similar agreements with the applicable counterparty. Financial assets, including derivative assets, subject to offsetting and enforceable master netting arrangements were $10 million and $17 million at December 31, 2017 and December 31, 2016, respectively.

There were no financial liabilities, including derivative liabilities, subject to offsetting and enforceable master netting arrangements at December 31, 2017 or December 31, 2016.

6. Goodwill and Other Acquired Intangible Assets

The change in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2017 and 2016 was as follows:

(Millions)	**Health Care**	**Group Insurance**	**Total Company**
Balance at January 1, 2016	$ 10,524	$ 113	$ 10,637
Acquisitions	—	—	—
Dispositions	—	—	—
Subsequent adjustments	—	—	—
Balance at December 31, 2016	**10,524**	**113**	**10,637**
Acquisitions	**47**	**—**	**47**
Dispositions	**—**	**(113)**	**(113)**
Subsequent adjustments	—	—	—
Balance at December 31, 2017	**$ 10,571**	**$ —**	**$ 10,571**

No goodwill is allocated to the Large Case Pensions segment. The increase in goodwill allocated to our Health Care segment in 2017 was due to goodwill associated with an immaterial acquisition. The decrease in goodwill allocated to our Group Insurance segment in 2017 was due to the Group Insurance sale.

Other acquired intangible assets at December 31, 2017 and 2016 consisted of the following:

(Millions)	Cost	Accumulated Amortization	Net Balance	Amortization Period (Years)	
2017					
Provider networks	**$ 1,254**	**$ 756**	**$ 498**	**12-25**	**(1)**
Customer lists	**1,172**	**610**	**562**	**3-20**	**(1)**
Value of business acquired	**149**	**102**	**47**	**20**	
Technology	**176**	**160**	**16**	**5**	
Other	**14**	**5**	**9**	**10-15**	
Definite-lived trademarks	**170**	**144**	**26**	**5-20**	
Indefinite-lived trademarks	**22**	**—**	**22**		
Total other acquired intangible assets	**$ 2,957**	**$ 1,777**	**$ 1,180**		
2016					
Provider networks	$ 1,254	$ 694	$ 560	12-25	(1)
Customer lists	1,166	485	681	3-14	(1)
Value of business acquired	149	92	57	20	
Technology	176	123	53	4-10	
Other	10	4	6	10-15	
Definite-lived trademarks	170	107	63	5-20	
Indefinite-lived trademarks	22	—	22		
Total other acquired intangible assets	$ 2,947	$ 1,505	$ 1,442		

(1) The amortization period for our provider networks and customer lists includes an assumption of renewal or extension of these arrangements. At both December 31, 2017 and 2016, the periods prior to the next renewal or extension for our provider networks primarily ranged from 1 to 3 years, and the period prior to the next renewal or extension for our customer lists was 1 year. Any costs related to the renewal or extension of these contracts are expensed as incurred.

We estimate annual pre-tax amortization for other acquired intangible assets over the next five years to be as follows:

(Millions)	
2018	**$ 187**
2019	**181**
2020	**169**
2021	**156**
2022	**140**

7. Health Care and Other Insurance Liabilities

Our insurance liabilities below are disaggregated by reportable segment. Health care costs payable relate to our Health Care segment and unpaid claims relate to our Group Insurance segment. On November 1, 2017, we sold a substantial portion of our Group Insurance segment consisting of our domestic group life insurance, group disability insurance and absence management businesses to HLAIC. The transaction was accomplished through an indemnity reinsurance arrangement and accordingly, substantially all of our life and disability insurance reserves were fully ceded at December 31, 2017. As a result, we did not include disclosures related to the development of our unpaid claims insurance liabilities.

Health Care Costs Payable

The following is information about incurred and cumulative paid Health Care claims development as of December 31, 2017, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. Refer to Note 2 for information on how we estimate our IBNR reserve and health care costs payable as well as changes to those methodologies, if any. Our estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of our liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to our inability to gather consistent claim frequency information across our multiple claims processing systems. Any claim frequency count disclosure would not be comparable across our different claim

processing systems and would not be consistent from period to period based on the volume of claims processed through each system. As a result, we have not included health care claim count frequency in the disclosures included below.

The information about incurred and paid Health Care claims development for the year ended December 31, 2016 is presented as required unaudited supplemental information.

(Millions)	Incurred Health Care Claims, Net of Reinsurance For the Years Ended December 31,	
Date of Service	**2016**	**2017**
	(Unaudited)	
2016	$ 44,110	**$ 43,434**
2017		**42,498**
	Total	**$ 85,932**

(Millions)	Cumulative Paid Health Care Claims, Net of Reinsurance For the Years Ended December 31,	
Date of Service	**2016**	**2017**
	(Unaudited)	
2016	$ 37,888	**$ 43,273**
2017		**37,022**
	Total	**$ 80,295**
All outstanding liabilities for health care costs payable prior to 2016, net of reinsurance		**54**
Total outstanding liabilities for health care costs payable, net of reinsurance		**$ 5,691**

At December 31, 2017, total Health Care liabilities for IBNR plus expected development on reported claims totaled approximately $5.0 billion. Substantially all of the total Health Care liabilities for IBNR plus expected development on reported claims at December 31, 2017 related to the current year.

The reconciliation of the December 31, 2017 Health Care net incurred and paid claims development tables to the health care costs payable liability in our Consolidated Balance Sheet is as follows:

(Millions)	December 31, 2017
Short-duration health care costs payable, net of reinsurance	**$ 5,691**
Reinsurance recoverables	**6**
Premium deficiency reserve	**16**
Insurance lines other than short duration	**102**
Total health care costs payable	**$ 5,815**

The following table shows the components of the change in health care costs payable during 2017, 2016 and 2015:

(Millions)	2017	2016	2015
Health care costs payable, beginning of the period	**$ 6,558**	$ 6,306	$ 5,621
Less: Reinsurance recoverables	**5**	4	6
Health care costs payable, beginning of the period, net	**6,553**	6,302	5,615
Add: Components of incurred health care costs			
Current year	**43,551**	45,019	42,553
Prior years	**(814)**	(764)	(841)
Total incurred health care costs	**42,737**	44,255	41,712
Less: Claims paid			
Current year	**37,974**	38,700	36,389
Prior years	**5,523**	5,304	4,636
Total claims paid	**43,497**	44,004	41,025
Health care costs payable, end of period, net	**5,793**	6,553	6,302
Add: Premium deficiency reserve	**16**	—	—
Add: Reinsurance recoverables	**6**	5	4
Health care costs payable, end of period	**$ 5,815**	$ 6,558	$ 6,306

Our estimates of prior years' health care costs payable decreased by $814 million, $764 million and $841 million in 2017, 2016 and 2015, respectively, because claims were settled for amounts less than originally estimated (i.e., the amount of claims incurred was lower than we originally estimated), primarily due to lower health care cost trends as well as the actual claim submission time being faster than we originally assumed (i.e., our completion factors were higher than we originally assumed) in estimating our health care costs payable at the end of the prior year. This development does not directly correspond to an increase in our current year operating results as these reductions were offset by estimated current period health care costs when we established our estimate of the current year health care costs payable.

8. The ACA's Reinsurance, Risk Adjustment and Risk Corridor Programs (the "3Rs")

Through December 31, 2017, we participated in certain public health insurance exchanges ("Public Exchanges") established pursuant to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA"). Under regulations established by the U.S. Department of Health and Human Services ("HHS"), HHS pays us a portion of the premium ("Premium Subsidy") and through September 30, 2017, paid a portion of the health care costs ("Cost Sharing Subsidy") for low-income individual Public Exchange members. In addition, HHS administers the 3Rs risk management programs. The ACA's temporary reinsurance and risk corridor programs expired at the end of 2016.

Our net receivable (payable) related to the 3Rs risk management programs at December 31, 2017 and 2016 was as follows:

	At December 31, 2017			At December 31, 2016		
(Millions)	Reinsurance	Risk Adjustment	Risk Corridor	Reinsurance	Risk Adjustment	Risk Corridor
Current	**$ 37**	**$ (41)**	**$ —**	$ 202	$ (690)	$ (10)
Long-term	**$ —**	**$ 2**	**$ —**	$ —	$ —	$ —
Total net receivable (payable)	**$ 37**	**$ (39)**	**$ —**	$ 202	$ (690)	$ (10)

At December 31, 2017, we estimate that we are entitled to receive a total of $314 million from HHS under the three-year ACA risk corridor program for the 2014 through 2016 program years. In November 2016, HHS announced that all 2015 ACA risk corridor collections will be used to pay a portion of the balances on the 2014 ACA risk corridor payments. At December 31, 2017 and 2016, we did not record any ACA risk corridor receivables related to the 2016 or 2015 program years or any amount in excess of HHS's announced pro-rated funding amount for the 2014 program year because payments from HHS are uncertain.

We expect to perform an annual final reconciliation and settlement with HHS of the 3Rs in each subsequent year. The final reconciliation and settlement with HHS of the 2014 and 2015 Cost Sharing Subsidies occurred in 2016 and 2017, respectively. The final reconciliation and settlement of the 2016 Cost Sharing Subsidy is scheduled to occur in 2018.

9. Debt

Long-term debt

The carrying value of our long-term debt at December 31, 2017 and 2016 was as follows:

(Millions)	2017	2016
Senior notes, 5.95% due March 2017 [1]	**$ —**	$ 386
Senior notes, 1.75% due May 2017 [1]	**—**	250
Senior notes, 1.5% due November 2017 [1]	**—**	499
Senior notes, floating rate due December 2017 [1]	**—**	499
Senior notes, 1.7% due June 2018 [1]	**999**	997
Senior notes, 2.2% due March 2019	**374**	374
Senior notes, 1.9% due June 2019	**—**	1,642
Senior notes, 3.95% due September 2020	**—**	745
Senior notes, 2.4% due June 2021	**—**	1,839
Senior notes, 5.45% due June 2021	**647**	661
Senior notes, 4.125% due June 2021	**496**	495
Senior notes, 2.75% due November 2022	**988**	986
Senior notes, 2.8% due June 2023	**1,292**	1,290
Senior notes, 3.5% due November 2024	**743**	742
Senior notes, 3.2% due June 2026	**—**	2,771
Senior notes, 4.25% due June 2036	**—**	1,480
Senior notes, 6.625% due June 2036	**766**	765
Senior notes, 6.75% due December 2037	**527**	527
Senior notes, 4.5% due May 2042	**479**	478
Senior notes, 4.125% due November 2042	**489**	489
Senior notes, 4.75% due March 2044	**371**	371
Senior notes, 4.375% due June 2046	**—**	2,375
Senior notes, 3.875% due August 2047	**988**	—
Total long-term debt	**9,159**	20,661
Less current portion of long-term debt	**999**	1,634
Total long-term debt, less current portion and credit facility issuance costs	**$ 8,160**	$ 19,027

(1) At December 31, 2017, our 1.7% senior notes due June 2018 are classified as current in our Consolidated Balance Sheet. At December 31, 2016, our 5.95% senior notes due March 2017, 1.75% senior notes due May 2017, 1.5% senior notes due November 2017 and floating rate senior notes due December 2017 were each classified as current in our Consolidated Balance Sheet.

At December 31, 2017 the amount of future maturities of our long-term debt are as follows:

(Millions)	
2018	**$ 999**
2019	**374**
2020	**—**
2021	**1,143**
2022	**988**
Thereafter	**5,655**

2017 Senior Notes
In August 2017, we issued $1.0 billion of 3.875% senior notes due 2047. We used the net proceeds of this offering to repay a portion of our 1.5% senior notes due in November 2017, repay a portion of our floating rate senior notes due in December 2017 and for general corporate purposes.

2016 Senior Notes
In June 2016, in connection with the Humana Transaction, we issued the 2016 senior notes, which consisted of: $500 million of floating rate senior notes due December 2017, $1.0 billion of 1.7% senior notes due June 2018, approximately $1.7 billion of 1.9% senior notes due June 2019, approximately $1.9 billion of 2.4% senior notes due June 2021, $1.3 billion of 2.8% senior notes due June 2023, $2.8 billion of 3.2% senior notes due June 2026, $1.5 billion of 4.25% senior notes due June 2036 and $2.4 billion of 4.375% senior notes due June 2046.

Early Extinguishment of Long-Term Debt
Special Mandatory Redemption Notes
As a result of the termination of the Humana Merger Agreement, we redeemed the entire $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes, which were due in 2019, 2021, 2026, 2036 and 2046, at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We redeemed those notes on March 16, 2017, and we funded the redemption with the proceeds of the 2016 senior notes. As a result of the redemption, we recorded a loss on early extinguishment of long-term debt of $125 million ($192 million pretax) in the year ended December 31, 2017.

Prior to issuing the 2016 senior notes, during 2015 and 2016 we entered into various interest rate swaps and treasury rate locks that were designated as cash flow hedges against interest rate exposure related to the forecasted future issuance of fixed-rate debt to be primarily used to finance a portion of the purchase price of the Humana Transaction. In addition, we redesignated existing interest rate swaps with an aggregate notional value of $500 million as cash flow hedges against interest rate exposure related to the forecasted future issuance of fixed rate debt.

Prior to issuing the 2016 senior notes in June 2016, we terminated all outstanding hedges and paid an aggregate of $348 million to the hedge counter parties upon termination. The aggregate effective portion of the hedge loss of $342 million pretax was recorded in accumulated other comprehensive loss, net of tax. Upon the redemption of the Special Mandatory Redemption Notes, the entire remaining unamortized effective portion of the hedge loss of $323 million pretax recorded in accumulated other comprehensive loss was recognized as a realized capital loss in the year ended December 31, 2017.

2020 Notes
On February 27, 2017, we announced the redemption for cash of the entire $750 million aggregate principal amount outstanding of our 3.95% senior notes due September 1, 2020 (the “2020 Notes”). We redeemed the 2020 Notes on March 29, 2017 at a redemption price that included a make-whole premium, plus accrued and unpaid interest. We funded the redemption from available cash and short-term debt. As a result of the redemption, we recorded a loss on early extinguishment of long-term debt of $35 million ($54 million pretax) in the year ended December 31, 2017. Upon redemption of the 2020 Notes, the entire remaining unamortized effective portion of the hedge loss of $13 million pretax related to the issuance of the 2020 Notes recorded in accumulated other comprehensive loss was recognized as a realized capital loss in the year ended December 31, 2017.

Refer to Note 14 for additional information regarding hedge losses reclassified from accumulated other comprehensive loss to net income during the year ended December 31, 2017.

Revolving Credit Facility
On March 27, 2012, we entered into an unsecured $1.5 billion five-year revolving credit agreement (the "Credit Agreement") with several financial institutions. On September 24, 2012, in connection with the acquisition of Coventry, we entered into a First Amendment (the "First Amendment") to the Credit Agreement and also entered into an Incremental Commitment Agreement (the "Incremental Commitment Agreement"). On March 2, 2015, we entered into a Second Amendment to the Credit Agreement (the "Second Amendment"). On July 30, 2015, in connection with the Humana Transaction, we entered into a Third Amendment to the Credit Agreement (the "Third Amendment"). On March 17, 2017, we entered into a Fourth Amendment to the Credit Agreement (the "Fourth Amendment," and together with the First Amendment, the Incremental Commitment Agreement, the Second Amendment, the Third Amendment and the Credit Agreement, resulting in the "Facility"). The Facility is an unsecured $2.0 billion revolving credit agreement. The Third Amendment modified the calculation of total debt for purposes of determining compliance prior to the closing date of the Humana Transaction (the "Closing Date") with certain covenants to exclude debt incurred by us to finance the Humana Transaction, the other financing transactions related to the Humana Transaction and/or the payment of fees and expenses incurred in connection therewith so long as either (A) the net proceeds of such debt were set aside to finance the Humana Transaction, the other financing transactions related to the Humana Transaction and/or the payment of fees and expenses incurred in connection therewith or (B) such debt was subject to mandatory redemption in the event that the Humana Merger Agreement was terminated or expired. Among other things, the Fourth Amendment extended the maturity date of the existing Credit Agreement to March 27, 2021, eliminated the availability of swingline loans, provided us with additional time on each business day to provide notice of borrowings and added customary provisions to reflect European Union "bail-in" directive legislation.

In addition, upon our agreement with one or more financial institutions, we may expand the commitments under the Facility by an additional $500 million. The Facility also provides for the issuance of up to $200 million of letters of credit at our request, which count as usage of the available commitments under the Facility. In each of 2013, 2014, 2015 and 2017, we extended the maturity date of the Facility by one year. The maturity date of the Facility is March 27, 2021.

Various interest rate options are available under the Facility. Any revolving borrowings mature on the termination date of the Facility. We pay facility fees on the Facility ranging from .050% to .150% per annum, depending upon our long-term senior unsecured debt rating. The facility fee was .100% at December 31, 2017. The Facility contains a financial covenant that requires us to maintain a ratio of total debt to consolidated capitalization as of the end of each fiscal quarter at or below 50%. For this purpose, consolidated capitalization equals the sum of total shareholders' equity, excluding any overfunded or underfunded status of our pension and OPEB plans and any net unrealized capital gains and losses, and total debt (as defined in the Facility). We met this requirement at December 31, 2017. There were no amounts outstanding under the Facility at any time during the year ended December 31, 2017 or 2016.

Term Loan Agreement
On July 30, 2015, in connection with the Humana Transaction, we entered into a senior three-year $3.2 billion term loan credit agreement (the "Term Loan Agreement") with a group of seventeen lenders. The lenders' commitments under the Term Loan Agreement terminated on February 14, 2017, as a result of the termination of the Humana Merger Agreement.

Federal Home Loan Bank of Boston
We are a member of the Federal Home Loan Bank of Boston (the "FHLBB"), and as a member we have the ability to obtain cash advances, subject to certain minimum collateral requirements. Our maximum borrowing capacity available from the FHLBB at December 31, 2017 was approximately $700 million. At both December 31, 2017 and 2016, we did not have any outstanding borrowings from the FHLBB.

10. Pension and Other Postretirement Plans

Defined Benefit Retirement Plans
We sponsor various defined benefit plans, including two pension plans, and OPEB plans that provide certain health care and life insurance benefits for retired employees, including those of our former parent company.

During 2017, 2016 and 2015 we did not make any contribution to the Aetna Pension Plan. Effective December 31, 2010, our employees no longer earn future pension service credits in the Aetna Pension Plan (i.e., the Plan was "frozen" effective December 31, 2010), although the Aetna Pension Plan will continue to operate and account balances will continue to earn annual interest credits.

We also sponsor a non-qualified supplemental pension plan (the "Non-qualified Pension Plan") that, prior to January 1, 2007, had been used to provide benefits for wages above the Internal Revenue Code wage limits applicable to tax qualified pension plans (such as the Aetna Pension Plan). Effective January 1, 2007, no new benefits accrue under the Non-qualified Pension Plan,

but interest will continue to be credited on outstanding supplemental cash balance accounts; and the plan may continue to be used to credit special pension arrangements.

In addition, we currently provide certain medical and life insurance benefits for retired employees, including those of our former parent company. We provide subsidized health care benefits to certain eligible employees who terminated employment prior to December 31, 2006. There is a cap on our portion of the cost of providing medical and dental benefits to our retirees. Through December 31, 2015, all current and future retirees and employees who terminated employment at age 45 or later with at least five years of service were eligible to participate in our group health plans at their own cost. Effective January 1, 2016, only current and future retirees and employees who terminate employment at age 55 or later are eligible for such participation.

The information set forth in the following tables is based upon current actuarial reports using the annual measurement dates (December 31, for each year presented) for our pension and OPEB plans.

The following table shows the changes in the benefit obligations during 2017 and 2016 for our pension and OPEB plans:

	Pension Plans		OPEB Plans	
(Millions)	**2017**	**2016**	**2017**	**2016**
Benefit obligation, beginning of year	**$ 6,032**	$ 5,946	**$ 248**	$ 257
Interest cost	**203**	260	**8**	11
Actuarial loss	**394**	161	**11**	—
Benefits paid	**(411)**	(335)	**(18)**	(20)
Benefit obligation, end of year	**$ 6,218**	$ 6,032	**$ 249**	$ 248

The pension plans' benefit obligation increased in 2017 driven by interest cost recognized in 2017 and an increase in actuarial losses arising as a result of a lower discount rate as further described below; substantially offset by benefits paid in 2017.

The Aetna Pension Plan comprises 96% of the pension plans' total benefit obligation at December 31, 2017. The discount rates used to determine the benefit obligation of our pension and OPEB plans were calculated using a yield curve as of our annual measurement date. Each yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve. The weighted average discount rate for our pension plans was 3.68% and 4.22% for 2017 and 2016, respectively. The discount rate for our OPEB plans was 3.63% and 4.12% for 2017 and 2016, respectively. The discount rates differ for our pension and OPEB plans due to the duration of the projected benefit payments for each plan.

Effective as of the beginning of 2017, we refined the approach used to estimate the interest cost component of net periodic benefit cost for pension and OPEB plans that utilize a yield curve approach. Historically, we estimated the interest cost using a single weighted average discount rate derived from the yield curve used to measure the projected benefit obligation. We have now elected to measure interest cost by applying the specific spot rates along that yield curve to the relevant projected cash flows for each component. We believe the new approach provides a more precise estimate of such interest cost. We have accounted for this refinement as a change in accounting estimate and, accordingly, have accounted for it on a prospective basis beginning in 2017. The reduction in net periodic benefit cost associated with this refinement for the year ended December 31, 2017 was $26 million ($41 million pre-tax). For our pension benefits, the 2017 weighted-average discount rate for interest costs under the refined approach adopted as of the beginning of 2017 was 3.51%. Under the prior methodology, the 2017 weighted-average discount rate would have been 4.22%.

Additionally, based on the mortality experience of our pension and OPEB plans, in 2017 we utilized the RP-2014 Mortality Table with a generation projection of future mortality improvements using Scale MP-2017. In 2016, we utilized the RP-2014 Mortality Table with a generation projection of future mortality improvements using Scale MP-2016. In 2015 we utilized the RP-2014 Mortality Table with a generation projection of future mortality improvements using Scale MP-2015.

The following table reconciles the beginning and ending balances of the fair value of plan assets during 2017 and 2016 for our pension and OPEB plans:

	Pension Plans		OPEB Plans	
(Millions)	**2017**	**2016**	**2017**	**2016**
Fair value of plan assets, beginning of year	**$ 5,914**	$ 5,802	**$ 52**	$ 55
Actual return on plan assets	**808**	426	**2**	1
Employer contributions	**20**	21	**14**	16
Benefits paid	**(411)**	(335)	**(18)**	(20)
Fair value of plan assets, end of year	**$ 6,331**	$ 5,914	**$ 50**	$ 52

The difference between the fair value of plan assets and the plan's benefit obligation is referred to as the plan's funded status. This funded status is an accounting-based calculation and is not indicative of our mandatory funding requirements.

The funded status of our pension and OPEB plans at the measurement date for 2017 and 2016 was as follows:

	Pension Plans		OPEB Plans	
(Millions)	**2017**	**2016**	**2017**	**2016**
Benefit obligation	**$ (6,218)**	$ (6,032)	**$ (249)**	$ (248)
Fair value of plan assets	**6,331**	5,914	**50**	52
Funded status	**$ 113**	$ (118)	**$ (199)**	$ (196)

At December 31, 2017, the fair value of plan assets of the Aetna Pension Plan was in excess of the benefit obligations, while the Non-qualified Pension Plan had benefit obligations in excess of the fair value of plan assets. Below is the funded status of each of our Pension Plans:

	Aetna Pension Plan		Non-qualified Pension Plan	
(Millions)	**2017**	**2016**	**2017**	**2016**
Benefit obligation	**$ (5,995)**	$ (5,807)	**$ (223)**	$ (225)
Fair value of plan assets	**6,331**	5,914	**—**	—
Funded status	**$ 336**	$ 107	**$ (223)**	$ (225)

The amounts in accumulated other comprehensive loss that have not yet been recognized in net periodic benefit cost as of December 31, 2017 and 2016 were as follows:

	Pension Plans		OPEB Plans	
(Millions)	**2017**	**2016**	**2017**	**2016**
Unrecognized prior service credit	**$ —**	$ —	**$ (15)**	$ (19)
Unrecognized net actuarial losses	**2,361**	2,460	**75**	66
Amount recognized in accumulated other comprehensive loss	**$ (2,361)**	$ (2,460)	**$ (60)**	$ (47)

The assets (liabilities) recognized on our Consolidated Balance Sheets at December 31, 2017 and 2016 for our pension and OPEB plans were consisted of the following:

	Pension Plans		OPEB Plans	
(Millions)	**2017**	**2016**	**2017**	**2016**
Accrued benefit assets reflected in other long-term assets	**$ 336**	$ 107	**$ —**	$ —
Accrued benefit liabilities reflected in other current liabilities	**(20)**	(20)	**(12)**	(13)
Accrued benefit liabilities reflected in other long-term liabilities	**(203)**	(205)	**(187)**	(183)
Net amount of assets (liabilities) recognized at December 31,	**$ 113**	$ (118)	**$ (199)**	$ (196)

At December 31, 2017, we had approximately $2.4 billion and $75 million of net actuarial losses for our pension and OPEB plans, respectively, and $15 million of prior service credits for our OPEB plans and an immaterial amount of prior service credits

for our pension plan, that have not been recognized as components of net periodic benefit costs. We expect to recognize $63 million and $3 million in amortization of net actuarial losses for our pension and OPEB plans, respectively, and $4 million in amortization of prior service credits for our OPEB plans in 2018. Our amortization of prior service credits for our pension plans in 2018 is not expected to be material.

Components of the net periodic benefit (income) cost of our defined benefit pension plans and OPEB plans for the years ended December 31, 2017, 2016 and 2015 were as follows:

	Pension Plans			OPEB Plans		
(Millions)	**2017**	**2016**	**2015**	**2017**	**2016**	**2015**
Amortization of prior service credit	**$ —**	$ —	$ (1)	**$ (4)**	$ (4)	$ (4)
Interest cost	**203**	260	261	**8**	11	11
Expected return on plan assets	**(380)**	(389)	(419)	**(2)**	(3)	(3)
Recognized net actuarial losses	**65**	61	62	**3**	3	3
Net periodic (income) benefit cost	**$ (112)**	$ (68)	$ (97)	**$ 5**	$ 7	$ 7

The weighted average assumptions used to determine net periodic benefit (income) cost in 2017, 2016 and 2015 for the pension and OPEB plans were as follows:

	Pension Plans			OPEB Plans		
	2017	**2016**	**2015**	**2017**	**2016**	**2015**
Discount rate	**4.22%**	4.50%	4.12%	**4.12%**	4.39%	4.02%
Expected long-term return on plan assets	**6.70%**	6.90%	7.00%	**4.75%**	4.75%	5.30%

We assume different health care cost trend rates for medical costs and prescription drug costs in estimating the expected costs of our OPEB plans. The assumed medical cost trend rate for 2018 is 5.4%, decreasing gradually to 4.5% by 2026. The assumed prescription drug cost trend rate for 2018 is 9.4%, decreasing gradually to 4.5% by 2026. These assumptions reflect our historical as well as expected future trends for retirees. In addition, the trend assumptions reflect factors specific to our retiree medical plan, such as plan design, cost-sharing provisions, benefits covered and the presence of subsidy caps. A one-percentage point increase in both the assumed medical cost and assumed prescription drug cost trend rates would result in an immaterial pretax increase in the aggregate of the service and interest cost components of OPEB costs and a $8 million increase in the OPEB benefit obligation. A one-percentage point decrease in both the assumed medical cost and assumed prescription drug cost trend rates would result in an immaterial pretax decrease in the aggregate of the service and interest cost components of OPEB costs and an $8 million decrease in the OPEB benefit obligation.

Our current funding strategy for the Aetna Pension Plan is to fund an amount at least equal to the minimum funding requirement as determined under applicable regulatory requirements with consideration of factors such as the maximum tax deductibility of such amounts. Minimum funding requirements for the Aetna Pension Plan were met in 2017 and 2016, and we were not required to make cash contributions for either of those years. We do not have any required contribution to the Aetna Pension Plan in 2018. Employer contributions related to the supplemental pension and OPEB plans represent payments to retirees for current benefits. We have no plans to return any pension or OPEB plan assets to the Company in 2018. Our non-qualified supplemental pension plan and OPEB plans do not have minimum funding requirements.

Expected benefit payments, which reflect future employee service, as appropriate, of the pension and OPEB plans to be paid for each of the next five years and in the aggregate for the next five years thereafter at December 31, 2017 were as follows:

(Millions)	**Pension Plans**	**OPEB Plans**
2018	$ 374	$ 17
2019	364	17
2020	367	17
2021	371	17
2022	374	17
2023-2027	1,867	79

Assets of the Aetna Pension Plan

The assets of the Aetna Pension Plan ("Pension Assets") primarily include debt and equity securities held in separate accounts, as well as common/collective trusts and real estate investments. The valuation methodologies used to price these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 5. Pension Assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodology used to price real estate investments and these additional investments, including the general classification pursuant to the valuation hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which includes, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity limited partnerships - Private equity limited partnerships are carried at fair value which is estimated based on the fair value of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. We typically do not have a controlling ownership in our private equity limited partnership investments, and therefore we apply the equity method of accounting for these investments. Accordingly, these investments have been excluded from the fair value table below.

Hedge fund limited partnerships - Hedge fund limited partnerships are carried at fair value which is estimated using the net asset value ("NAV") per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Pension Assets with changes in fair value measured on a recurring basis at December 31, 2017 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total
Debt securities:				
U.S. government securities	$ 644	$ 38	$ —	$ 682
States, municipalities and political subdivisions	—	150	—	150
U.S. corporate securities	—	1,506	—	1,506
Foreign securities	—	165	—	165
Residential mortgage-backed securities	—	322	—	322
Commercial mortgage-backed securities	—	57	1	58
Other asset-backed securities	—	130	—	130
Redeemable preferred securities	—	8	—	8
Total debt securities	644	2,376	1	3,021
Equity securities:				
U.S. Domestic	939	4	—	943
International	556	—	—	556
Domestic real estate	26	—	—	26
Total equity securities	1,521	4	—	1,525
Other investments:				
Real estate	—	—	479	479
Common/collective trusts [1]	—	478	—	478
Derivatives	—	1	—	1
Total other investments	—	479	479	958
Total pension investments [2]	$ 2,165	$ 2,859	$ 480	$ 5,504

(1) The assets in the underlying funds of common/collective trusts consist of $294 million of equity securities and $184 million of debt securities.

(2) Excludes $119 million of cash and cash equivalents and other payables, $530 million of private equity limited partnership investments and $178 million of hedge fund limited partnership investments.

Pension Assets with changes in fair value measured on a recurring basis at December 31, 2016 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total
Debt securities:				
U.S. government securities	$ 460	$ 122	$ —	$ 582
States, municipalities and political subdivisions	—	128	—	128
U.S. corporate securities	—	1,291	—	1,291
Foreign securities	—	103	—	103
Residential mortgage-backed securities	—	163	—	163
Commercial mortgage-backed securities	—	57	—	57
Other asset-backed securities	—	60	—	60
Redeemable preferred securities	—	6	—	6
Total debt securities	460	1,930	—	2,390
Equity securities:				
U.S. Domestic	1,305	5	—	1,310
International	611	—	—	611
Domestic real estate	34	—	—	34
Total equity securities	1,950	5	—	1,955
Other investments:				
Real estate	—	—	478	478
Common/collective trusts [1]	—	465	—	465
Total other investments	—	465	478	943
Total pension investments [2]	$ 2,410	$ 2,400	$ 478	$ 5,288

[1] The assets in the underlying funds of common/collective trusts consist of $307 million of equity securities and $158 million of debt securities.
[2] Excludes $180 million of cash and cash equivalents and other payables, $255 million of private equity limited partnership investments and $191 million of hedge fund limited partnership investments.

The changes in the balances of Level 3 Pension Assets during 2017 and 2016 were as follows:

	2017		
(Millions)	Real Estate	Other	Total
Beginning balance	**$ 478**	**$ —**	**$ 478**
Actual return on plan assets	**23**	**—**	**23**
Purchases, sales and settlements	**(22)**	**—**	**(22)**
Transfers into Level 3	**—**	**1**	**1**
Ending balance	**$ 479**	**$ 1**	**$ 480**

	2016		
(Millions)	Real Estate	Other	Total
Beginning balance	$ 497	$ 3	$ 500
Actual return on plan assets	42	—	42
Purchases, sales and settlements	(61)	(1)	(62)
Transfers out of Level 3	—	(2)	(2)
Ending balance	$ 478	$ —	$ 478

The Aetna Pension Plan invests in a diversified mix of assets intended to maximize long-term returns while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons, and by assessing the Aetna Pension Plan's liability characteristics, our financial position and our future potential obligations from both the pension and general corporate perspectives. Complementary investment styles and techniques are utilized by multiple professional investment firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed

favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2017, target investment allocations for the Aetna Pension Plan were: 33% in equity securities, 54% in debt securities, 6% in real estate, 4% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the Plan's Benefit Finance Committee. Forecasting of asset and liability growth is performed at least annually.

We have several benefit plans for retired employees currently supported by the OPEB plan assets. OPEB plan assets are directly and indirectly invested in a diversified mix of traditional asset classes, primarily high-quality fixed income securities.

The actual and target asset allocations of the OPEB plans used at December 31, 2017 and 2016 presented as a percentage of total plan assets, were as follows:

(Millions)	**2017**	**Target Allocation**	**2016**	**Target Allocation**
Equity securities	**13%**	**10-15%**	11%	5-15%
Debt securities	**81%**	**75-85%**	82%	80-90%
Real estate/other	**6%**	**5-10%**	7%	0-10%

Our expected return on plan assets assumption is based on many factors, including forecasted capital market real returns over a long-term horizon, forecasted inflation rates, historical compounded asset returns and patterns and correlations on those returns. Expectations for modest increases in interest rates, normal inflation trends and average capital market real returns led us to an expected return on pension plan assets assumption of 6.70% for 2017, 6.90% for 2016 and 7.00% for 2015, and an expected return on OPEB plan assets assumption of 4.75% for both 2017 and 2016 and 5.30% for 2015. We regularly review actual asset allocations and periodically rebalance our investments to the mid-point of our targeted allocation ranges when we consider it appropriate.

401(k) Plan

Our employees are eligible to participate in a defined contribution retirement savings plan under which designated contributions may be invested in our common stock or certain other investments (the "Aetna 401(k) Plan"). Our 401(k) contribution to the Aetna 401(k) Plan provides for a match of 100% of up to 6% of the eligible pay contributed by the employee. During 2017, 2016 and 2015, we made $196 million, $197 million and $198 million, respectively, in aggregate of matching contributions to our 401(k) plans. The matching contributions are made in cash and invested according to each participant's investment elections. The plan trustee held 6 million shares of our common stock for plan participants at December 31, 2017. At December 31, 2017, 34 million shares of our common stock were reserved for issuance under the Aetna 401(k) Plan.

11. Income Taxes

The components of our income tax provision in 2017, 2016 and 2015 were:

(Millions)	2017	2016	2015
Current income taxes:			
Federal	**$ 1,369**	$ 1,662	$ 1,797
State	**73**	129	112
Total current income taxes	**1,442**	1,791	1,909
Deferred income tax benefits:			
Federal	**(328)**	(55)	(59)
State	**(27)**	(1)	(9)
Total deferred income tax benefits	**(355)**	(56)	(68)
Total income taxes	**$ 1,087**	$ 1,735	$ 1,841

Income taxes were different from the amount computed by applying the statutory federal income tax rate to income before income taxes as follows:

	2017		2016		2015	
(Millions)	Amount	Percent	Amount	Percent	Amount	Percent
Amount at statutory rate	**$ 1,047**	**35.0%**	$ 1,397	35.0 %	$ 1,483	35.0 %
Health insurer fee	**—**	**—%**	293	7.3 %	300	7.1 %
State income taxes	**21**	.7%	83	2.1 %	63	1.5 %
Other, net	**19**	**.6%**	(38)	(.9)%	(5)	(.1)%
Income taxes	**$ 1,087**	**36.3%**	$ 1,735	43.5 %	$ 1,841	43.5 %

The significant components of our net deferred tax liabilities at December 31, 2017 and 2016 were as follows:

(Millions)	2017	2016
Deferred tax assets:		
Insurance reserves	**$ 187**	$ 231
Reserve for anticipated future losses on discontinued products	**135**	225
Employee and postretirement benefits	**75**	196
Net operating losses	**184**	147
Severance and facilities	**32**	135
Investments, net	**58**	80
Debt fair value adjustments	**10**	23
Deferred revenue	**231**	21
Other	**116**	117
Gross deferred tax assets	**1,028**	1,175
Less: Valuation allowance	**154**	118
Deferred tax assets, net of valuation allowance	**874**	1,057
Deferred tax liabilities:		
Goodwill and other acquired intangible assets	**451**	814
Cumulative depreciation and amortization	**101**	185
Unrealized gains on investment securities	**105**	42
Other	**22**	20
Total gross deferred tax liabilities	**679**	1,061
Net deferred tax assets (liabilities)	**$ 195**	$ (4)

Valuation allowances are provided when we estimate that it is more likely than not that deferred tax assets will not be realized. A valuation allowance has been established primarily related to state net operating losses. We base our estimates of the future realization of deferred tax assets primarily on historic taxable income and existing deferred tax liabilities.

We participate in the Compliance Assurance Process (the "CAP") with the Internal Revenue Service (the "IRS"). Under the CAP, the IRS undertakes audit procedures during the tax year and as the return is prepared for filing. The IRS has concluded its CAP audit of our 2016 tax return as well as all the prior years. We expect the IRS will conclude its CAP audit of our 2017 tax return in 2018.

We are also subject to audits by various state taxing authorities for tax years from 2000 through 2016. We believe we carry appropriate reserves for any exposure to state tax issues.

At both December 31, 2017 and December 31, 2016 we did not have material uncertain tax positions reflected in our Consolidated Balance Sheets.

On December 22, 2017, the TCJA was enacted. Refer to Note 2 for additional information related to the TCJA.

12. Stock-based Employee Incentive Plans

Our stock-based employee compensation plans (collectively, the "Plans") provide for awards of stock options, SARs, PSARs, RSUs, MSUs, PSUs, deferred contingent common stock and the ability for employees to purchase common stock at a discount. At December 31, 2017, 27 million common shares were available for issuance under the Plans. Executive, middle management and non-management employees may be granted stock options, SARs, PSARs, RSUs, MSUs and PSUs, each of which are described below:

Stock Options, SARs and PSARs

We have not granted stock options since 2005, and no stock options were outstanding as of December 31, 2017. SARs granted will be settled in our common stock, net of taxes, based on the appreciation of our stock price on the exercise date over the market price on the date of grant. SARs generally become 100% vested three years after the grant is made, with one-third vesting each year. Vested SARs may be exercised at any time during the ten years after grant, except in certain circumstances, generally related to employment termination or retirement. At the end of the ten year period, any unexercised SARs expire.

The SARs granted to certain employees during 2017 and 2016 and described above had an estimated grant date fair value per SAR of $32.30 and $34.33, respectively. The grant date fair value was calculated using a modified Black-Scholes option pricing model using the following assumptions:

	2017	2016
Expected term (in years)	**7.21**	7.11
Volatility	**26.52%**	32.9%
Risk-free interest rate	**2.22%**	1.52%
Dividend yield	**1.71%**	0.91%
Initial price	**$ 125.27**	$ 103.45

The expected term is based on historical equity award activity. Volatility is based on a weighted average of the historical volatility of our stock price and implied volatility from traded options on our stock. The risk-free interest rate is based on a U.S. Treasury rate with a life equal to the expected life of the SARs grant. This rate was calculated by interpolating between the 7-year and 10-year U.S. Treasury rates for both the 2017 and 2016 SARs grants. The dividend yield is based on our expected dividends for the upcoming 12 months subsequent to the grant date.

PSARs represent the opportunity to vest in SARs. For the PSARs granted in 2013 ("2013 PSARs"), the number of vested PSARs (which could range in specified increments from zero to 700,000 SARs) was dependent on Aetna's total shareholder return over a three year performance period relative to a defined peer group of companies. The 2013 PSARs were subject to a three-year vesting period that ended on August 5, 2016, and vested at 500,000 SARs.

We estimated the grant date fair value of the 2013 PSARs using a Monte Carlo simulation. The 2013 PSARs had a grant date per PSAR fair value of $18.64. That grant date fair value was calculated using the following assumptions:

Expected settlement period (in years)	6.12
Volatility	40.4%
Risk-free interest rate	.6%
Dividend yield	1.25%
Initial price	$ 64.25

The stock option, SAR and PSAR transactions during 2017, 2016 and 2015 were as follows:

(Millions, except exercise price and remaining life)	Number of Stock Options, SARs and PSARs	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life	Aggregate Intrinsic Value
2015				
Outstanding, beginning of year	8.1	$ 49.37	4.2	$ 318
Granted	2.0	101.41	—	—
Exercised	(2.5)	43.90	—	155
Expired or forfeited	(.2)	91.25	—	—
Outstanding, end of year [1]	7.4	$ 64.11	5.3	$ 325
Exercisable, end of year	4.1	$ 45.88	2.6	$ 252
2016				
Outstanding, beginning of year	7.4	$ 64.11	5.3	$ 325
Granted	2.4	104.47	—	—
Exercised	(1.4)	52.99	—	85
Expired or forfeited	(.4)	83.25	—	—
Outstanding, end of year	8.0	$ 77.20	5.9	$ 373
Exercisable, end of year	4.3	$ 57.26	3.6	$ 287
2017				
Outstanding, beginning of year	**8.0**	**$ 77.20**	**5.9**	**$ 373**
Granted	**2.2**	**125.82**	**—**	**—**
Exercised	**(2.4)**	**65.42**	**—**	**185**
Expired or forfeited	**(.2)**	**108.24**	**—**	**—**
Outstanding, end of year	**7.6**	**$ 94.03**	**6.6**	**$ 398**
Exercisable, end of year	**3.6**	**$ 71.06**	**4.6**	**$ 397**

[1] PSARs are included in this table in 2015 at the maximum amount that could potentially vest.

The following is a summary of information regarding SARs outstanding at December 31, 2017 (millions, except remaining contractual life and exercise price):

	Outstanding				Exercisable		
Range of Exercise Prices	Number Outstanding	Weighted Average Remaining Contractual Life (Years)	Weighted Average Exercise Price	Aggregate Intrinsic Value	Number Exercisable	Weighted Average Exercise Price	Aggregate Intrinsic Value
20.00-30.00 [1]	—	1.4	$ 25.50	$ 3	—	$ 25.50	$ 3
30.00-40.00	.8	1.1	32.11	125	.8	32.11	125
40.00-50.00 [1]	—	.3	45.84	1	—	45.84	1
50.00-60.00	.4	.1	50.70	55	.4	50.70	55
60.00-70.00	.5	5.6	64.25	58	.5	64.25	58
70.00-80.00	.5	6.1	72.42	49	.5	72.42	49
80.00-90.00 [1]	—	4.4	80.27	—	—	80.27	—
100.00-110.00	2.9	7.6	102.51	227	1.3	102.11	99
110.00-120.00	.2	8.3	115.16	16	.1	115.36	7
120.00-130.00	2.0	9.1	125.24	112	—	124.41	1
130.00-140.00 [1]	—	9.2	132.80	—	—	—	—
140.00-150.00	.1	9.4	145.10	2	—	—	—
160.00-170.00 [1]	—	9.7	163.21	—	—	—	—
$20.00-$170.00 [2]	7.4	6.6	$ 94.03	$ 648	3.6	$ 71.06	$ 398

[1] The number of outstanding and exercisable SARs with exercise prices between $20 and $30, $40 and $50, $80 and $90, $130 and $140 and $160 and $170 rounded to zero.
[2] The number of outstanding SARs with exercise prices between $90 and $100 and $150 and $160 rounded to zero.

During 2017, 2016 and 2015, the following activity occurred under the Plans:

(Millions)	2017	2016	2015
Cash received from stock option exercises	$ —	$ —	$ 7
Intrinsic value of stock options/SARs exercised and stock units vested	499	384	413
Tax benefits realized for the tax deductions from stock options and SARs exercised and stock units vested	99	77	101
Fair value of stock options, SARs, PSARs and stock units vested [1]	300	223	126

[1] The fair value represents the aggregate grant date fair value of the stock options, SARs, PSARs and stock units as of the respective grant dates.

We settle our SARs and stock units with newly-issued common stock and generally utilized the proceeds from stock options to repurchase our common stock in the open market in the same period.

RSUs, MSUs and PSUs

For each RSU granted, employees receive one share of common stock, net of taxes, at the end of the vesting period. RSUs generally become 100% vested approximately three years from the grant date, with one third vesting each December. The grant date fair value is determined based on the market price of our common stock on the date of grant.

The number of vested MSUs (which could range from zero to 150% of the original number of units granted) is dependent on the weighted average closing price of our common stock for the thirty trading days prior to the vesting date, including the vesting date. Each vested MSU represents one share of common stock and will be paid in shares of common stock, net of taxes. MSUs representing 50% of the grant date fair value of the MSUs granted in 2012 were subject to a two-year vesting period while the remaining MSUs granted in 2012 were subject to a three-year vesting period. MSUs granted in 2014 and 2013 were subject to a three-year vesting period. There were no MSUs granted from 2015 through 2017.

The number of vested PSUs (which could range from zero to 200% of the original number of units granted) is dependent upon the degree to which we achieve performance goals, which for the most part, are set at the time of grant as determined by our

Board's Committee on Compensation and Talent Management (the "Compensation Committee"). Each vested PSU represents one share of common stock and will be paid in shares of common stock, net of taxes. The grant date fair value is determined based on the market price of our common stock on the date of grant. Below is a summary of the performance period and vesting percentages for each tranche of PSUs granted by the Company:

- *PSUs granted in 2013 ("2013 PSUs"):* Certain PSUs granted in 2013 were subject to a single three-year performance period that ended on December 31, 2015, and vested at 74.61% of the original number of units granted. Certain PSUs granted in 2013 were subject to a two-year vesting period with two separate performance periods. Half of these PSUs were subject to a one-year performance period that ended on December 31, 2013, and vested at 127.08% of the original number of units granted. The remaining half were subject to a one-year performance period that ended on December 31, 2014, and vested at 131.62% of the original number of units granted.
- *PSUs granted in 2014 ("2014 PSUs"):* The 2014 PSUs had a two-year performance period that ended on December 31, 2015, and a three-year vesting period. The 2014 PSUs vested at 200% of the original number of units granted.
- *PSUs granted in 2015 ("2015 PSUs"):* The 2015 PSUs have a three-year performance period that ended on December 31, 2017, and are subject to a three-year vesting period. The 2015 PSUs vested at 120% of the original number of units granted.
- *PSUs granted in 2016 ("2016 PSUs"):* The 2016 PSUs have a three-year performance period that will end on December 31, 2018, and are subject to a three-year vesting period.
- *PSUs granted in 2017 ("2017 PSUs"):* The 2017 PSUs have a three-year performance period that will end on December 31, 2019, and are subject to a three-year vesting period.

From 2010 through 2014, we granted MSUs to certain employees. We did not grant any MSUs from 2015 through 2017. We estimate the grant date fair value of MSUs using a Monte Carlo simulation. MSUs granted in 2014 had a weighted average per MSU grant date fair value of $74.99. The weighted-average per MSU grant date fair value was calculated using the following assumptions:

	2014
Volatility	26.4%
Risk-free interest rate	.7%
Dividend yield	1.3%
Initial price	$ 72.26

The annualized volatility of the price of our common stock was calculated over the three-year period preceding the grant date of the MSUs. The risk-free interest rates for periods within the expected life of the MSUs were based on a constant maturity yield curve in effect on the grant date of the MSUs. The dividend yield assumption was based on our expected 2014 annual dividend payout. There were no MSUs outstanding as of December 31, 2017.

RSU, MSU and PSU transactions in 2017, 2016 and 2015 were as follows (number of units in millions):

	2017		2016		2015	
	RSUs, MSUs and PSUs	**Weighted Average Grant Date Fair Value**	**RSUs, MSUs and PSUs**	**Weighted Average Grant Date Fair Value**	**RSUs, MSUs and PSUs**	**Weighted Average Grant Date Fair Value**
RSUs, MSUs and PSUs at beginning of year	**2.9**	**$ 91.95**	3.9	$ 73.40	5.1	$ 58.57
Granted	**0.9**	**126.56**	2.1	98.60	1.8	100.52
Vested	**(2.1)**	**88.17**	(2.7)	68.87	(2.6)	59.72
Forfeited	**(.2)**	**101.69**	(.4)	71.17	(.4)	70.94
RSUs, MSUs and PSUs at end of year	**1.5**	**$ 112.71**	2.9	$ 91.95	3.9	$ 73.40

Stock Compensation Expense

In 2017, 2016 and 2015 we recorded share-based compensation expense of $187 million, $191 million and $181 million, respectively, in general and administrative expenses. We also recorded related tax benefits of $39 million, $33 million and $37 million in 2017, 2016 and 2015, respectively. At December 31, 2017, $153 million of total unrecognized compensation costs related to unvested SARs, RSUs and PSUs is expected to be recognized over a weighted-average period of 1.6 years.

13. Shareholders' Equity

Share Repurchases

From time to time, our Board authorizes us to repurchase our common stock. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase ("ASR") agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. The activity under Board authorized share repurchase programs in 2017, 2016 and 2015 was as follows:

		Shares Purchased					
		2017		2016		2015	
(Millions)	Purchase Not to Exceed	Shares	Cost	Shares	Cost	Shares	Cost
Authorization date:							
February 17, 2017	$ 4,000	**19.3**	**$ 2,762**	—	$ —	—	$ —
November 21, 2014	1,000	**7.1**	**1,000**	—	—	—	—
February 28, 2014	1,000	**0.6**	**83**	—	—	3.0	296
Total repurchases	N/A	**27.0**	**$ 3,845**	—	$ —	3.0	$ 296
Repurchase authorization remaining at December 31,		**N/A**	**$ 1,238**	N/A	$ 1,083	N/A	$ 1,083

On February 22, 2017, we entered into ASR agreements with two unrelated third party financial institutions to repurchase an aggregate of $3.3 billion of Aetna's common shares. Under the terms of the ASR agreements, we made an approximately $1.7 billion payment to each unrelated third party financial institution on February 22, 2017 and received from each of them an initial delivery of approximately 10.4 million of our common shares on the same day, which represented approximately 80 percent of the total common shares expected to be repurchased under the ASR agreements based on the closing price of $126.34 per share on the day before we entered into the ASR agreements. In August 2017, we settled the ASR agreements and received approximately 2.7 million of our common shares based on the volume-weighted average share price of our common shares during the term of the applicable transaction, less a discount. The average price of our common shares repurchased under the ASR agreements was $140.09 per share.

We recorded the initial delivery of our common shares as a decrease to retained earnings of approximately $2.6 billion, and recorded the remaining approximately $0.7 billion as a decrease to additional paid-in capital on our Consolidated Balance Sheet. In August 2017, we reclassified the approximately $0.7 billion recorded as a reduction to additional paid-in capital to a reduction of retained earnings upon final settlement of the ASR agreements.

During the year ended December 31, 2017, we also repurchased approximately 3.4 million of our common shares in the open market at a cost of approximately $545 million. As a result of the CVS Merger Agreement, our ability to repurchase shares of our common stock prior to the completion of the merger contemplated by the CVS Merger Agreement (the "Merger") is limited.

Dividends

Prior to termination of the Humana Merger Agreement, Aetna was not permitted to declare, set aside or pay any dividend or other distribution other than a regular quarterly cash dividend in the ordinary course of business, which could not exceed $.25 per share. In addition, the Term Loan Agreement contained a covenant limiting "Restricted Payments" (as defined in the Term Loan Agreement) by Aetna, subject to certain exceptions and baskets, including an exception permitting the payment of regular cash dividends. Under the terms of the CVS Merger Agreement, prior to the completion of the Merger, Aetna is not permitted to declare, set aside or pay any dividend or make any other distribution other than a regular quarterly cash dividend in the ordinary course of business, which cannot exceed $.50 per share. Declaration and payment of future dividends is at the discretion of our Board and may be adjusted as business needs or marketplace conditions change. In addition, under the terms of the CVS Merger Agreement, we have agreed with CVS Health to coordinate the declaration and payment of dividends so that our shareholders do not fail to receive a quarterly dividend around the time of closing the Merger.

In 2017 and 2016 our Board declared the following cash dividends:

Date Declared	Dividend Amount Per Share	Stockholders of Record Date	Date Paid/ To be Paid	Total Dividends (Millions)
Year ended December 31, 2016				
February 19, 2016	$ .25	April 14, 2016	April 29, 2016	$ 88
May 20, 2016	.25	July 14, 2016	July 29, 2016	88
September 30, 2016	.25	October 13, 2016	October 28, 2016	88
December 2, 2016	.25	January 12, 2017	January 27, 2017	88
Year ended December 31, 2017				
February 17, 2017	$ .50	April 13, 2017	April 28, 2017	$ 166
May 19, 2017	.50	July 13, 2017	July 28, 2017	166
September 29, 2017	.50	October 12, 2017	October 27, 2017	163
December 3, 2017	.50	January 11, 2018	January 26, 2018	163

On February 23, 2018, our Board declared a cash dividend of $.50 per share that will be paid on April 27, 2018 to shareholders of record at the close of business on April 12, 2018.

Preferred Stock and Undesignated Shares
In addition to the common stock disclosed on our Consolidated Balance Sheets, 8 million shares of Class A voting preferred stock, $.01 par value per share, have been authorized and none are issued or outstanding at December 31, 2017. At December 31, 2017, there were also 469 million undesignated shares that our Board has the power to divide into such classes and series, with such voting rights, designations, preferences, limitations and special rights as our Board determines.

Regulatory Requirements
Our business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. Our HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP. The combined statutory net income for the years ended and combined statutory capital and surplus at December 31, 2017, 2016 and 2015 for our insurance and HMO subsidiaries were as follows:

(Millions)	2017	2016	2015
Statutory net income	**$ 2,908**	$ 2,229	$ 2,186
Statutory capital and surplus	**9,948**	10,413	9,883

During 2017, our insurance and HMO subsidiaries paid approximately $3.9 billion of gross dividends to the Company.

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. At December 31, 2017, these amounts were as follows:

(Millions)	
Minimum statutory surplus required by regulators	$ 3,685
Investments on deposit with regulatory bodies	621
Maximum dividend distributions permitted in 2018 without state approval	1,573

Non-controlling (Minority) Interests
At December 31, 2017 and 2016, continuing business non-controlling interests were $257 million and $62 million, respectively, primarily related to third party interests in our operating entities. At December 31, 2016, continuing business non-controlling interests also included third party interests in our investment holdings. During the fourth quarter of 2017, we redeemed the entire minority shareholder interests in our investment holdings. The non-controlling entities' share is included in total equity.

14. Other Comprehensive Income (Loss)

Shareholders' equity included the following activity in accumulated other comprehensive income (loss) in 2017, 2016 and 2015:

	At December 31,		
(Millions)	**2017**	**2016**	**2015**
Previously impaired debt securities: [1]			
Beginning of period balance	**$ 16**	$ 19	$ 35
Net unrealized losses *($(9), $(31) and $(69) pretax)*	**(6)**	(20)	(45)
Less: Net reclassification of gains (losses) to earnings *($8, $(26) and $(44) pretax)* [2]	**5**	(17)	(29)
Other comprehensive loss	**(11)**	(3)	(16)
End of period balance	**5**	16	19
All other securities:			
Beginning of period balance	**297**	312	568
Net unrealized gains (losses) *($165, $(12) and $(490) pretax)*	**107**	(8)	(318)
Less: Net reclassification of gains (losses) to earnings *($120, $11 and $(97) pretax)* [2]	**78**	7	(62)
Other comprehensive income (loss)	**29**	(15)	(256)
End of period balance	**326**	297	312
Derivatives and foreign currency:			
Beginning of period balance	**(235)**	$ (74)	$ (61)
Net unrealized gains (losses) *($11, $(273) and $(26) pretax)*	**7**	(177)	(17)
Less: Net reclassification of losses to earnings *($(345), $(25) and $(6) pretax)* [3]	**(224)**	(16)	(4)
Other comprehensive income (loss)	**231**	(161)	(13)
End of period balance	**(4)**	(235)	(74)
Pension and OPEB plans:			
Beginning of period balance	**(1,630)**	(1,587)	(1,653)
Net unrealized net actuarial gains (losses) arising during the period *($23, $(126) and $41 pretax)*	**18**	(82)	27
Less: Net amortization of net actuarial losses *($(68), $(64) and $(64) pretax)* [4]	**(44)**	(42)	(42)
Less: Net amortization of prior service credit *($5, $5 and $4 pretax)* [4]	**3**	3	3
Other comprehensive income (loss)	**59**	(43)	66
End of period balance	**(1,571)**	(1,630)	(1,587)
Total beginning of period accumulated other comprehensive loss	**(1,552)**	(1,330)	(1,111)
Total other comprehensive income (loss)	**308**	(222)	(219)
Total end of period accumulated other comprehensive loss	**$ (1,244)**	$ (1,552)	$ (1,330)

(1) Represents specifically identified unrealized gains on the non-credit related component of impaired debt securities that we do not intend to sell and subsequent changes in the fair value of any previously impaired security.

(2) Reclassifications out of accumulated other comprehensive income for specifically identified previously impaired debt securities and all other securities are reflected in net realized capital (losses) gains within our Consolidated Statements of Income.

(3) Reclassifications out of accumulated other comprehensive income for specifically identified foreign currency gains (losses) and derivatives are reflected in net realized capital (losses) gains within our Consolidated Statements of Income, except for the specifically identified effective portion of derivatives related to interest rate swaps which are reflected in interest expense. During the year ended December 31, 2017, we redeemed the entire $10.2 billion aggregate principal amount outstanding of the Special Mandatory Redemption Notes and the entire $750 million aggregate principal amount outstanding of our senior notes due 2020 and reclassified out of accumulated other comprehensive income the remaining $336 million pre-tax unrealized hedge losses as a realized capital loss within our Consolidated Statements of Income. Refer to Note 9 for additional information.

(4) Reclassifications out of accumulated other comprehensive income for specifically identified pension and OPEB plan expenses are reflected in general and administrative expenses within our Consolidated Statements of Income. Refer to Note 10 for additional information.

15. Earnings Per Common Share

Basic earnings per common share ("EPS") is computed by dividing net income attributable to Aetna by the weighted-average number of common shares outstanding during the reporting period. Diluted EPS is computed in a similar manner, except that the weighted average number of common shares outstanding is adjusted for the dilutive effects of our outstanding stock-based compensation awards, but only if the effect is dilutive.

The computations of basic and diluted EPS for 2017, 2016 and 2015 are as follows:

(Millions, except per common share data)	2017	2016	2015
Net income attributable to Aetna	**$ 1,904**	$ 2,271	$ 2,390
Weighted average shares used to compute basic EPS	**333.2**	351.3	349.3
Dilutive effect of outstanding stock-based compensation awards	**2.2**	3.0	3.3
Weighted average shares used to compute diluted EPS	**335.4**	354.3	352.6
Basic EPS	**$ 5.71**	$ 6.46	$ 6.84
Diluted EPS	**$ 5.68**	$ 6.41	$ 6.78

The stock-based compensation awards excluded from the calculation of diluted EPS for 2017, 2016 and 2015 are as follows:

(Millions)	2017	2016	2015
Stock appreciation rights ("SARs") [1]	—	.1	.5
Other stock-based compensation awards [2]	**.7**	.7	.8

[1] SARs are excluded from the calculation of diluted EPS if the exercise price is greater than the average market price of Aetna common shares during the period (i.e., the awards are anti-dilutive).

[2] Performance stock units ("PSUs"), certain market stock units ("MSUs") with performance conditions, and performance stock appreciation rights ("PSARs") are excluded from the calculation of diluted EPS if all necessary performance conditions have not been satisfied at the end of the reporting period (refer to Note 12 for additional information about PSARs).

16. Reinsurance

We utilize reinsurance agreements primarily to reduce our required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit us to recover a portion of our losses from reinsurers, although they do not discharge our primary liability as the direct insurer of the risks reinsured.

On November 1, 2017, we completed the sale of a substantial portion of our Group Insurance segment consisting of our domestic group life insurance, group disability insurance and absence management businesses to HLAIC. The transaction was accomplished through an indemnity reinsurance arrangement under which HLAIC contractually assumed certain of our policyholder liabilities and obligations, although we remain directly obligated to policyholders. The liability related to our obligation is primarily recorded in unpaid claims on our Consolidated Balance Sheets. Assets related to and supporting the reinsured life and disability insurance policies were transferred to a trust established by HLAIC for our benefit, and we recorded a reinsurance receivable from HLAIC.

Effective October 1, 1998, we reinsured certain policyholder liabilities and obligations related to individual life insurance in conjunction with our former parent company's sale of this business. These transactions were in the form of indemnity reinsurance arrangements, whereby the assuming companies contractually assumed certain policyholder liabilities and obligations, although we remain directly obligated to policyholders. The liability related to our obligation is recorded in future policy benefits and policyholders' funds on our Consolidated Balance Sheets. Assets related to and supporting these policies were transferred to the assuming companies, and we recorded a reinsurance recoverable.

Effective 2014 to 2017, we entered into certain three to five-year reinsurance agreements with unrelated reinsurers that allowed us to reduce our required capital and provided collateralized excess of loss reinsurance coverage on a portion of our group Commercial Insured Health Care business. In January 2018, we entered into two four-year reinsurance agreements with an unrelated reinsurer that allowed us to reduce our required capital and provided collateralized excess of loss reinsurance coverage on a portion of our group Commercial Insured Health Care business.

The ACA established a temporary reinsurance program that expired at the end of 2016. Under this program, all issuers of major medical commercial insurance products and self-insured plan sponsors were required to contribute funding in amounts set by HHS. Funds collected were utilized to reimburse issuers' high claims costs incurred for qualified individual members. The expense related to this required funding was reflected in general and administrative expenses for all of our insurance products with the exception of products associated with qualified individual members; this expense for qualified individual members was reflected as a reduction of premium revenue. When annual claim costs incurred by our qualified individual members exceeded a specified attachment point, we were entitled to certain reimbursements from this program. We recorded a receivable and offset health care costs to reflect our estimate of these recoveries. Refer to Note 2 for additional information about the ACA's temporary three-year reinsurance program.

Reinsurance recoverables recorded at December 31, 2017 and 2016 were as follows:

(Millions)	**Total Recoverables**	
Reinsurer	**2017**	**2016**
Hartford Life and Accident Insurance Company	**$ 3,555**	**$ —**
Lincoln Life & Annuity Company of New York	**431**	444
VOYA Retirement Insurance and Annuity Company	**197**	209
Affordable Care Act	**37**	202
All Other	**153**	164
Total	**$ 4,373**	$ 1,019

Direct, assumed and ceded premiums earned for the years ended December 31 were as follows:

	Health Care			**Group Insurance**		
(Millions)	**2017**	**2016**	**2015**	**2017**	**2016**	**2015**
Direct	**$ 51,964**	$ 54,062	$ 51,539	**$ 2,171**	$ 2,155	$ 2,155
Assumed	**413**	402	368	**1**	1	1
Ceded	**(355)**	(348)	(289)	**(353)**	(13)	(17)
Net premiums	**$ 52,022**	$ 54,116	$ 51,618	**$ 1,819**	$ 2,143	$ 2,139

The impact of reinsurance on benefit costs (health care costs for our Health Care segment and current and future benefits for our Group Insurance segment) for the years ended December 31 were as follows:

	Health Care			**Group Insurance**		
(Millions)	**2017**	**2016**	**2015**	**2017**	**2016**	**2015**
Direct	**$ 42,780**	$ 44,341	$ 42,038	**$ 2,181**	$ 1,861	$ 1,845
Assumed	**318**	339	298	**4**	2	2
Ceded	**(345)**	(425)	(624)	**(597)**	(13)	(10)
Net benefit costs	**$ 42,753**	$ 44,255	$ 41,712	**$ 1,588**	$ 1,850	$ 1,837

Assumed and ceded other premiums and current and future benefit expense related to our Large Case Pensions segment was not material during the years ended 2017, 2016 or 2015. There is not a material difference between premiums on a written basis versus an earned basis.

We also have various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. We entered into these contracts to reduce the risk of catastrophic loss which in turn reduces our capital and surplus requirements surrounding certain portions of our group term life, group accidental death and dismemberment, Medicare Advantage and group Commercial Insured Health Care businesses. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2017 or 2016.

17. Commitments and Contingencies

Guarantees
We have the following significant guarantee and indemnification arrangements at December 31, 2017.

- ASC Claim Funding Accounts - We have arrangements with certain banks for the processing of claim payments for our ASC customers. The banks maintain accounts to fund claims of our ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, we guarantee that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million. We can limit our exposure to this guarantee by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.
- Indemnification Agreements - In connection with certain acquisitions and dispositions of assets and/or businesses, our various issuances of long-term debt and certain of our reinsurance agreements, we have incurred certain customary indemnification obligations to the applicable seller, purchaser, underwriters and/or various other participants. In general, we have agreed to indemnify the other party for certain losses relating to the assets or business that we or they purchased or sold or for other matters on terms that are customary for similar transactions. Certain portions of our indemnification obligations are capped at the applicable transaction price, while other arrangements are not subject to such a limit. At December 31, 2017, we do not believe that our future obligations under any of these agreements will be material to our financial position.
- Separate Accounts assets - Certain Separate Accounts assets associated with the Large Case Pensions business represent funds maintained as a contractual requirement to fund specific pension annuities that we have guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $1.7 billion and $1.8 billion at December 31, 2017 and 2016, respectively. Refer to Note 2 for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Account balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Account assets to meet the annuity guarantees, we would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2017 exceeded the value of the guaranteed benefit obligation. As a result, we were not required to maintain any additional liability for our related guarantees at December 31, 2017.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner (the "Commissioner") placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. We recorded a discounted estimated liability and expense of $231 million pretax during the first quarter of 2017 for our estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The undiscounted estimated liability was $347 million. The expense was recorded in general and administrative expenses in our Consolidated Statements of Income, and the liability was recorded in accrued expenses and other current liabilities in our Consolidated Balance Sheets. We did not record an asset for expected premium tax offsets for our in force business at December 31, 2017 as the amount was not material. It is reasonably possible that in the future we may record a liability and expense relating to other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment, and the ultimate

liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

Out-of-Network Benefit Proceedings

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to defend ourselves vigorously against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other

litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing our risk adjustment-related data and that of other companies. We expect CMS and the OIG to continue these types of audits.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and

international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $36 million ($55 million pretax). Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of further changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

Other Obligations
We have operating leases for office space and certain computer and other equipment. Rental expenses for these items were $159 million, $167 million and $165 million in 2017, 2016 and 2015, respectively. For 2018 through 2022, our future net minimum payments under non-cancelable leases and funding obligations relating to equity limited partnership investments, commercial mortgage loans and real estate partnerships were:

(Millions)	2018	2019	2020	2021	2022
Future net minimum payments under non-cancelable leases	$ 142	$ 115	$ 79	$ 65	$ 51
Funding requirements for equity limited partnership investments, commercial mortgage loans and real estate partnerships	139	106	90	53	35
Total	$ 281	$ 221	$ 169	$ 118	$ 86

18. Segment Information

Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment; it is added to our business segments to reconcile to our consolidated results. The Corporate Financing segment includes transaction and integration-related costs, restructuring costs, income taxes, interest expense on our outstanding debt and the financing components of our pension and OPEB expense (the service cost and prior service cost components of this expense are allocated to our business segments). Effective for the first quarter of 2018, we will realign our business segments to correspond with changes to our management structure and internal management reporting which reflect our evolving business strategy of helping our members live healthier lives. Refer to Note 1 for further discussion.

Non-GAAP financial measures we disclose, such as adjusted earnings and pre-tax adjusted earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. Effective March 31, 2017, to more clearly differentiate between the GAAP and non-GAAP financial measures used in our reports filed with or furnished to the Securities and Exchange Commission and our other disclosures, we changed the naming convention for our non-GAAP financial measures from “operating” measures to “adjusted” measures. The underlying calculations of our consolidated non-GAAP financial measures did not change. Prior to March 31, 2017, operating earnings was the measure reported to the chief executive officer for purposes of assessing financial performance and making operating decisions, such as the allocation of resources among our business segments. Effective March 31, 2017, the chief executive officer assesses our consolidated results based on adjusted earnings and assesses business segment results based on pre-tax adjusted earnings because income taxes are recorded in our Corporate Financing segment and are not allocated to our business segments. Also effective March 31, 2017, transaction and integration-related costs and restructuring costs were reclassified to our Corporate Financing segment because they do not reflect our underlying business performance. Prior periods have been restated to reflect this presentation.

Summarized financial information of our segment operations [1] for 2017, 2016 and 2015 were as follows:

(Millions)	Health Care	Group Insurance	Large Case Pensions	Corporate Financing	Total Company
2017					
Revenue from external customers	**$ 57,771**	**$ 1,992**	**$ 61**	**$ —**	**$ 59,824**
Net investment income	**476**	**210**	**253**	**11**	**950**
Interest expense	**—**	**—**	**—**	**442**	**442**
Depreciation and amortization expense	**705**	**—**	**—**	**—**	**705**
Pre-tax adjusted earnings (loss) [2]	**5,207**	**125**	**15**	**(254)**	**5,093**
2016					
Revenue from external customers	$ 59,860	$ 2,251	$ 48	$ —	$ 62,159
Net investment income	435	226	226	23	910
Interest expense	—	—	—	604	604
Depreciation and amortization expense	681	—	—	—	681
Pre-tax adjusted earnings (loss) [2]	5,073	141	10	(259)	4,965
2015					
Revenue from external customers	$ 57,203	$ 2,240	$ 42	$ —	$ 59,485
Net investment income	408	238	271	—	917
Interest expense	—	—	—	369	369
Depreciation and amortization expense	671	—	—	—	671
Pre-tax adjusted earnings (loss) [2]	4,751	174	14	(227)	4,712

(1) Total Assets by segment are not disclosed as this information is not reviewed by the chief executive officer.

(2) Pre-tax adjusted earnings (loss) excludes net realized capital gains or losses, amortization of other acquired intangible assets and the other items described in the reconciliation below.

A reconciliation of income before income taxes attributable to Aetna to pre-tax adjusted earnings[1] in 2017, 2016 and 2015 follows.

(Millions)	2017	2016	2015
Income before income taxes (GAAP measure)	**$ 2,992**	$ 3,991	$ 4,236
Less: (Loss) income before income taxes attributable to non-controlling interests (GAAP measure)	**(10)**	(20)	7
Income before income taxes attributable to Aetna (GAAP measure)	**3,002**	4,011	4,229
Gain related to sale of certain domestic group insurance businesses	**(88)**	—	—
Loss on early extinguishment of long-term debt	**246**	—	—
Penn Treaty-related guaranty fund assessments	**231**	—	—
Transaction and integration-related costs	**1,240**	517	258
Restructuring costs	**60**	404	15
Reduction of reserve for anticipated future losses on discontinued products	**(109)**	(128)	—
Litigation related proceeds	**—**	—	(110)
Amortization of other acquired intangible assets	**272**	247	255
Net realized capital losses (gains)	**239**	(86)	65
Pre-tax adjusted earnings	**$ 5,093**	$ 4,965	$ 4,712

(1) In addition to net realized capital gains and losses and amortization of other acquired intangible assets, the following other items are excluded from adjusted earnings and pre-tax adjusted earnings because we believe they neither relate to the ordinary course of our business nor reflect our underlying business performance:

- During the year ended December 31, 2017, we sold a substantial portion of our Group Insurance segment consisting of our domestic group life insurance, group disability insurance, and absence management business. The transaction was accomplished through an indemnity reinsurance arrangement. The sale is expected to result in an after-tax gain of approximately $710 million ($1.1 billion pre-tax), a significant portion of which has been deferred and will be amortized into earnings: (i) over the remaining contract period (estimated to be approximately 3 years) in proportion to the amount of insurance protection provided for the prospective reinsurance portion of the gain; and (ii) as we recover amounts due from HLAIC over a period estimated to be approximately 30 years for the retrospective reinsurance portion of the gain. The gain recognized does not directly relate to the underwriting or servicing of products for customers and is not directly related to the core performance of Aetna's business operations.
- During the year ended December 31, 2017, we incurred losses on the early extinguishment of long-term debt due to (a) the mandatory redemption of the $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes following the termination of the Humana Merger Agreement and (b) the early redemption of $750 million aggregate principal amount of our outstanding senior notes due 2020.
- During the year ended December 31, 2017, we recorded an expense for estimated future guaranty fund assessments related to Penn Treaty, which was placed in rehabilitation in 2009 and placed in liquidation in March 2017. This expense does not directly relate to the underwriting or servicing of products for customers and is not directly related to the core performance of our business operations.
- We recorded transaction-related costs during the year ended December 31, 2017 related to our proposed acquisition by CVS Health. We also recorded transaction and integration-related costs during the years ended December 31, 2017, 2016 and 2015 primarily related to the Humana Transaction. Transaction costs include costs associated with the transactions contemplated by the CVS Merger Agreement, the termination of the Humana Merger Agreement, the termination of our agreement to sell certain assets to Molina and advisory, legal and other professional fees which are reflected in our GAAP Consolidated Statements of Income in general and administrative expenses. Transaction costs also include the negative cost of carry associated with the debt financing that we obtained in June 2016 for the Humana Transaction. Prior to the mandatory redemption of the Special Mandatory Redemption Notes, the negative cost of carry associated with these senior notes was excluded from adjusted earnings and pre-tax adjusted earnings. The negative cost of carry associated with the $2.8 billion aggregate principal amount of our senior notes issued in June 2016 that are not subject to mandatory redemption (the “Other 2016 Senior Notes”) was excluded from adjusted earnings and pre-tax adjusted earnings through the date of the termination of the Humana Merger Agreement. The components of the negative cost of carry are reflected in our GAAP Consolidated Statements of Income in interest expense and net investment income. Subsequent to the termination of the Humana Merger Agreement, the interest expense and net investment income associated with the Other 2016 Senior Notes were no longer excluded from adjusted earnings and pre-tax adjusted earnings.
- Restructuring costs for 2017 include severance costs associated with our expense management and cost control initiatives. Restructuring costs for 2016 include costs related to our voluntary early retirement program, severance and real estate consolidation costs associated with our expense management and cost control initiatives and an accrual for minimum volume commitments which require us to make payments to suppliers if the level of medical membership subject to the agreements falls below specified levels. We did not expect to meet these minimum volume commitments as a result of our reduced participation on the ACA’s individual Public Exchanges in 2017. Restructuring costs for 2015 include severance costs associated with our expense management and cost control initiatives. The 2017, 2016 and 2015 restructuring costs are reflected in the GAAP Consolidated Statements of Income in general and administrative expenses.

- In 1993, we discontinued the sale of fully guaranteed large case pensions products and established a reserve for anticipated future losses on these products, which we review quarterly. During the year ended December 31, 2017 and December 31, 2016, we reduced the reserve for anticipated future losses on discontinued products. We believe excluding any changes in the reserve for anticipated future losses on discontinued products from adjusted earnings provides more useful information as to our continuing products and is consistent with the treatment of the operating results of these discontinued products, which are credited or charged to the reserve and do not affect our operating results.
- In 2015, we received proceeds net of legal costs, in connection with a litigation settlement. These net proceeds were recorded in fees and other revenue in our GAAP Consolidated Statements of Income.

Revenues from external customers by product in 2017, 2016 and 2015 were as follows:

(Millions)	**2017**	**2016**	**2015**
Health care premiums	**$ 52,022**	$ 54,116	$ 51,618
Health care fees and other revenue	**5,749**	5,744	5,585
Group insurance premiums	**1,819**	2,143	2,139
Group insurance fees and other revenues	**173**	108	101
Large case pensions premiums	**53**	39	32
Large case pensions other revenue	**8**	9	10
Total revenue from external customers [1] [2]	**$ 59,824**	$ 62,159	$ 59,485

[1] All within the U.S., except approximately $634 million, $642 million and $1.3 billion in 2017, 2016 and 2015, respectively, which were derived from foreign customers.

[2] Revenue from the U.S. federal government was approximately $20.8 billion, $20.5 billion and $17.8 billion in 2017, 2016 and 2015, respectively, in the Health Care and Group Insurance segments. These amounts exceeded 10 percent of our total revenue from external customers in each of 2017, 2016 and 2015.

The following is a reconciliation of revenue from external customers to total revenues included in our Consolidated Statements of Income in 2017, 2016 and 2015:

(Millions)	**2017**	**2016**	**2015**
Revenue from external customers	**$ 59,824**	$ 62,159	$ 59,485
Net investment income	**950**	910	917
Net realized capital (losses) gains	**(239)**	86	(65)
Total revenue	**$ 60,535**	$ 63,155	$ 60,337

Long-lived assets, which are principally within the U.S., were $576 million and $579 million at December 31, 2017 and 2016, respectively.

19. Discontinued Products

Prior to 1993, we sold single-premium annuities ("SPAs") and guaranteed investment contracts ("GICs"), primarily to employer sponsored pension plans. In 1993, we discontinued selling these products to Large Case Pensions customers, and now we refer to these products as discontinued products. In November 2016, the last outstanding GIC matured.

We discontinued selling these products because they were generating losses for us, and we projected that they would continue to generate losses over their life (which is currently greater than 30 years for SPAs); so we established a reserve for anticipated future losses at the time of discontinuance. This reserve represents the present value (at the risk-free rate of return consistent with the duration of the liabilities) of the difference between the expected cash flows from the assets supporting these products and the cash flows expected to be required to meet the obligations of the outstanding contracts.

Key assumptions in setting the reserve for anticipated future losses include future investment results, payments to retirees, mortality and retirement rates and the cost of asset management and customer service. In 2014, we modified the mortality tables used in order to reflect the more up-to-date 2014 Retired Pensioner's Mortality table. The mortality tables were previously modified in 2012, in order to reflect the more up-to-date 2000 Retired Pensioner's Mortality table, and in 1995, in order to reflect the more up-to-date 1994 Uninsured Pensioner's Mortality table. In 1997, we began the use of a bond default assumption to reflect historical default experience. Other than these changes, since 1993 there have been no significant changes to the assumptions underlying the reserve.

We review the adequacy of this reserve quarterly based on actual experience. As long as our expected future losses remain consistent with prior projections, the results of the discontinued products are applied against the reserve and do not impact net income attributable to Aetna. If actual or expected future losses are greater than we currently estimate, we may increase the reserve, which could adversely impact net income attributable to Aetna. If actual or expected future losses are less than we currently estimate, we may decrease the reserve, which could favorably impact net income attributable to Aetna. As a result of this review, we released $71 million ($109 million pretax) and $84 million ($128 million pretax) in the years ended December 31, 2017 and 2016, respectively. No releases were made to the reserve in 2015. The reserve release during the year ended December 31, 2017 was primarily due to favorable mortality experience compared to assumptions we previously made in estimating the reserve. The reserve release in the years ended December 31, 2017 and 2016 also was due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve. The reserve at each of December 31, 2017 and 2016 reflects management's best estimate of anticipated future losses and is included in future policy benefits on our Consolidated Balance Sheets.

The activity in the reserve for anticipated future losses on discontinued products in 2017, 2016 and 2015 was as follows (pretax):

(Millions)	**2017**	**2016**	**2015**
Reserve, beginning of period	**$ 962**	$ 1,067	$ 1,015
Operating income (loss)	**29**	(34)	(9)
Net realized capital gains	**72**	57	61
Reserve reduction	**(109)**	(128)	—
Reserve, end of period	**$ 954**	$ 962	$ 1,067

During 2017, our discontinued products reflected operating income and net realized capital gains, primarily attributable to gains from other investments and the sale of debt securities and investment real estate. During 2016, our discontinued products reflected operating losses and net realized capital gains, primarily attributable to gains from the sale of debt securities. During 2015, our discontinued products reflected operating losses and net realized capital gains, primarily attributable to gains from the sale of other invested assets and investment real estate. We evaluated these 2017 results against the expectations of future cash flows assumed in estimating the reserve for anticipated future losses and do not believe that an adjustment to the reserve was required at December 31, 2017.

The anticipated run-off of the discontinued products reserve balance at December 31, 2017 (assuming that assets are held until maturity and that the reserve run-off is proportional to the liability run-off) is as follows:

(Millions)	
2018	$ 55
2019	54
2020	52
2021	50
2022	48
Thereafter	695

Assets and liabilities supporting discontinued products[1] at December 31, 2017 and 2016 were as follows:

(Millions)	2017	2016
Assets:		
Debt and equity securities available for sale	**$ 1,623**	$ 1,913
Mortgage loans	**567**	370
Other investments	**564**	646
Total investments	**2,754**	2,929
Other assets	**71**	104
Receivable from continuing products [2]	**474**	554
Total assets	**$ 3,299**	$ 3,587
Liabilities:		
Future policy benefits	**$ 2,165**	$ 2,326
Reserve for anticipated future losses on discontinued products	**954**	962
Current and deferred income taxes	**22**	42
Other liabilities [3]	**158**	257
Total liabilities	**$ 3,299**	$ 3,587

(1) Assets supporting the discontinued products are distinguished from assets supporting continuing products.

(2) At the time of discontinuance, a receivable from Large Case Pensions' continuing products was established on the discontinued products balance sheet. This receivable represented the net present value of anticipated cash shortfalls in the discontinued products, which will be funded from continuing products. Interest on the receivable is accrued at the discount rate that was used to calculate the reserve. The offsetting payable, on which interest is similarly accrued, is reflected in continuing products. Interest on the payable generally offsets investment income on the assets available to fund the shortfall. These amounts are eliminated in consolidation.

(3) Net unrealized capital gains on the available-for-sale debt securities are included in other liabilities and are not reflected in consolidated shareholders' equity.

The discontinued products investment portfolio has changed since inception. Mortgage loans have decreased from $5.4 billion (37% of the investment portfolio) at December 31, 1993 to $567 million (21% of the investment portfolio) at December 31, 2017. This was a result of maturities, prepayments and the securitization and sale of commercial mortgages. Also, real estate decreased from $500 million (4% of the investment portfolio) at December 31, 1993 to $113 million (4% of the investment portfolio) at December 31, 2017, primarily as a result of sales. The resulting proceeds were primarily reinvested in debt securities, equity securities and other investments. Over time, the then-existing mortgage loan and real estate portfolios and the reinvested proceeds have resulted in greater investment returns than we originally assumed in 1993.

At December 31, 2017, the expected run-off of the SPA liabilities, including future interest, was as follows:

(Millions)	
2018	$ 328
2019	312
2020	297
2021	281
2022	266
Thereafter	3,240

The liability expected as of December 31, 1993 and the actual liability balances at December 31, 2017, 2016 and 2015 for the GIC and SPA liabilities were as follows:

	Expected		Actual	
(Millions)	**GIC**	**SPA**	**GIC**	**SPA**
2015	$ 10	$ 2,112	$ —	$ 2,494
2016	9	1,942	—	2,326
2017	**9**	**1,771**	**—**	**2,165**

The GIC balances were lower than expected in each period because several contract holders redeemed their contracts prior to contract maturity. In November 2016, the last outstanding GIC matured. The SPA balances in each period were higher than expected because of additional amounts received under existing contracts.

The distributions on our discontinued products consisted of scheduled contract maturities, settlements and benefit payments of $323 million, $364 million and $356 million for the years ended December 31, 2017, 2016 and 2015, respectively. Participant-directed withdrawals from our discontinued products were not significant in the years ended December 31, 2017, 2016 or 2015. Cash required to fund these distributions was provided by earnings and scheduled payments on, and sales of, invested assets.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
Aetna Inc.:

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Aetna Inc. and subsidiaries (the "Company") as of December 31, 2017 and 2016, and the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the years in the three-year period ended December 31, 2017, and the related notes and the accompanying financial statement schedule I (collectively, the "financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO").

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2017, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control - Integrated Framework (2013) issued by COSO.

Basis for Opinion

The Company's management is responsible for these financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on these financial statements and an opinion on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) ("PCAOB") and are required to be independent with the respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the financial statements included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definitions and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with U.S. generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ KPMG LLP

We have served as the Company's auditor since 1972.

Hartford, Connecticut
February 23, 2018

Quarterly Data (unaudited)

(Millions, except per share and common stock data)	First	Second	Third	Fourth
2017				
Total revenue	$ 15,165	$ 15,523	$ 14,994	$ 14,853
(Loss) income before income taxes	$ (628)	$ 1,820	$ 1,274	$ 526
Income tax benefit (expense)	249	(637)	(426)	(272)
Net income including non-controlling interests	(379)	1,183	848	254
Less: Net income (loss) attributable to non-controlling interests	2	(20)	10	10
Net (loss) income attributable to Aetna	$ (381)	$ 1,203	$ 838	$ 244
Net (loss) income attributable to Aetna per share - basic [1]	$ (1.11)	$ 3.62	$ 2.54	$ .75
Net (loss) income attributable to Aetna per share - diluted [1]	(1.11)	3.60	2.52	.74
2016				
Total revenue	$ 15,694	$ 15,952	$ 15,782	$ 15,727
Income before income taxes	$ 1,289	$ 1,354	$ 1,073	$ 275
Income tax expense	(551)	(561)	(476)	(147)
Net income including non-controlling interests	738	793	597	128
Less: Net income (loss) attributable to non-controlling interests	1	2	(7)	(11)
Net income attributable to Aetna	$ 737	$ 791	$ 604	$ 139
Net income attributable to Aetna per share - basic [1]	$ 2.10	$ 2.25	$ 1.72	$ .40
Net income attributable to Aetna per share - diluted [1]	2.09	2.23	1.70	.39

(1) Calculation of net income (loss) attributable to Aetna per share is based on weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Disclosure Controls and Procedures
We maintain disclosure controls and procedures, which are designed to ensure that information that we are required to disclose in the reports we file or submit under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.

An evaluation of the effectiveness of our disclosure controls and procedures as of December 31, 2017 was conducted under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures as of December 31, 2017 were designed to ensure that material information relating to Aetna Inc. and its consolidated subsidiaries would be made known to the Chief Executive Officer and Chief Financial Officer by others within those entities, particularly during the periods when periodic reports under the Exchange Act are being prepared and were effective. Refer to the Certifications by our Chief Executive Officer and Chief Financial Officer filed as Exhibits 31.1 and 31.2 to this Annual Report on Form 10-K.

Management's Report on Internal Control over Financial Reporting
Management is responsible for establishing and maintaining adequate internal control over financial reporting ("ICoFR") for the Company. ICoFR is defined as a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Our ICoFR process includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the consolidated financial statements in accordance with GAAP, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on our consolidated financial statements.

Because of its inherent limitations, ICoFR may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Under the supervision and with the participation of management, including our Chief Executive and Chief Financial Officers, management assessed the effectiveness of our ICoFR at December 31, 2017. In making this assessment, management used the framework set forth by the Committee of Sponsoring Organizations of the Treadway Commission in "*Internal Control - Integrated Framework*" *(2013)*. Based on this assessment, management concluded that our ICoFR was effective at December 31, 2017. Our ICoFR as well as our consolidated financial statements have been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which appears on page 153.

Management's Responsibility for Financial Statements
Management is responsible for our consolidated financial statements, which have been prepared in accordance with GAAP. Management believes the consolidated financial statements, and other financial information included in this report, fairly present in all material respects our financial position, results of operations and cash flows as of and for the periods presented in this report.

The financial statements are the product of a number of processes that include the gathering of financial data developed from the records of our day-to-day business transactions. Informed judgments and estimates are used for those transactions not yet complete or for which the ultimate effects cannot be measured precisely. We emphasize the selection and training of personnel who are qualified to perform these functions. In addition, our personnel are subject to rigorous standards of ethical conduct that are widely communicated throughout the organization.

The Audit Committee of Aetna's Board of Directors engages KPMG LLP, an independent registered public accounting firm, to audit our consolidated financial statements and express their opinion thereon. Members of that firm also have the right of full

access to each member of management in conducting their audits. The report of KPMG LLP on their audit of our consolidated financial statements appears on page 153.

Audit Committee Oversight
The Audit Committee of Aetna's Board of Directors is comprised solely of independent directors. The Audit Committee meets regularly with management, our internal auditors and KPMG LLP to oversee and monitor the work of each and to inquire of each as to their assessment of the performance of the others in their work relating to our consolidated financial statements and ICoFR. Both KPMG LLP and our internal auditors have, at all times, the right of full access to the Audit Committee, without management present, to discuss any matter they believe should be brought to the attention of the Audit Committee.

Changes in Internal Control over Financial Reporting
There has been no change in our internal control over financial reporting identified in connection with the evaluation of such control that occurred during our fourth fiscal quarter that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

None.

Part III

Item 10. Directors, Executive Officers and Corporate Governance

Information concerning our Directors, our Directors' and certain of our executives' compliance with Section 16(a) of the Exchange Act, our Code of Conduct (our written code of ethics) and our audit committee and audit committee financial experts is incorporated herein by reference to the information under the captions "Nominees for Directorships," "Section 16(a) Beneficial Ownership Reporting Compliance," "Aetna's Code of Conduct" and "Board and Committee Membership; Committee Descriptions" in the Proxy Statement.

EXECUTIVE OFFICERS OF THE REGISTRANT
Aetna's Chairman is elected by Aetna's Board of Directors (our "Board"). All of Aetna's other executive officers listed below are appointed by our Board, generally at its Annual Meeting, and such persons hold office until the next Annual Meeting of our Board or until their successors are elected or appointed. None of these officers has a family relationship with any other executive officer or Director. In addition, there are no arrangements or understandings, other than those with Directors or executive officers acting solely in their capacities as such, pursuant to which these executive officers were appointed.

Name of Executive Officer	Position*	Age *
Mark T. Bertolini	Chairman and Chief Executive Officer	61
Karen S. Lynch	President	55
Shawn M. Guertin	Executive Vice President, Chief Financial Officer and Chief Enterprise Risk Officer	54
Richard M. Jelinek	Executive Vice President, Enterprise Strategy	52
Margaret M. McCarthy	Executive Vice President, Operations and Technology	64
Harold L. Paz, M.D, M.S.	Executive Vice President, Chief Medical Officer	63
Thomas J. Sabatino, Jr.	Executive Vice President and General Counsel	59
Francis S. Soistman, Jr.	Executive Vice President, Government Services	61

*As of February 23, 2018

Executive Officers' Business Experience During Past Five Years

Mark T. Bertolini serves as Aetna's Chairman, having held that position since April 8, 2011. Mr. Bertolini was elected to Aetna's Board and has served as Chief Executive Officer since November 29, 2010. Mr. Bertolini also served as President from July 24, 2007 to December 31, 2014.

Karen S. Lynch became President of Aetna on January 1, 2015, having served as Executive Vice President, Local and Regional Businesses since February 2013 and Executive Vice President, Head of Specialty Products since July 23, 2012. Prior to joining Aetna, Ms. Lynch served as President of Magellan Health Services, a position she assumed in August 2009.

Shawn M. Guertin became Executive Vice President, Chief Financial Officer and Chief Enterprise Risk Officer on January 2, 2014, having served as Senior Vice President, Chief Financial Officer and Chief Enterprise Risk Officer since February 25, 2013. Prior to that, Mr. Guertin served as the Head of Business Segment Finance since April 2011.

Richard M. Jelinek became Executive Vice President, Enterprise Strategy in March 2017, having served as Executive Vice President, Humana Integration since November 2, 2015. Prior to joining Aetna, Mr. Jelinek served as an operating partner at Advent International, a position he assumed in September 2013. Prior to that, Mr. Jelinek held a series of senior leadership positions at UnitedHealth Group and its affiliates from 1994-2013, including Executive Vice President of UnitedHealth Group and CEO of OptumHealth.

Margaret M. McCarthy became Executive Vice President, Operations and Technology on November 29, 2010, having served as Chief Information Officer since June 3, 2005 and Senior Vice President Innovation, Technology and Service Operations since January 1, 2010.

Harold J. Paz, M.D, M.S. became Executive Vice President, Chief Medical Officer on July 28, 2014. Prior to joining Aetna, Dr. Paz served as Chief Executive Officer of Penn State Hershey Medical Center and Health System, Senior Vice President for Health Affairs for Penn State University, dean of its College of Medicine and professor of medicine and public health sciences, a position he assumed in April 2006.

Thomas J. Sabatino, Jr. became Executive Vice President and General Counsel on April 25, 2016. Prior to joining Aetna, Mr. Sabatino served as Senior Executive Vice President, Chief Administrative Officer and General Counsel of Hertz Global Holdings, Inc. from February 2015 through April 2016; Executive Vice President, Global Legal and Chief Administrative Officer of Walgreens Boots Alliance from September 2011 through January 2015; and Senior Vice President and General Counsel of UAL Corporation and United Airlines, Inc. from March 2010 to December 2010.

Francis S. Soistman, Jr. became Executive Vice President, Government Services on June 14, 2013, having served as Vice President, Medicare since May 20, 2013 and Head of Medicare since January 14, 2013. Prior to joining Aetna, Mr. Soistman served as Executive Vice President of Jessamine Healthcare, a position he assumed in 2010.

Item 11. Executive Compensation

The information under the captions “Compensation Discussion and Analysis,” “Director Compensation Philosophy and Elements,” “2017 Nonmanagement Director Compensation,” “Additional Director Compensation Information,” “Executive Compensation,” “Compensation Committee Interlocks and Insider Participation” and “Compensation Committee Report” in the Proxy Statement is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The CVS Merger Agreement dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. is expected to result in a change in control of Aetna Inc. at a subsequent date.

The information under the caption “Security Ownership of Certain Beneficial Owners, Directors, Nominees and Executive Officers” and “Equity Compensation Plans” in an amendment to this Form 10-K in the Proxy Statement is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information under the captions “Director Independence” and “Related Party Transaction Policy” in an amendment to this Form 10-K in the Proxy Statement is incorporated herein by reference.

Item 14. Principal Accounting Fees and Services

The information under the captions “Fees Incurred for 2017 and 2016 Services Performed by the Independent Registered Public Accounting Firm” and “Nonaudit Services and Other Relationships Between the Company and the Independent Registered Public Accounting Firm” in an amendment to this Form 10-K in the Proxy Statement is incorporated herein by reference.

Part IV

Item 15. Exhibits, Financial Statement Schedules

The following documents are filed as part of this Annual Report on Form 10-K:

1. Financial Statements. See “Index to Consolidated Financial Statements” in Part II, Item 8 of this Annual Report on Form 10-K.

2. Financial Statement Schedule. The following financial statement schedule of the Company is included in this Item 15:
   Schedule I: Condensed Financial Information of Aetna Inc. (Parent Company Only)

3. Exhibits. The exhibits listed in the accompanying “Index to Exhibits” in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K.

Index to Financial Statement Schedule

Schedule I - Financial Information of Aetna Inc.

Aetna Inc. (Parent Company Only)
Balance Sheets

(Millions)	At December 31, 2017	2016
Assets:		
Current assets:		
Cash and cash equivalents	**$ 1,981**	$ 14,972
Investments	**—**	4
Income taxes receivable	**184**	48
Other current assets	**56**	109
Total current assets	**2,221**	15,133
Investment in affiliates [1]	**23,192**	23,415
Deferred income taxes	**162**	285
Other long-term assets	**350**	107
Total assets	**$ 25,925**	$ 38,940
Liabilities and shareholders' equity:		
Current liabilities:		
Accrued expenses and other current liabilities	**$ 977**	$ 792
Current portion of long-term debt	**999**	— 1,248
Total current liabilities	**1,976**	2,040
Long-term debt, less current portion	**7,513**	18,366
Employee benefit liabilities	**531**	545
Other long-term liabilities	**68**	46
Total liabilities	**10,088**	20,997
Shareholders' equity:		
Common stock ($.01 par value; 2.5 billion shares authorized and 326.8 million shares issued and outstanding in 2017; 2.5 billion shares authorized and 351.7 million shares issued and outstanding in 2016) and additional paid-in capital	**4,706**	4,716
Retained earnings	**12,118**	14,717
Accumulated other comprehensive loss	**(1,244)**	(1,552)
Total Aetna shareholders' equity	**15,580**	17,881
Non-controlling interests	**257**	62
Total equity	**15,837**	17,943
Total liabilities and equity	**$ 25,925**	$ 38,940

[1] Includes goodwill and other acquired intangible assets of $11.8 billion and $12.1 billion at December 31, 2017 and 2016, respectively.

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Statements of Income

	For the Years Ended December 31,		
(Millions)	**2017**	**2016**	**2015**
Other revenue [1]	**$ —**	$ —	$ 110
Net investment income	**18**	31	—
Net realized capital losses	**(336)**	(6)	—
Total revenue	**(318)**	25	110
Operating expenses	**1,282**	289	183
Interest expense	**422**	578	343
Loss on early extinguishment of long-term debt	**246**	—	—
Total expenses	**1,950**	867	526
Loss before income tax benefit and equity in earnings of affiliates, net	**(2,268)**	(842)	(416)
Income tax benefit	**759**	249	93
Equity in earnings of affiliates, net [2]	**3,413**	2,864	2,713
Net income attributable to Aetna	**$ 1,904**	$ 2,271	$ 2,390

(1) In the year ended December 31, 2015, other revenue includes litigation-related proceeds, net of legal costs. Refer to Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

(2) Includes after-tax amortization of other acquired intangible assets of $171 million, $161 million and $166 million for the years ended December 31, 2017, 2016 and 2015, respectively.

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Statements of Comprehensive Income

	For the Years Ended December 31,		
(Millions)	**2017**	**2016**	**2015**
Net income attributable to Aetna	**$ 1,904**	$ 2,271	$ 2,390
Other comprehensive income (loss), net of tax:			
Previously impaired debt securities	**(11)**	(3)	(16)
All other securities	**29**	(15)	(256)
Derivatives and foreign currency	**231**	(161)	(13)
Pension and OPEB plans	**59**	(43)	66
Other comprehensive income (loss)	**308**	(222)	(219)
Comprehensive income attributable to Aetna	**$ 2,212**	$ 2,049	$ 2,171

Refer to Note 14 “Other Comprehensive (Loss) Income” included in Part II, Item 8 of this Annual Report on Form 10-K for further information about other comprehensive income or loss.

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Statements of Shareholders' Equity

(Millions)	Number of Common Shares Outstanding	Attributable to Aetna: Common Stock and Additional Paid-in Capital	Attributable to Aetna: Retained Earnings	Attributable to Aetna: Accumulated Other Comprehensive Loss	Attributable to Aetna: Total Aetna Shareholders' Equity	Non-Controlling Interests	Total Equity
Balance at December 31, 2014	349.8	$ 4,542	$ 11,052	$ (1,111)	$ 14,483	$ 69	$ 14,552
Net income	—	—	2,390	—	2,390	5	2,395
Other decreases in non-controlling interests	—	—	—	—	—	(9)	(9)
Other comprehensive loss	—	—	—	(219)	(219)	—	(219)
Common shares issued for benefit plans, including tax benefits, net of employee tax withholdings	2.7	105	—	—	105	—	105
Repurchases of common shares	(3.0)	—	(296)	—	(296)	—	(296)
Dividends declared	—	—	(349)	—	(349)	—	(349)
Balance at December 31, 2015	349.5	4,647	12,797	(1,330)	16,114	65	16,179
Net income (loss)	—	—	2,271	—	2,271	(15)	2,256
Other increases in non-controlling interests	—	—	—	—	—	12	12
Other comprehensive loss	—	—	—	(222)	(222)	—	(222)
Common shares issued for benefit plans, including tax benefits, net of employee tax withholdings	2.2	69	—	—	69	—	69
Dividends declared	—	—	(351)	—	(351)	—	(351)
Balance at December 31, 2016	**351.7**	**4,716**	**14,717**	**(1,552)**	**17,881**	**62**	**17,943**
Net income	**—**	**—**	**1,904**	**—**	**1,904**	**1**	**1,905**
Other increases in non-controlling interests	**—**	**—**	**—**	**—**	**—**	**194**	**194**
Other comprehensive income	**—**	**—**	**—**	**308**	**308**	**—**	**308**
Common shares issued for benefit plans, net of employee tax withholdings	**2.1**	**(10)**	**—**	**—**	**(10)**	**—**	**(10)**
Repurchases of common shares	**(27.0)**	**—**	**(3,845)**	**—**	**(3,845)**	**—**	**(3,845)**
Dividends declared	**—**	**—**	**(658)**	**—**	**(658)**	**—**	**(658)**
Balance at December 31, 2017	**326.8**	**$ 4,706**	**$ 12,118**	**$ (1,244)**	**$ 15,580**	**$ 257**	**$ 15,837**

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Statements of Cash Flows

(Millions)	For the Years Ended December 31, 2017	2016	2015
Cash flows from operating activities:			
Net income attributable to Aetna	**$ 1,904**	$ 2,271	$ 2,390
Adjustments to reconcile net income including non-controlling interests to net cash used for operating activities:			
Loss on early extinguishment of long-term debt	**246**	—	—
Equity earnings of affiliates, net [1]	**(3,413)**	(2,864)	(2,713)
Stock-based compensation expense	**187**	191	181
Net realized capital losses	**336**	6	—
Net change in other assets and other liabilities	**(72)**	328	(239)
Net cash used for operating activities	**(812)**	(68)	(381)
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	**4**	—	66
Dividends received from affiliates, net	**3,721**	2,742	1,733
Proceeds from sale of businesses, net of cash transferred	**67**	—	—
Net cash provided by investing activities	**3,792**	2,742	1,799
Cash flows from financing activities:			
Issuance of long-term debt	**988**	12,886	—
Repayment of long-term debt	**(12,351)**	—	—
Net repayment of short-term debt	**—**	—	(500)
Common shares issued under benefit plans, net	**(180)**	(139)	(143)
Stock-based compensation tax benefits	**—**	—	53
Common shares repurchased	**(3,845)**	—	(296)
Net payment on interest rate derivatives	**—**	(274)	(25)
Dividends paid to shareholders	**(583)**	(351)	(349)
Net cash (used for) provided by financing activities	**(15,971)**	12,122	(1,260)
Net (decrease) increase in cash and cash equivalents	**(12,991)**	14,796	158
Cash and cash equivalents, beginning of period	**14,972**	176	18
Cash and cash equivalents, end of period	**$ 1,981**	$ 14,972	$ 176
Supplemental cash flow information:			
Interest paid	**$ 409**	$ 485	$ 276
Income taxes refunded	**733**	252	282

(1) Includes after-tax amortization of other acquired intangible assets of $171 million, $161 million and $166 million for the years ended December 31, 2017, 2016 and 2015, respectively.

Refer to accompanying Notes to Financial Statements.

Aetna Inc. (Parent Company Only)
Notes to Financial Statements

1. Organization

The financial statements reflect financial information for Aetna Inc. (a Pennsylvania corporation) only (the "Parent Company"). The financial information presented herein includes the Balance Sheets of the Parent Company as of December 31, 2017 and 2016 and the related Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for the years ended December 31, 2017, 2016 and 2015. The accompanying financial statements should be read in conjunction with the consolidated financial statements and notes thereto in the Annual Report.

2. Summary of Significant Accounting Policies

Refer to Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for the summary of significant accounting policies.

3. Dividends

Gross cash dividends received from subsidiaries and included in net cash provided by investing activities in the Statements of Cash Flows were $4.3 billion, $2.9 billion and $2.2 billion in 2017, 2016 and 2015, respectively.

4. Acquisitions and Dispositions

Refer to Note 3 "Acquisition, Divestiture, Terminated Acquisition and Terminated Divestiture" included in Part II, Item 8 of this Annual Report on Form 10-K for a description of acquisitions and dispositions.

5. Other Comprehensive Income (Loss)

Refer to Note 14 "Other Comprehensive Income (Loss) " included in Part II, Item 8 of this Annual Report on Form 10-K for a description of accumulated other comprehensive income (loss).

6. Debt

Long-term debt on the Parent Company Only balance sheet excludes long-term debt of a subsidiary. That debt was acquired in the Parent Company's acquisition of Coventry Health Care, Inc. Refer to Note 9 "Debt" included in Part II, Item 8 of this Annual Report on Form 10-K for a description of the Parent Company's consolidated total debt.

7. Share Repurchases

Refer to Note 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K for a description of share repurchases.

INDEX TO EXHIBITS

*Exhibits**

Exhibits to this Form 10-K are as follows:

2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Master Transaction Agreement by and between Aetna Inc. and Hartford Life and Accident Insurance Company dated as of October 22, 2017, incorporated herein by reference to Exhibit 2.1 to Aetna Inc.'s Form 8-K filed on October 26, 2017.
2.2	Agreement and Plan of Merger among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. dated as of December 3, 2017, incorporated herein by reference to Exhibit 2.1 to Aetna Inc.'s Form 8-K filed on December 6, 2017.
3	**Articles of Incorporation and By-Laws**
3.1	Amended and Restated Articles of Incorporation of Aetna Inc., incorporated herein by reference to Exhibit 3.1 to Aetna Inc.'s Form 8-K filed on June 4, 2014.
3.2	Amended and Restated By-Laws of Aetna Inc., incorporated herein by reference to Exhibit 3.2 to Aetna Inc.'s Form 8-K filed on June 4, 2014.
4	**Instruments defining the rights of security holders, including indentures**
4.1	Form of Aetna Inc. Common Share certificate, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Amendment No. 2 to Registration Statement on Form 10 filed on December 1, 2000.
4.2	Senior Indenture dated as of March 2, 2001, between Aetna Inc. and U.S. Bank National Association, successor in interest to State Street Bank and Trust Company, incorporated herein by reference to Exhibit 4.2 to Aetna Inc.'s Registration Statement on Form S-3 filed on November 30, 2017.
4.3	Form of Subordinated Indenture between Aetna Inc. and U.S. Bank National Association, incorporated herein by reference to Exhibit 4.3 to Aetna Inc.'s Registration Statement on Form S-3 filed on November 30, 2017.
4.4	Supplemental Indenture dated as of May 20, 2011, between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 4.125% Senior Notes due June 1, 2021, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on May 20, 2011 (SEC file number 001-16095).
4.5	Supplemental Indenture dated as of May 4, 2012, between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 1.750% Senior Notes due May 15, 2017 and 4.500% Senior Notes due May 15, 2042, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on May 4, 2012 (SEC file number 001-16095).
4.6	Supplemental Indenture dated as of November 7, 2012, between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 1.500% Senior Notes due November 15, 2017, 2.750% Senior Notes due November 15, 2022 and 4.125% Senior Notes due November 15, 2042, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on November 7, 2012 (SEC file number 001-16095).
4.7	Supplemental Indenture dated as of March 7, 2014, between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 2.200% Senior Notes due March 15, 2019 and 4.750% Senior Notes due March 15, 2044, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on March 7, 2014.
4.8	Supplemental Indenture dated as of November 10, 2014, between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 3.500% Senior Notes due November 15, 2024, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on November 10, 2014.
4.9	Supplemental Indenture dated as of June 9, 2016, between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating the Aetna Inc.'s Floating Rate Senior Notes due December 8, 2017, 1.700% Senior Notes due June 7, 2018, 1.900% Senior Notes due June 7, 2019, 2.400% Senior Notes due June 15, 2021, 2.800% Senior Notes due June 15, 2023, 3.200% Senior Notes due June 15, 2026, 4.250% Senior Notes due June 15, 2036 and 4.375% Senior Notes due June 15, 2046, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on June 9, 2016.
4.10	Supplemental Indenture dated as of August 10, 2017, between Aetna Inc. and U.S. Bank National Association, as successor-in-interest to State Street Bank and Trust Company, as trustee, establishing and designating Aetna Inc.'s 3.875% Senior Notes due August 15, 2047, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.'s Form 8-K filed on August 10, 2017.
4.11	Indenture, dated as of March 20, 2007, between Coventry Health Care, Inc., as Issuer, and The Bank of New York, as Trustee (incorporated by reference to Exhibit 4.1 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on March 20, 2007 (SEC file number 001-16477)), incorporated herein by reference to Exhibit 4.4 to Aetna Inc.'s Form 10-Q filed July 30, 2013.
4.12	Second Supplemental Indenture, dated as of June 7, 2011, among Coventry Health Care, Inc. and Union Bank, National Association, as Trustee (incorporated by reference to Exhibit 4.3 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on June 7, 2011), incorporated herein by reference to Exhibit 4.10 to Aetna Inc.'s Form 10-Q filed July 30, 2013.

4.13	Officers' Certificate pursuant to the Indenture, dated as of June 7, 2011 (incorporated by reference to Exhibit 4.4 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on June 7, 2011), incorporated herein by reference to Exhibit 4.11 to Aetna Inc.'s Form 10-Q filed July 30, 2013.
4.14	Global Note for the 2021 Notes, dated June 7, 2011, of Coventry Health Care, Inc. (incorporated by reference to Exhibit 4.5 to Coventry Health Care, Inc.'s Current Report on Form 8-K filed on June 7, 2011), incorporated herein by reference to Exhibit 4.12 to Aetna Inc.'s Form 10-Q filed July 30, 2013.
10	**Material contracts**
10.1	$1,500,000,000 Five-Year Credit Agreement dated as of March 27, 2012, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on March 28, 2012 (SEC file number 001-16095).
10.2	First Amendment dated as of September 24, 2012, to the $1,500,000,000 Five Year Credit Agreement dated as of March 27, 2012, incorporated herein by reference to Exhibit 99.2 to Aetna Inc.'s Form 8-K filed on September 27, 2012 (SEC file number 001-16095).
10.3	Incremental Commitment Agreement dated as of September 24, 2012, incorporated herein by reference to Exhibit 99.3 to Aetna Inc.'s Form 8-K filed on September 27, 2012 (SEC file number 001-16095).
10.4	Extension of the Maturity Date of the Five-Year Credit Agreement dated March 27, 2012, as amended, incorporated herein by reference to Exhibits 99.1 to 99.22 to Aetna Inc.'s Form 8-K filed on March 27, 2013.
10.5	Extension of the Maturity Date of the Five-Year Credit Agreement dated March 27, 2012, as amended, incorporated herein by reference to Exhibits 99.1 through 99.22 to Aetna Inc.'s Form 8-K filed on March 28, 2014.
10.6	Maturity Data Extension Request, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on March 5, 2015.
10.7	Second Amendment dated as of March 2, 2015, to $1,500,000,000 Five-Year Credit Agreement dated as of March 27, 2012, incorporated herein by reference to Exhibit 99.2 to Aetna Inc.'s Form 8-K filed on March 5, 2015.
10.8	Notice of closing dated March 2, 2015, incorporated herein by reference to Exhibit 99.3 to Aetna Inc.'s Form 8-K filed on March 5, 2015.
10.9	Third Amendment dated as of July 30, 2015, to the Five-Year Credit Agreement dated as of March 27, 2012, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on July 31, 2015.
10.10	Notice of Effectiveness (Third Amendment), incorporated herein by reference to Exhibit 99.2 to Aetna Inc.'s Form 8-K filed on July 31, 2015.
10.11	Fourth Amendment dated as of March 17, 2017, to the Five-Year Credit Agreement dated as of March 27, 2012, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on March 21, 2017.
10.12	Notice of closing (Fourth Amendment) dated March 17, 2017, incorporated herein by reference to Exhibit 99.2 to Aetna Inc.'s Form 8-K filed on March 21, 2017.
10.13	Amended and Restated Aetna Inc. 2000 Stock Incentive Plan, incorporated herein by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-K filed on February 27, 2009 (SEC file number 001-16095). **
10.14	Form of Aetna Inc. 2000 Stock Incentive Plan - Stock Appreciation Right Terms of Award, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on October 26, 2006 (SEC file number 001-16095). **
10.15	Form of Aetna Inc. 2010 Stock Incentive Plan – Restricted Stock Unit Terms of Award (with non-compete provision), incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on April 28, 2011 (SEC file number 001-16095). **
10.16	Form of Aetna Inc. 2010 Stock Incentive Plan – Market Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on April 28, 2011 (SEC file number 001-16095). **
10.17	Form of Aetna Inc. 2010 Stock Incentive Plan – Performance Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on April 28, 2011 (SEC file number 001-16095). **
10.18	Form of Aetna Inc. 2010 Stock Incentive Plan – Performance Stock Unit Terms of Award (2015), incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on April 28, 2015. **
10.19	Form of Aetna Inc. 2010 Stock Incentive Plan – Executive Restricted Stock Unit Terms of Award (2015), incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on April 28, 2015. **
10.20	Form of Aetna Inc. 2010 Stock Incentive Plan – Restricted Stock Unit Terms of Award (2011, with retirement vesting), incorporated herein by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-Q filed on April 28, 2011 (SEC file number 001-16095). **
10.21	Form of Aetna Inc. 2010 Stock Incentive Plan – Restricted Stock Unit Terms of Award (2011, without retirement vesting), incorporated herein by reference to Exhibit 10.5 to Aetna Inc.'s Form 10-Q filed on April 28, 2011 (SEC file number 001-16095). **

10.22	Form of Aetna Inc. 2010 Stock Incentive Plan – Stock Appreciation Right Terms of Award (2015), incorporated herein by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-Q filed on April 28, 2015. **
10.23	Form of Aetna Inc. 2010 Stock Incentive Plan – Stock Appreciation Right Agreement, incorporated herein by reference to Exhibit 10.6 to Aetna Inc.'s Form 10-Q filed on April 28, 2011 (SEC file number 001-16095). **
10.24	Amended and Restated Aetna Inc. 2001 Annual Incentive Plan, incorporated herein by reference to Exhibit 10.5 to Aetna Inc.'s Form 10-Q filed on April 29, 2010 (SEC file number 001-16095). **
10.25	Aetna Inc. 2010 Non-Employee Director Compensation Plan, incorporated herein by reference to Annex C to Aetna Inc.'s definitive proxy statement on Schedule 14A filed on April 12, 2010 (SEC file number 001-16095). **
10.26	Aetna Inc. Non-Employee Director Compensation Plan as Amended through December 5, 2008, incorporated herein by reference to Exhibit 10.13 to Aetna Inc.'s Form 10-K filed on February 27, 2009 (SEC file number 001-16095). **
10.27	Form of Aetna Inc. Non-Employee Director Compensation Plan - Restricted Stock Unit Agreement, incorporated herein by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-Q filed on October 26, 2006 (SEC file number 001-16095). **
10.28	1999 Director Charitable Award Program, as Amended and Restated on January 25, 2008, incorporated herein by referenced to Exhibit 10.15 to Aetna Inc.'s Form 10-K filed on February 29, 2008 (SEC file number 001-16095). **
10.29	Aetna Inc. 2016 Employee Stock Purchase Plan, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on August 2, 2016. **
10.30	Amended Aetna Inc. 2010 Stock Incentive Plan, as amended May 19, 2017, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on August 3, 2017. **
10.31	Amended and Restated Employment Agreement dated October 19, 2010 between Aetna Inc. and Mark T. Bertolini, incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed November 3, 2010 (SEC file number 001-16095). **
10.32	Amendment No. 1, dated as of August 4, 2013, to Amended and Restated Employment Agreement dated October 19, 2010 between Aetna Inc. and Mark T. Bertolini, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 8-K filed on August 5, 2013. **
10.33	Letter agreement dated March 23, 2011, between Aetna Life Insurance Company and Shawn M. Guertin, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on April 30, 2013. **
10.34	Letter agreement dated September 17, 2015, between Aetna Inc. and Gary W. Loveman, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed April 28, 2016. **
10.35	Letter agreement dated May 18, 2012, between Aetna Life Insurance Company and Karen S. Rohan (Lynch), incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on April 30, 2013. **
10.36	Employment Agreement dated December 10, 2014, between Aetna Inc. and Karen S. Rohan (Lynch), incorporated herein by reference to Exhibit 10.29 to Aetna Inc.'s Form 10-K filed on February 27, 2015. **
10.37	Letter agreement dated December 17, 2012, between Aetna Life Insurance Company and Francis S. Soistman, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on April 28, 2015. **
10.38	Letter agreement dated March 31, 2016, between Aetna Inc. and Thomas J. Sabatino, Jr., incorporated by reference herein to Exhibit 10.5 to Aetna Inc.'s Form 10-Q filed on May 2, 2017. **
10.39	Letter agreement dated December 22, 2017, between Aetna Inc. and Gary W. Loveman. **
10.40	Letter agreement dated December 22, 2017, between Aetna Inc. and Richard M. Jelinek. **
10.41	Letter agreement dated December 22, 2017, between Aetna Inc. and Thomas J. Sabatino, Jr. **
10.42	Form of Non-Competition, Non-Solicitation, Confidentiality and Assignment Agreement, incorporated herein by reference to Exhibit 10.32 to Aetna Inc.'s Form 10-K filed on February 27, 2015. **
10.43	Separation Agreement dated February 13, 2018, between Aetna Inc. and Gary W. Loveman, Ph. D, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 8-K filed on February 20, 2018. **
10.44	Descriptions of certain arrangements not embodied in formal documents as described under the headings "2017 Nonmanagement Director Compensation" and "Additional Director Compensation Information" are incorporated herein by reference to the Proxy Statement (when filed). **

11	**Statement re: computation of per share earnings**
11.1	"Computation of per share earnings" is incorporated herein by reference to Note 15 of Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.
12	**Statement re: computation of ratios**
12.1	Computation of ratio of earnings to fixed charges.
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of Aetna Inc.
23	**Consents of experts and counsel**
23.1	Consent of Independent Registered Public Accounting Firm.
24	**Power of Attorney**
24.1	Power of Attorney.
31	**Rule 13a - 14(a)/15d - 14(e) Certifications**
31.1	Certification.
31.2	Certification.
32	**Section 1350 Certifications**
32.1	Certification.
32.2	Certification.
99	**Additional Exhibits**
99.1	Risk Factors of CVS Health Corporation
101	**XBRL Documents**
101.INS	XBRL Instance Document.
101.SCH	XBRL Taxonomy Extension Schema.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase.
101.DEF	XBRL Taxonomy Extension Definition Linkbase.
101.LAB	XBRL Taxonomy Extension Label Linkbase.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase.

* Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Copies of exhibits, including exhibits that are not required to be listed, will be furnished without charge upon written request to the Office of the Corporate Secretary, Aetna Inc., 151 Farmington Avenue, Hartford, Connecticut 06156.

** Management contract or compensatory plan or arrangement.

Item 16. Form 10-K Summary

None.

Signatures

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: February 23, 2018

Aetna Inc.

By: /s/ Heather Dixon
Heather Dixon
Vice President, Controller and Chief Accounting Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signer	Title	Date
/s/ Mark T. Bertolini Mark T. Bertolini	Chairman and Chief Executive Officer and Director (Principal Executive Officer)	February 23, 2018
/s/ Shawn M. Guertin Shawn M. Guertin	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 23, 2018
/s/ Heather Dixon Heather Dixon	Vice President, Controller and Chief Accounting Officer (Principal Accounting Officer)	February 23, 2018
Fernando Aguirre *	Director	
Frank M. Clark *	Director	
Betsy Z. Cohen *	Director	
Molly J. Coye, M.D. *	Director	
Roger N. Farah *	Director	
Jeffrey E. Garten *	Director	
Ellen M. Hancock *	Director	
Richard J. Harrington *	Director	
Edward J. Ludwig *	Director	
Joseph P. Newhouse *	Director	
Olympia J. Snowe *	Director	

* By: /s/ Heather Dixon
Heather Dixon
Attorney-in-fact
February 23, 2018

Exhibit 10.39

[Aetna Logo]

Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156

Thomas W. Weidenkopf
Executive Vice President and Chief
Human Resources Officer
Phone: 212-457-0752

December 22, 2017

Gary W. Loveman
Executive Vice President, Consumer Health and Services
93 Worcester Street
Wellesley, MA 02481

Dear Gary,

In connection with the transactions contemplated by the Agreement and Plan of Merger dated as of December 3, 2017 among CVS Health Corporation, Hudson Merger Sub. Corp. and Aetna Inc., and in order to mitigate the potential adverse tax consequences to you under Section 280G and 4999 of the Internal Revenue Code arising from compensation that may become payable to you in connection with a termination of employment, we have agreed as follows:

- The 2015 Performance Stock Unit Awards otherwise scheduled to vest on October 26, 2018, shall automatically, without further action of the Company or its Committee on Compensation and Talent Management, be fully vested (at 120% of the target number granted), accelerated and paid to you in Company shares (net of applicable taxes) on December 27, 2017.

- The Restricted Stock Units otherwise scheduled to vest on October 26, 2018, shall automatically, without further action of the Company or its Committee on Compensation and Talent Management, be fully vested, accelerated and paid to you in Company shares (net of applicable taxes) on December 27, 2017.

We have agreed that the shares paid to you pursuant to this agreement are transferable on December 29, 2017 upon delivery to your UBS account (subject to normal Company preclearance procedures). We have also agreed that, if prior to October 26, 2018, the original vesting date of your 2015 Performance Stock Unit Award and Restricted Stock Units, your employment is terminated for cause (as defined in your Employment Agreement dated September 17, 2015) or you voluntarily terminate your employment prior to such date, then promptly following such termination of employment, you will surrender to the Company the net after-tax shares issued to you pursuant to this agreement that would not have vested other than because of the acceleration provided to you pursuant to this agreement (or, if applicable, you will repay to the Company the net after-tax amount of cash received by you on any sale of such shares).

AETNA INC.

/s/ Thomas W. Weidenkopf

By: Thomas J. Weidenkopf

Dated: 12/27/17

AGREED AND ACCEPTED

/s/ Gary W. Loveman

Gary W. Loveman

Dated: 12-22-17

Exhibit 10.40

[Aetna Logo]

Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156

Thomas W. Weidenkopf
Executive Vice President and Chief
Human Resources Officer
Phone: 212-457-0752

December 22, 2017

Richard M. Jelinek
Executive Vice President, Enterprise Strategy
100 Park Avenue, 12th Floor
New York, NY 10017

Dear Rick,

In connection with the transactions contemplated by the Agreement and Plan of Merger dated as of December 3, 2017 among CVS Health Corporation, Hudson Merger Sub. Corp. and Aetna Inc., and in order to mitigate the potential adverse tax consequences to you under Section 280G and 4999 of the Internal Revenue Code arising from compensation that may become payable to you in connection with a termination of employment, we have agreed as follows:

- The 2015 Performance Stock Unit Awards otherwise scheduled to vest on November 2, 2018, shall automatically, without further action of the Company or its Committee on Compensation and Talent Management, be fully vested (at 120% of the target number granted), accelerated and paid to you in Company shares (net of applicable taxes) on December 27, 2017.

- The Restricted Stock Units otherwise scheduled to vest on November 2, 2018, shall automatically, without further action of the Company or its Committee on Compensation and Talent Management, be fully vested, accelerated and paid to you in Company shares (net of applicable taxes) on December 27, 2017.

We have agreed that the shares paid to you pursuant to this agreement are transferable on December 29, 2017 upon delivery to your UBS account (subject to normal Company preclearance procedures). We have also agreed that, if prior to November 2, 2018, the original vesting date of your 2015 Performance Stock Unit Award and Restricted Stock Units, your employment is terminated for cause or you voluntarily terminate your employment prior to such date, then promptly following such termination of employment, you will surrender to the Company the net after-tax shares issued to you pursuant to this agreement that would not have vested other than because of the acceleration provided to you pursuant to this agreement (or, if applicable, you will repay to the Company the net after-tax amount of cash received by you on any sale of such shares).

AETNA INC.

AGREED AND ACCEPTED

	/s/ Thomas W. Weidenkopf	/s/ Rick Jelinek	
By:	Thomas J. Weidenkopf	Rick Jelinek	
Dated:	12/27/17	Dated:	12/22/17

Exhibit 10.41

[Aetna Logo]

Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156

Thomas W. Weidenkopf
Executive Vice President and Chief
Human Resources Officer
Phone: 212-457-0752

December 22, 2017

Thomas J. Sabatino, Jr.
Executive Vice President and General Counsel
100 Park Avenue, 12th Floor
New York, NY 10017

Dear Tom,

In connection with the transactions contemplated by the Agreement and Plan of Merger dated as of December 3, 2017 among CVS Health Corporation, Hudson Merger Sub. Corp. and Aetna Inc., and in order to mitigate the potential adverse tax consequences to you under Section 280G and 4999 of the Internal Revenue Code arising from compensation that may become payable to you in connection with a termination of employment, we have agreed that the Restricted Stock Units previously awarded to you and otherwise scheduled to vest on May 10, 2018, shall automatically, without further action of the Company or its Committee on Compensation and Talent Management, be fully vested, accelerated and paid to you in Company shares (net of applicable taxes) on December 27, 2017.

We have agreed that the shares paid to you pursuant to this agreement are transferable on December 29, 2017 upon delivery to your UBS account (subject to normal Company preclearance procedures). We have also agreed that, if prior to May 10, 2018 (the original vesting date of the Restricted Stock Units), your employment is terminated for cause (as defined in your Employment Agreement dated March 31, 2016) or you voluntarily terminate your employment prior to such date, then promptly following such termination of employment, you will surrender to the Company the net after-tax shares issued to you pursuant to this agreement that would not have vested other than because of the acceleration provided to you pursuant to this agreement (or, if applicable, you will repay to the Company the net after-tax amount of cash received by you on any sale of such shares).

AETNA INC.	AGREED AND ACCEPTED
/s/ Thomas W. Weidenkopf	/s/ Thomas J. Sabatino, Jr.
By: Thomas J. Weidenkopf	Thomas J. Sabatino, Jr.
Dated: 12/27/17	Dated: 12-22-17

Exhibit 12.1

Statement re: Computation of Ratios

The computation of the ratio of earnings to fixed charges for the years ended December 31, 2013 through 2017 are as follows:

	Years Ended December 31,				
(Millions)	**2017**	**2016**	**2015**	**2014**	**2013**
Income from continuing operations before income taxes	**$ 2,991**	**$ 3,991**	$ 4,234	$ 3,497	$ 2,937
Add back fixed charges	**498**	**663**	426	396	396
Income as adjusted ("earnings")	**$ 3,489**	**$ 4,654**	$ 4,660	$ 3,893	$ 3,333
Fixed charges:					
Interest expense	**$ 442**	**$ 604**	$ 369	$ 334	$ 336
Portion of rents representative of interest factor	**56**	**59**	57	62	60
Total fixed charges	**$ 498**	**$ 663**	$ 426	$ 396	$ 396
Ratio of earnings to fixed charges	**7.01**	**7.02**	10.94	9.83	8.42

Exhibit 21.1

Subsidiaries of Aetna Inc.

Listed below are subsidiaries of Aetna Inc. at December 31, 2017 with their jurisdictions of organization shown in parentheses. Subsidiaries excluded from the list below would not, in the aggregate, constitute a "significant subsidiary" of Aetna Inc., as that term is defined in Rule 1-02(w) of Regulation S-X.

- Aetna Health Holdings, LLC (Delaware)
  - Aetna Health of California Inc. (California)
  - Aetna Health Inc. (Connecticut)
  - Aetna Health Inc. (Florida)
  - Aetna Health Inc. (Georgia)
  - Aetna Health Inc. (Maine)
  - Aetna Health Inc. (Michigan)
  - Aetna Health Inc. (New Jersey)
  - Aetna Health Inc. (New York)
    - Aetna Better Health Inc. (New York)
  - Aetna Health Inc. (Pennsylvania)
  - Aetna Health Inc. (Texas)
  - Aetna Better Health of California Inc. (California)
  - Aetna Better Health of Iowa Inc. (Iowa)
  - Aetna Better Health of Texas Inc. (Texas)
  - Aetna Better Health Inc. (Georgia)
  - Aetna HealthAssurance Pennsylvania, Inc. (Pennsylvania)
  - Aetna Dental of California Inc. (California)
  - Aetna Dental Inc. (New Jersey)
  - Aetna Dental Inc. (Texas)
  - Aetna Rx Home Delivery, LLC (Delaware)
  - Aetna Health Management, LLC (Delaware)
  - Aetna Ireland Inc. (Delaware)
  - Aetna Specialty Pharmacy, LLC (Delaware)
  - Cofinity, Inc. (Delaware)
  - @Credentials Inc. (Delaware)
  - Strategic Resource Company (South Carolina)
  - Aetna Better Health Inc. (Pennsylvania)
  - Aetna Better Health Inc. (Connecticut)
  - Aetna Better Health Inc. (Illinois)
  - Aetna Better Health of Kansas Inc. (Kansas)
  - Aetna Better Health, Inc. (Louisiana)
  - Aetna Florida Inc. (Florida)
  - Aetna Better Health Inc. (Ohio)
  - Aetna Better Health of Oklahoma Inc. (Oklahoma)
  - Aetna Better Health of Nevada Inc. (Nevada)
  - Aetna Better Health Inc. (New Jersey)
  - Aetna Better Health of Washington Inc. (Washington)
  - Aetna Better Health of North Carolina Inc. (North Carolina)
  - Aetna Network Services LLC (Connecticut)
  - Aetna Risk Assurance Company of Connecticut Inc. (Connecticut)
  - Aetna Student Health Agency Inc. (Massachusetts)
  - Delaware Physicians Care, Incorporated (Delaware)
  - Schaller Anderson Medical Administrators, Incorporated (Delaware)
  - Aetna Medicaid Administrators LLC (Arizona)
  - iTriage, LLC (Delaware)
  - bswift LLC (Illinois)
    - Corporate Benefit Strategies, Inc. (Delaware)
  - Prodigy Health Group, Inc. (Delaware)
    - Niagara Re, Inc. (New York)
    - Performax, Inc. (Delaware)

        - Scrip World, LLC (Utah)
        - Precision Benefit Services, Inc. (Delaware)
        - American Health Holding, Inc. (Ohio)
        - Meritain Health, Inc. (New York)
            - Administrative Enterprises, Inc. (Arizona)
            - U.S Healthcare Holdings, LLC (Ohio)
            - Prime Net, Inc. (Ohio)
            - Professional Risk Management, Inc. (Ohio)
    - ADMINCO, Inc. (Arizona)
    - Coventry Transplant Network, Inc. (Delaware)
    - Aetna Health of Iowa Inc. (Iowa)
    - Coventry Health Care of Nebraska, Inc. (Nebraska)
    - Aetna Health Inc. (Louisiana)
    - HealthAssuance Pennsylvania, Inc. (Pennsylvania)
    - Coventry Prescription Management Services Inc. (Nevada)
    - Coventry Health and Life Insurance Company (Missouri)
        - Aetna Better Health of Kentucky Insurance Company (Kentucky)
    - Coventry Health Care of Virginia, Inc. (Virginia)
    - Coventry Health Care of Missouri, Inc. (Missouri)
    - Aetna Better Health of Missouri LLC (Missouri)
    - Coventry Health Care of Illinois, Inc. (Illinois)
    - Coventry Health Care of West Virginia, Inc. (West Virginia)
    - Coventry HealthCare Management Corporation (Delaware)
    - Coventry Health Care of Kansas, Inc. (Kansas)
    - Coventry Health Care National Accounts, Inc. (Delaware)
    - Aetna Better Health of Michigan Inc. (Michigan)
    - Aetna Health of Utah Inc. (Utah)
    - Aetna Better Health Inc. (Tennessee)
    - Coventry Health Care National Network, Inc. (Delaware)
    - Coventry Consumer Advantage, Inc. (Delaware)
    - MHNet Specialty Services, LLC (Maryland)
        - Mental Health Network of New York IPA, Inc. (New York)
        - Mental Health Associates, Inc. (Louisiana)
        - MHNet of Florida, Inc. (Florida)
        - MHNet Life and Health Insurance Company (Texas)
    - Group Dental Service, Inc. (Maryland)
        - Group Dental Service of Maryland, Inc. (Maryland)
    - Florida Health Plan Administrators, LLC (Florida)
        - Coventry Health Care of Florida, Inc. (Florida)
        - Carefree Insurance Services, Inc. (Florida)
        - Coventry Health Plan of Florida, Inc. (Florida)
    - First Health Group Corp. (Delaware)
        - First Health Life & Health Insurance Company (Texas)
        - Claims Administration Corp. (Maryland)
    - Coventry Health Care Workers' Compensation, Inc. (Delaware)
        - Coventry Rehabilitation Services, Inc. (Delaware)
        - First Script Network Services, Inc. (Nevada)
        - FOCUS HealthCare Management, Inc. (Tennessee)
        - Medical Examinations of New York, P.C. (New York)
        - MetraComp, Inc. (Connecticut)
    - Aetna Pharmacy Management Services LLC (Delaware)
- Continental Life Insurance Company of Brentwood, Tennessee (Tennessee)
    - American Continental Insurance Company (Tennessee)
- Aetna Life Insurance Company (Connecticut)
    - AHP Holdings, Inc. (Connecticut)
        - Aetna Insurance Company of Connecticut (Connecticut)
        - AE Fourteen, Incorporated (Connecticut)
        - Aetna Life Assignment Company (Connecticut)
    - Aetna ACO Holdings Inc. (Delaware)

        - Innovation Health Holdings, LLC (Delaware)
            - Innovation Health Insurance Company (Virginia)
                - Innovation Health Plan, Inc. (Virginia)
        - Banner Health and Aetna Health Insurance Holding Company LLC (Delaware)
            - Banner Health and Aetna Health Insurance Company (Arizona)
                - Banner Health and Aetna Health Plan Inc. (Arizona)
        - Allina Health and Aetna Insurance Holding Company LLC (Delaware)
            - Allina Health and Aetna Insurance Company (Minnesota)
        - Sutter Health and Aetna Insurance Holding Company LLC (Delaware)
            - Sutter Health and Aetna Administrative Services LLC (Delaware)
            - Sutter Health and Aetna Insurance Company (California)
        - Texas Health + Aetna Health Insurance Holding Company LLC (Texas)
            - Texas Health + Aetna Health Insurance Company (Texas)
                - Texas Health + Aetna Health Plan Inc. (Texas)
    - PE Holdings, LLC (Connecticut)
    - Aetna Resources LLC (Delaware)
    - Canal Place, LLC (Delaware)
    - Aetna Ventures, LLC (Delaware)
    - Broadspire National Services, Inc. (Florida)
    - Aetna Multi-Strategy 1099 Fund (Delaware)
- Phoenix Data Solutions LLC (Delaware)
- Aetna Financial Holdings, LLC (Delaware)
    - Aetna Asset Advisors, LLC (Delaware)
    - U.S. Healthcare Properties, Inc. (Pennsylvania)
    - Aetna Capital Management, LLC (Delaware)
        - Aetna Partners Diversified Fund, LLC (Delaware)
        - Aetna Partners Diversified Fund (Cayman), Limited (Cayman)
    - Aetna Workers' Comp Access, LLC (Delaware)
    - Aetna Behavioral Health, LLC (Delaware)
    - Managed Care Coordinators, Inc. (Delaware)
    - Horizon Behavioral Services, LLC (Delaware)
        - Employee Assistance Services, LLC (Kentucky)
        - Health and Human Resource Center, Inc. (California)
        - Resources for Living, LLC (Texas)
        - The Vasquez Group Inc. (Illinois)
        - Work and Family Benefits, Inc. (New Jersey)
    - Aetna Card Solutions, LLC (Connecticut)
    - PayFlex Holdings, Inc. (Delaware)
        - PayFlex Systems USA, Inc. (Nebraska)
- Aetna Health and Life lnsurance Company (Connecticut)
- Aetna Health Insurance Company (Pennsylvania)
- Aetna Health Insurance Company of New York (New York)
- Aetna International Inc. (Connecticut)
    - Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
    - Aetna Global Benefits (Bahamas) Limited (Bahamas)
    - Aetna Global Holdings Limited (England & Wales)
        - Healthagen International Limited (England & Wales)
        - Aetna Korea Ltd. (South Korea)
        - Health Care Management Co. Ltd.
        - Minor Health Entreprise Co, Ltd.
        - Bupa Health Insurance (Thailand) Public Company Limited
    - Aetna Global Benefits (Bermuda) Limited (Bermuda)
        - Goodhealth Worldwide (Global) Limited (Bermuda)
        - Aetna Global Benefits (Europe) Limited (England & Wales)
        - Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)
        - Goodhealth Worldwide (Asia) Limited (Hong Kong)
        - Aetna Global Benefits Limited (DIFC, UAE)
        - PT Aetna Global Benefits Indonesia (Indonesia)
        - Spinnaker Topco Limited (Bermuda)

- Spinnaker Bidco Limited (England and Wales)
    - Aetna Holdco (UK) Limited (England and Wales)
        - Aetna Global Benefits (UK) Limited (England and Wales)
        - Aetna Insurance Company Limited (England and Wales)
  - Aetna Insurance (Singapore) Pte. Ltd. (Singapore)
  - Aetna Health Insurance Company of Europe DAC (Ireland)
  - Aetna (Shanghai) Enterprise Services Co. Ltd. (China)
    - Aetna (Beijing) Enterprise Management Services Co., Ltd. (China)
  - Aetna Global Benefits (Singapore) PTE. LTD. (Singapore)
    - Indian Health Organisation Private Limited (India)
  - PT Asuransi Aetna Asia (Indonesia)
- AUSHC Holdings, Inc. (Connecticut)
  - PHPSNE Parent Corporation (Delaware)
- Active Health Management, Inc. (Delaware)
  - Health Data & Management Solutions, Inc. (Delaware)
    - Futrix Limited (New Zealand)
  - Aetna Integrated Informatics, Inc. (Pennsylvania)
- Health Re, Inc. (Vermont)
- ASI Wings, LLC (Delaware)
- Healthagen LLC
- Aetna Corporate Services LLC (Delaware)
- Echo Merger Sub, Inc. (Delaware)
- Medicity LLC (Delaware)
  - Novo Innovations, LLC (Delaware)
  - Allviant Corporation (Delaware)

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

The Board of Directors

Aetna Inc:

We consent to the incorporation by reference in the registration statement (No. 333-221818) on Form S-3, and the registration statements (Nos. 333-52120, 52122, 52124, 73052, 87722, 87726, 124619, 124620, 136176, 136177, 168497, 168498, 176009, 176011, 188792, 188814, 190272, 197707, 212841 and 219668 on Form S-8 of Aetna Inc. of our report dated February 23, 2018 with respect to the consolidated balance sheets of Aetna Inc. and subsidiaries as of December 31, 2017 and 2016, and the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the years in the three-year period ended December 31, 2017, and the related notes and the accompanying financial statement schedule I, and the effectiveness of internal control over financial reporting as of December 31, 2017, which report appears in the December 31, 2017 Annual Report on Form 10-K of Aetna Inc.

/s/ KPMG LLP

Hartford, Connecticut
February 23, 2018

Exhibit 24.1

Power of Attorney

We, the undersigned Directors of Aetna Inc. (the "Company"), hereby severally constitute and appoint Shawn M. Guertin, Heather Dixon and William C. Baskin III, and each of them individually, our true and lawful attorneys-in-fact, with full power to them and each of them to sign for us, and in our names and in the capacities indicated below, the Company's 2017 Annual Report on Form 10-K and any and all amendments thereto to be filed with the Securities and Exchange Commission under the Securities Exchange Act of 1934, hereby ratifying and confirming our signatures as they may be signed by any of our said attorneys to such Form 10-K and to any and all amendments thereto.

Dated: February 23, 2018

/s/ Fernando Aguirre
Fernando Aguirre, Director

/s/ Ellen M. Hancock
Ellen M. Hancock, Director

/s/ Frank M. Clark
Frank M. Clark, Director

/s/ Richard J. Harrington
Richard J. Harrington, Director

/s/ Betsy Z. Cohen
Betsy Z. Cohen, Director

/s/ Edward J. Ludwig
Edward J. Ludwig, Director

/s/ Molly J. Coye, M.D.
Molly J. Coye, M.D., Director

/s/ Joseph P. Newhouse
Joseph P. Newhouse, Director

/s/ Roger N. Farah
Roger N. Farah, Director

/s/ Olympia J. Snowe
Olympia J. Snowe, Director

/s/ Jeffrey E. Garten
Jeffrey E. Garten, Director

Exhibit 31.1

Certification

I, Mark T. Bertolini, certify that:

1. I have reviewed this annual report on Form 10-K of Aetna Inc.;

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

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

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

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

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

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

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

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

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

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

Date: February 23, 2018

/s/ Mark T. Bertolini

Mark T. Bertolini

Chairman and Chief Executive Officer

Exhibit 31.2

Certification

I, Shawn M. Guertin, certify that:

1. I have reviewed this annual report on Form 10-K of Aetna Inc.;

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

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

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

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

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

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

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

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

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

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

Date: February 23, 2018

/s/ Shawn M. Guertin

Shawn M. Guertin

Executive Vice President and Chief Financial Officer

Exhibit 32.1

Certification

The certification set forth below is being submitted to the Securities and Exchange Commission in connection with the Annual Report on Form 10-K of Aetna Inc. for the period ended December 31, 2017 (the "Report") solely for the purpose of complying with Rule 13a-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

Mark T. Bertolini, Chairman and Chief Executive Officer of Aetna Inc., certifies that, to the best of his knowledge:

1. the Report fully complies with the requirements of Section 13(a) of the Exchange Act; and

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Aetna Inc.

Date: February 23, 2018

/s/ Mark T. Bertolini

Mark T. Bertolini

Chairman and Chief Executive Officer

Exhibit 32.2

Certification

The certification set forth below is being submitted to the Securities and Exchange Commission in connection with the Annual Report on Form 10-K of Aetna Inc. for the period ended December 31, 2017 (the "Report") solely for the purpose of complying with Rule 13a-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

Shawn M. Guertin, Executive Vice President and Chief Financial Officer of Aetna Inc., certifies that, to the best of his knowledge:

1. the Report fully complies with the requirements of Section 13(a) of the Exchange Act; and

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Aetna Inc.

Date: February 23, 2018

/s/ Shawn M. Guertin

Shawn M. Guertin
Executive Vice President and Chief Financial Officer

Exhibit 99.1

The following sets forth the risk factors of CVS Health Corporation ("CVS Health") and its subsidiaries described in Part I, Item 1A of CVS Health's Annual Report on Form 10-K for the year ended December 31, 2017, filed with the Securities and Exchange Commission (the "SEC") on February 14, 2018, which is incorporated by reference in Aetna Inc.'s Annual Report on Form 10-K for the year ended December 31, 2017.

In this Exhibit 99.1, "we", "our", "us", and "the Company" refer to CVS Health and its subsidiaries.

Part I, Item 1A of CVS Health's Annual Report on Form 10-K for the year ended December 31, 2017, filed with the SEC on February 14, 2018

Item 1A. Risk Factors

Our business is subject to various industry, economic, regulatory and other risks and uncertainties. Our business, financial condition, results of operations, cash flows and prospects could be materially adversely affected by any one or more of the following risk factors and by additional risks and uncertainties not presently known to us or that we currently deem to be immaterial:

Risks of declining gross margins in the PBM, retail pharmacy and LTC pharmacy industries.

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, enhanced service offerings and/or higher service levels. In that regard, we maintain contractual relationships with generic pharmaceutical manufacturers and brand name pharmaceutical manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more pharmaceutical manufacturers, or if the discounts or rebates provided by pharmaceutical manufacturers decline, our business and financial results could be adversely affected. Further, competitive pressures in the PBM industry have resulted in our clients sharing in a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. Market dynamics and regulatory changes have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could negatively impact our future profitability. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to patent term extensions, purchase discount and rebate arrangements with pharmaceutical manufacturers, or to formulary management or other PBM services could also reduce the discounts or rebates we receive. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, could adversely impact our profitability.

Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have also been affected by the margin pressures described above, including client demands for lower prices, generic pricing and network reimbursement pressure. In addition, as competition increases in the markets in which we operate, a significant increase in general pricing pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive. A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates could adversely affect our margins, including the shift in pharmacy mix towards 90-day prescriptions at retail and the shift in pharmacy mix towards Medicare Part D prescriptions. Finally, the margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements. These actions could also adversely affect the margins of our LTC business.

Efforts to reduce reimbursement levels and alter health care financing practices.

The continued efforts of health maintenance organizations, managed care organizations, PBMs, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, as well as litigation and other legal proceedings relating to how drugs are priced, may impact our profitability. In particular, increased utilization of generic pharmaceuticals (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail, specialty, LTC and mail order pharmacies for generic drugs, causing a reduction in the generic profit rate. Historically, the effect of this trend on generic profitability has been mitigated by our efforts to negotiate reduced acquisition costs of generic pharmaceuticals with manufacturers. However, in recent years, there has been significant

consolidation within the generic manufacturing industry, and it is possible that this and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic pharmaceuticals and diminish our ability to negotiate reduced acquisition costs. Any inability to offset increased costs or to modify our activities to lessen the impact could have a significant adverse effect on our results of operations.

In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and audits at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are continuing at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices. For example, we anticipate that federal and state governments will continue to review and assess alternative health care delivery systems, payment methodologies and operational requirements for health care providers, including LTC facilities and pharmacies. A change in the composition of pharmacy prescription volume toward programs offering lower reimbursement rates could negatively impact our profitability. Any action taken to repeal or replace all or significant parts of ACA could also impact our profitability, though it is unclear at this time what the full effects will be.

ACA made several significant changes to Medicaid rebates and to reimbursement. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for multi-source (i.e., generic) drugs. This change has negatively affected our reimbursement. In addition, ACA made other changes that affect the coverage and plan designs that are or will be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum medical loss ratio to avoid having to pay rebates to enrollees. These ACA changes may not affect our business directly, but they could indirectly impact our services and/or business practices.

A highly competitive business environment.

Each of our retail pharmacy, LTC pharmacy, retail health clinic and pharmacy services operations currently operates in a highly competitive and evolving health care environment.

The competitive success of our retail pharmacy business, as well as our specialty pharmacy operations with non-Caremark payors, is derived by their ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. As a pharmacy retail business, we compete with other drugstore chains, supermarkets, on-line and other discount retailers, independent pharmacies, membership clubs, convenience stores and mass merchants, some of which are aggressively expanding into markets we serve. We also face competition from other retail health clinics, as well as other mail order pharmacies and PBMs. Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such changes and make timely and effective changes to our strategies and business model to compete effectively. Competition may also come from other sources in the future. Changes in market dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and the exclusion from new narrow or restricted networks, could materially and adversely impact us.

We could also be adversely affected if we fail to identify or effectively respond to changes in market dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the United States, a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy operations focuses on complex and high-cost medications that serve a relatively limited universe of patients, the future growth of this business depends to a significant extent upon expanding our ability to access key drugs and successfully penetrate key treatment categories.

The competitive success of our LTC pharmacy operations is dependent upon our ability to compete in each geographic region where we have operations. In the geographic regions we serve, we compete with PharMerica, our largest competitor, as well as with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Our long-term care customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. We believe that the assisted living segment, where residents can choose which pharmacy will provide them with pharmaceuticals, is projected to grow the most as a percentage of the total LTC sector over the near term. The ability of a resident of an assisted living facility to select the pharmacy that supplies him or her with pharmaceuticals could adversely affect our business, financial condition and results of operations because there can be no assurance that such resident will select us.

The competitive success of our pharmacy services business is impacted by its ability to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or

restricted retail pharmacy networks. Competitors in the PBM industry (e.g., Express Scripts, OptumRx, Prime Therapeutics, MedImpact and Humana), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Competition may also come from other sources in the future. In addition, changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could adversely affect our claims volume and/or our competitiveness generally.

Competitors in each of our business areas may offer services and pricing terms that we may not be willing or able to offer. Strong competition in the PBM marketplace has generated greater client demand for lower pricing, increased revenue sharing and enhanced product and service offerings. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings, particularly in a rapidly changing health care industry, we may be unable to remain competitive.

Changes in U.S. policy, laws and regulations, including reform of the United States health care system.

The results of the November 2016 elections continue to generate some uncertainty with respect to, and could result in, significant changes in legislation, regulation and government policy that could significantly impact our business and the health care and retail industries. While it is not possible to predict whether and when any such changes will occur or what form any such changes may take (including through the use of Executive Orders), specific proposals discussed by the Presidential Administration could have a material adverse effect on our business, liquidity and results of operations include, but are not limited to, immigration policies, the modification of ACA. Other significant changes to health care system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries are also possible.

Potential modification to ACA, significant changes to Medicaid funding or even significant destabilization of the Health Insurance Marketplaces could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to ACA are possible and we cannot predict the effect, if any, on future changes to ACA, the implementation or failure to implement the outstanding provisions of ACA, or the enactment of new health care system legislation to replace current legislation may have on our retail pharmacy, LTC pharmacy, specialty pharmacy and pharmacy services operations.

In addition, much of the branded and generic drug product that we sell in our retail, mail and specialty pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material impact on our business, liquidity and results of operations. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our business.

Risks related to compliance with a broad and complex regulatory framework.

Our business is subject to numerous federal, state and local laws and regulations. See “Business - Government Regulation.” In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and enforcement activity at both the federal and state levels. Further, uncertainties exist regarding the application of many of these legal requirements to our business. In addition, it is possible that certain provisions of the current health care reform legislation may be modified, repealed or otherwise invalidated. Changes in these laws and regulations and the related interpretations and enforcement practices may require extensive system and operating changes that may be difficult to implement. Untimely compliance or noncompliance with applicable laws and regulations could adversely affect the continued operation of our business, including, but not limited to: imposition of civil or criminal penalties; significant fines or monetary penalties; suspension or disgorgement of payments from government programs; loss of required government certifications or approvals; loss of authorizations to participate in or exclusion from government reimbursement programs, such as the Medicare and Medicaid programs; or loss of registrations or licensure. The regulations to which we are subject include, but are not limited to: the laws and regulations described in the Government Regulation section; accounting standards; financial disclosure; securities laws and regulations; federal anti-trust laws; tax laws and regulations and their possible reform; laws and regulations relating to the protection of the environment and health and safety matters, including those governing exposure to, and the management and disposal of, hazardous materials and wastes; and laws and regulations of the FTC, the FCC, and the Consumer Product Safety Commission, as well as state regulatory authorities, governing the sale, advertisement and promotion of products that we sell, such as Boards of Pharmacy. The FDA, DEA and various states regulate the distribution of pharmaceuticals and controlled substances. We are required to hold valid DEA and state-level registrations and licenses, meet various security and operating standards and comply with the federal and various states’ controlled substances acts and their

accompanying regulations governing the sale, marketing, packaging, holding and distribution of controlled substances. The DEA, FDA and state regulatory authorities have broad enforcement powers, including the ability to suspend our registrations and licenses, seize or recall products and impose significant criminal, civil and administrative sanctions for violations of these laws and regulations. In addition, our business interests outside of the United States are subject to the Foreign Corrupt Practices Act and other applicable domestic and international laws and regulations. We are also subject to the terms of various government agreements and mandates, including those described in the Government Regulation section. In that regard, our business, financial position and results of operations could be adversely affected by existing and new government legislative, regulatory action and enforcement activity, including, without limitation, any one or more of the following:

- federal and state laws and regulations concerning the submission of claims for reimbursement by Medicare, Medicaid and other government programs, whether at retail, mail, specialty or LTC;
- federal and state laws and regulations governing the purchase, distribution, tracking, management, compounding, dispensing and reimbursement of prescription drugs and related services, whether at retail, mail, specialty or LTC, and applicable registration or licensing requirements;
- heighted enforcement of controlled substances regulations;
- the effect of the expiration of patents covering brand name drugs and the introduction of generic products;
- the frequency and rate of approvals by the FDA of new brand name and generic drugs, or of over-the-counter status for brand name drugs;
- rules and regulations issued pursuant to HIPAA and the HITECH Act; and other federal and state laws affecting the collection, use, disclosure and transmission of health or other personal information, such as federal laws on information privacy precipitated by concerns about information collection through the Internet, state security breach laws and state laws limiting the use and disclosure of prescriber information;
- health care fraud and abuse laws regulations;
- consumer protection laws affecting our health care services, our loyalty programs, our drug discount card programs, the products we sell, the informational calls we make and/or the marketing of our goods and services;
- federal, state and local environmental, health and safety laws and regulations applicable to our business, including the management of hazardous substances, storage and transportation of hazardous materials, and various recordkeeping disclosure and procedure requirements promulgated by the Occupational Safety and Health Administration that may apply to our operations;
- health care reform, managed care reform and plan design legislation;
- laws against the corporate practice of medicine;
- FDA regulation affecting the retail, LTC, specialty or PBM industry;
- government regulation of the development, administration, review and updating of formularies and drug lists including requirements and/or limitations around formulary tiering and patient cost sharing;
- state laws and regulations related to increased oversight of PBM activities by state departments of insurance pharmacy reimbursement for generics and pharmacy audits;
- drug pricing legislation, including “most favored nation” pricing;
- federal and state laws and regulations establishing or changing prompt payment requirements for payments to retail pharmacies;
- impact of network access legislation or regulations, including “any willing provider” laws, on our ability to manage pharmacy networks;
- ERISA and related regulations;
- administration of Medicare Part D, including legislative changes and/or CMS rulemaking and interpretation;
- Medicare and Medicaid regulations applicable to our business, in particular our LTC pharmacies and those of our client’s facilities;
- ongoing compliance with consent decrees, corporate integrity agreements, corrective action plans and other agreements with government agencies;
- insurance licensing and other insurance regulatory requirements applicable to offering Medicare Part D programs and services or other health care services; and
- direct regulation of pharmacies or PBMs by regulatory and quasi-regulatory bodies.

The possibility of client losses and/or the failure to win new business.

Our PBM business generates net revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM’s client base typically is subject to renewal each year. In some cases, however, PBM clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Our clients are generally well informed and organized, can move between our competitors and often seek competing bids prior to expiration of their contracts. In addition, the reputational impact of a service-related incident could negatively

affect our business. These factors, together with the impact of competitive pressures, could make it difficult for us to attract new clients, retain existing clients and cross-sell additional services. Further, the PBM industry has been affected by consolidation activity that may continue in the future. In the event one or more of our PBM clients is acquired by an entity that is not also our client, we may be unable to retain all or a portion of the acquired business. These circumstances, either individually or in the aggregate, could result in an adverse effect on our business and financial results. Therefore, we continually face challenges in competing for new PBM business and retaining or renewing our existing PBM business. With respect to our LTC business, reimbursement from skilled nursing facilities for prescriptions we dispense is determined pursuant to our agreements with those skilled nursing facilities. The termination of these agreements generally causes our ability to provide services to any of the residents of that facility to cease, resulting in the loss of revenue from any source for those residents. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to us as the present terms.

Additionally, with respect to our retail and LTC pharmacy businesses, reimbursement under Medicare Part D, as well as reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their pharmacy benefit manager representatives. The loss of those agreements, or a material change in the terms of those agreements, could negatively impact the Company. In addition, restricted networks that exclude our retail or specialty pharmacies negatively impact those businesses.

Risks relating to the market availability, suppliers and safety profiles of prescription drugs that we purchase and sell.

We dispense significant volumes of brand-name and generic drugs from our retail, LTC, specialty and mail-order pharmacies and through our PBM's network of retail pharmacies. When increased safety risk profiles or manufacturing or other supply issues of specific drugs or classes of drugs occur, or drugs become subject to greater restrictions as controlled substances, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced.

Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can result in lower prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our volumes, net revenues, profitability and cash flows may decline as a result of such regulatory rulings or market changes.

Further, we acquire a substantial amount of our mail and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers are often short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the agreement and may allow the supplier to distribute through channels other than ours. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could have a material adverse effect on our business, financial condition and results of operations. Moreover, many products distributed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply.

In addition, our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

A disruption in our business operations could occur as a result of contamination of drugs, a failure to maintain necessary shipment and storage conditions, errors in mail order processing, the unavailability of prescription drugs provided by suppliers, labor disruptions or other unanticipated disruptions at our mail order facilities, call centers, data centers or corporate facilities, among other factors. Such disruption could reduce our ability to process and dispense prescriptions and provide products and services to our customers.

In the event any products we distribute are in limited supply for significant periods of time, our financial condition and results of operations could be materially and adversely affected.

Risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription products.

The profitability of our business is dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription pharmaceuticals as well as lower-priced generic alternatives to existing brand name products, as the sale of generic alternatives normally yield higher gross margins than brand name equivalents. In addition, inflation in the price of the brand name drugs can affect utilization, particularly given the increase in high deductible health plans. Accordingly, our business could be impacted by a slowdown or delay in the number or magnitude of new and successful prescription pharmaceuticals and/or generic alternatives, as well as the pricing of brand name drugs.

The health of the economy in general and in the markets we serve.

Our business is affected by the economy and consumer confidence in general, including various economic factors, inflation and changes in consumer purchasing power, preferences and/or spending patterns. It is possible that an unfavorable, uncertain or volatile economic environment will cause a decline in drug and health care services utilization and dampen demand for pharmacy benefit management services as well as consumer demand for products sold in our retail stores. Further economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms and our ability to execute sale-leaseback transactions under acceptable terms. These changes in conditions could result in an adverse effect on our business and financial results. This could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments.

The failure or disruption of our information technology systems, our information security systems and our infrastructure to support our business and to protect the privacy and security of sensitive customer and business information.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, ExtraCare customer loyalty program, finance, human resource and other processes. Throughout our operations, we receive, retain and transmit certain confidential information, including PII that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks. Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches including credit card or personally identifiable information breaches, coordinated cyber attacks, vandalism, catastrophic events and human error. Although we deploy a layered approach to address information security threats and vulnerabilities, including ones from a cyber security standpoint, designed to protect confidential information against data security breaches, a compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our business, financial position, and results of operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

Failure to adequately protect receipt and use of confidential health information concerning individuals.

Many aspects of our business involve the collection, transmission and use of an individual's protected health information or other sensitive personal information. In some cases, we also use aggregated and de-identified data as defined by HIPAA for

analytical and research purposes, particularly data related to improving the quality of the care we provide. In other cases, we may provide de-identified data to pharmaceutical manufacturers and to third-party data aggregators where permitted by our contracts. These activities are subject to federal and state privacy and security laws and regulations and, in the future, may be subject to international regulatory requirements such as the General Data Protection Regulation, a new European Union privacy regulation that takes effect on May 25, 2018. At the federal level, HIPAA imposes extensive privacy and security requirements governing the transmission, use and disclosure of health information by all participants in the health care industry, whether directly as a covered entity or as a business associate. Our business encompasses both situations and includes our pharmacists, nurse practitioners and PBM operations. In addition, industry requirements, such as Generally Accepted Privacy Principles may be imposed on us by our contracts with our PBM clients or other customers. Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a security standard mandated by the credit card industry for the purpose of protecting credit card account data. These increasingly complex laws, regulations and industry requirements are subject to change and compliance with them may result in significant expenses associated with increased operational and compliance costs, particularly as we continue to collect and retain large amounts of information. To the extent that either we or our vendors with whom we share information are found to be out of compliance with applicable laws and regulations or experience a data security breach, we could be subject to additional litigation, regulatory risks and reputational harm. For example, the privacy and security of the information we maintain may be compromised by the actions of outside parties, by employee errors or by malfeasance. Such risks may result in an unauthorized party obtaining access to our data systems thereby threatening the privacy of protected health information or other sensitive personal information we use and maintain. Failure to comply with federal or state statutes or regulations may result in criminal penalties and civil sanctions. In addition, failure to comply with our own privacy or security policies may result in sanctions by the FTC or other federal oversight agencies. Future regulations and legislation that severely restrict or prohibit our use of patient, member or customer identifiable or other information could limit our ability to use information critical to the operation of our business. Furthermore, if we violate a patient's privacy or are found to have violated any federal or state statute or regulation with regard to confidentiality or dissemination or use of PHI, we could be liable for significant damages, fines or penalties and suffer reputational harm, any one of which could have a material adverse effect on our business and results of operations.

Regulatory and business changes relating to our participation in Medicare Part D.

Medicare Part D has resulted in increased utilization and puts pressure on pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of ACA and changes to the retiree drug subsidy rules, our PBM clients could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that impacts the profitability of our Medicare Part D business; if changes to the regulations impact our ability to retain fees from third parties including network pharmacies; if the government alters Medicare program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if the government mandates the use of point-of-sale manufacturer rebates or makes changes to how pharmacy pay-for-performance is calculated; if Congress acts to reduce reinsurance thresholds from 80% to 20%; if we fail to design and maintain programs that are attractive to Medicare participants; if CMS imposes restrictions on our Medicare Part D business as a result of audits or other regulatory actions; if we fail to successfully implement corrective action or other remedial measures sufficient to prevent or remove any applicable restrictions that may be imposed by CMS; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare Part D's competitive bidding process, our Medicare Part D services and the ability to expand our Medicare Part D services could be negatively impacted.

Possible changes in industry pricing benchmarks and drug pricing generally.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace Average Wholesale Price ("AWP") or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, pharmaceutical purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs ("FFS Medicaid") have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact in reimbursement practices in other commercial and government segments. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish pharmaceutical pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with pharmaceutical manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have an adverse effect on

our results of operations. Additionally, any future changes in drug prices could be significantly different than our projections. The effect of these possible changes on our business cannot be predicted at this time.

Product liability, product recall or personal injury issues could damage our reputation; failure to maintain adequate liability insurance coverage.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of pharmaceuticals could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the products or pharmaceuticals we sell or services we provide. Our business involves the provision of professional services including by pharmacists, nurses and nurse practitioners that exposes us to professional liability claims. Should a product or other liability issue arise, the coverage limits under our insurance programs and the indemnification amounts available to us may not be adequate to protect us against claims. We also may not be able to maintain this insurance on acceptable terms in the future. Damage to our reputation in the event of a product liability or personal injury issue or judgment against us or a product recall could have a significant adverse effect on our business, financial condition and results of operations.

Relationship with our retail and specialty pharmacy customers and the demand for our products and services, including propriety brands.

The success of our business depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in our markets, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could negatively affect our relationship with our clients and customers and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks and mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. Any failure to adequately address some or all of these risks could have an adverse effect on our business, results of operations and financial condition. Additionally, an increase in the sales of our proprietary brands may negatively affect our sales of products owned by our suppliers which, consequently, could adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our financial performance and erode customer loyalty.

Finally, our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs), that serve a relatively limited universe of patients. As a result, the future growth of our specialty pharmacy business is dependent largely upon expanding our base of drugs or penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our business, financial condition and results of operations.

Risks related to developing and maintaining a relevant omni-channel experience for our customers.

Our business has evolved from a retail store experience to interaction with customers across numerous channels, including in-store, online, mobile and social media, among others. Omni-channel retailing is rapidly evolving and we must keep pace with changing customer expectations and new developments by our competitors. Our customers are increasingly using computers, tablets, mobile phones, and other devices to comparison shop, determine product availability and complete purchases through mobile commerce applications. As a result, the portion of total consumer expenditures with all retailers occurring online and through mobile commerce applications is increasing and the pace of this increase could accelerate. We must compete by offering a consistent and convenient shopping experience for our customers regardless of the ultimate sales channel and by investing in, providing and maintaining mobile commerce applications for our customers that have the right features and are reliable and easy to use. If we are unable to make, improve, or develop relevant customer-facing technology in a timely manner that keeps pace with technological developments and dynamic customer expectations, our ability to compete and our results of operations could be materially and adversely affected. In addition, if our online activities or our other customer-facing technology systems do not function as designed, we may experience a loss of customer confidence, data security breaches, lost

sales, or be exposed to fraudulent purchases, any of which could materially and adversely affect our business operations, reputation and results of operations.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these companies are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our results of operations.

Solvency of our customers.

In the event that our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our business, financial condition and results of operations. In addition, both state and federal government sponsored payers, as a result of budget deficits or reductions, may suspend payments or seek to reduce their healthcare expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us. Any delay or reduction in payments by such government sponsored payers may adversely affect our business, financial condition and results of operations.

Our outstanding debt and associated payment obligations could significantly increase in the future if we incur additional debt and do not retire existing debt.

Our current debt service costs associated with our increased debt levels may negatively impact our ability to make important investments in our business and limit our flexibility to respond to industry changes and market conditions. In addition, our debt levels and related debt service obligations could make it more difficult or expensive for us to obtain financing for working capital, capital expenditures, acquisitions or other purposes in the future. These circumstances could have a material adverse effect on our business operations and financial condition.

Further, we may incur and assume significantly more debt in the future, including in connection with the Aetna Acquisition or other acquisitions, strategic investments or joint ventures. For example, in connection with the Aetna Acquisition, if it is completed, we expect to incur approximately, $45.0 billion of new indebtedness and assume approximately $8.2 billion of existing indebtedness of Aetna. If we do not retire our existing debt or debt we assume in acquisitions or other strategic transactions, the risks described above could increase. We also could be adversely impacted by any failure to renew or replace, on terms acceptable to us or at all, existing indebtedness when it expires, and by any failure to satisfy applicable covenants.

We may be unable to refinance existing indebtedness or otherwise access the capital markets for any reason, whether due to market conditions or otherwise. Our continued access to the capital markets, and the terms of such access, depend on multiple factors including the condition of debt capital markets, our operating performance, the amount of our indebtedness and debt service obligations and our credit ratings. Any disruptions or turmoil in the capital markets or any downgrade of our credit ratings could have a material adverse effect on our cost of funds, liquidity, competitive position and access to capital markets, which could materially and adversely affect our business operations, financial condition, and results of operations.

Our long-term debt obligations include covenants that limit our ability and the ability of our subsidiaries to secure indebtedness with a security interest on certain property or stock or engage in certain sale and leaseback transactions with respect to certain properties. In addition, our existing credit agreements require us to maintain a ratio of consolidated debt to total capitalization not to exceed specified levels. Our ability to comply with these restrictions and covenants may be affected by events beyond

our control, and if we fail to comply with such restrictions or covenants, our outstanding indebtedness could be declared immediately due and payable. This could have a material adverse effect on our business operations and financial condition.

We may be unable to successfully integrate companies acquired by us.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company may also be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems, while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disruption of management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays encountered in the integration process, could have a material adverse effect on our business and results of operation. Furthermore, these acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or geographic markets, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

Risks related to the seasonality of our business.

Although the majority of our revenues, particularly pharmacy revenues, are generally not seasonal in nature, front store revenues tend to be higher during the December holiday season. Uncharacteristic or extreme weather conditions can adversely impact consumer shopping patterns as well. This could lead to lost sales, as well as increased snow removal and other costs, thereby negatively affecting our short-term results of operations. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season, which is susceptible to large fluctuations from year to year, and our quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. See "Business - Pharmacy Services Seasonality."

Our operations are subject to a variety of business continuity hazards and risks, any of which could interrupt operations or otherwise adversely affect our performance and results.

We are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events might disrupt or shut down operations, or otherwise adversely impact our operations. We may also be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we have developed business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and, as such, our coverage may be insufficient to protect against all potential hazards and risks incident to our business. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our business financial condition and results of operations could be adversely affected.

Risks related to litigation and other legal proceedings.

Pharmacy services, retail pharmacy and LTC pharmacy are highly regulated and litigious industries. We are currently subject to various litigation matters, investigations, audits, inspections, government inquiries, and regulatory and legal proceedings. Litigation, and particularly securities and collective or class action litigation, is often expensive and disruptive. Further, under the *qui tam* or "whistleblower" provisions of the federal and various state false claims acts, private citizens may bring lawsuits alleging that a violation of the federal anti-kickback statute or similar laws has resulted in the submission of "false" claims to federal and/or state health care programs, including Medicare and Medicaid. Litigation related to our provision of professional services in our pharmacies, specialty pharmacies, clinics and LTC facilities has also increased as we expand our services along the continuum of health care. We cannot predict the outcome of any of these matters, and the costs incurred may be substantial

regardless of outcome. Our business, financial condition and results of operations may be adversely affected, or we may be required to materially change our business practices, as a result of such proceedings. We refer you to Item 3, "Legal Proceedings" for additional information.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could have an adverse impact on our future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet current and future goals and objectives and there is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased salaries or other benefits. An inability to retain existing employees or attract additional employees, or an unexpected loss of leadership, could have a material adverse effect on our business and results of operations.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our business and results of operations. While we have succession plans in place and employment arrangements with certain key executives, these do not guarantee the services of these executives will continue to be available to us.

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2017, we had $52.1 billion of goodwill and other intangible assets. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we first compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow model and a comparable market multiple model. If the estimated fair value of the reporting unit is less than its carrying amount, an impairment loss calculation is prepared. The impairment loss calculation compares the fair value of a reporting unit to its carrying amount. If the carrying amount of the reporting unit exceeds the fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows, or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our results of operations, which could have a material adverse effect on our financial condition and results of operations.

The foregoing is not a comprehensive listing of all possible risks and there can be no assurance that we have correctly identified and appropriately assessed all factors affecting the business. As such, we refer you to "Management's Discussion and Analysis of Financial Condition and Results of Operations," which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section, of our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

Aetna-Related Risk Factors In addition to the risk factors described above that could materially adversely affect our business, financial condition, results of operations, cash flows and prospects, the following risk factors, and additional risks not presently known to us or that we currently deem to be immaterial, could also materially adversely affect us and the Aetna Acquisition.

In order to complete the merger, we and Aetna must obtain certain governmental authorizations, and if such authorizations are not granted or are granted with conditions that become applicable to the parties, completion of the merger may be jeopardized or prevented or the anticipated benefits of the merger could be reduced.

Completion of the merger is conditioned upon the expiration or early termination of the waiting period relating to the merger under the HSR Act and certain other applicable laws or regulations and the required governmental authorizations having been obtained and being in full force and effect. Although we and Aetna have agreed in the merger agreement to use our reasonable best efforts, subject to certain limitations, to make certain governmental filings or obtain the governmental authorizations required to complete the merger (the "required governmental authorizations"), as the case may be, there can be no assurance that the relevant waiting periods will expire or authorizations will be obtained and no assurance that the merger will be completed.

In addition, the governmental authorities from which these authorizations are required have broad discretion in administering the governing laws and regulations, and may take into account various facts and circumstances in their consideration of the merger, including other potential transactions in the health care industry or other industries. These governmental authorities

may initiate proceedings seeking to prevent, or otherwise seek to prevent, the merger. As a condition to authorization of the merger or related transactions, these governmental authorities also may impose requirements, limitations or costs, require divestitures or place restrictions on the conduct of our business after completion of the merger. Under the terms of the merger agreement, we are not required, and Aetna is not permitted without our consent, to take any actions or agree to any terms or conditions in connection with (i) the expiration or early termination of the waiting period relating to the merger under the HSR Act, (ii) any other antitrust law or (iii) the required governmental authorizations, in each case if such action, term or condition would have, or would reasonably be expected to have, individually or in the aggregate, a regulatory material adverse effect on us or Aetna.

However, notwithstanding the provisions of the merger agreement, either we or Aetna could become subject to terms or conditions in connection with such waiting periods, laws or other authorizations (whether because such term or condition does not rise to the specified level of materiality or we otherwise consent to its imposition) the imposition of which could adversely affect our ability to integrate Aetna's operations with our operations, reduce the anticipated benefits of the merger or otherwise materially and adversely affect our business and results of operations after completion of the merger.

In addition to receipt of certain governmental authorizations, completion of the merger is subject to a number of other conditions, and if these conditions are not satisfied or waived, the merger will not be completed.

Our obligations and the obligations of Aetna to complete the merger are subject to satisfaction or waiver of a number of conditions in addition to receipt of certain governmental authorizations, including, among other conditions: (i) approval and adoption of the merger agreement by Aetna shareholders at an Aetna special meeting, (ii) approval of the stock issuance by our stockholders at the CVS Health special meeting, (iii) approval for the listing on the New York Stock Exchange of the shares of CVS Health common stock to be issued in the merger, (iv) absence of any applicable law or order that prohibits completion of the transaction, (v) accuracy of the representations and warranties made in the merger agreement by the other party, subject to certain materiality qualifications, (vi) performance in all material respects by the other party of the material obligations required to be performed by it at or prior to completion of the transaction, and (vii) the absence of a material adverse effect on the other party. There can be no assurance that the conditions to completion of the merger will be satisfied or waived or that the merger will be completed.

In addition, the CVS Health special meeting and the Aetna special meeting may take place before certain governmental authorizations have been obtained and, therefore, before the terms on which such governmental authorizations may be obtained, or the conditions to obtaining such governmental authorizations that may be imposed, are known. As a result, if CVS Health stockholders approve the stock issuance at the CVS Health special meeting, or Aetna shareholders approve and adopt the merger agreement at the Aetna special meeting, we and Aetna may make decisions after the respective meetings to waive a condition as to the receipt of certain governmental authorizations or to take certain actions required to obtain such governmental authorizations without seeking further stockholder or shareholder approval, as applicable, and such actions could have an adverse effect on the combined company.

After completion of the merger, we may fail to realize the anticipated benefits and cost savings of the merger, which could adversely affect the value of shares of our common stock.

The success of the merger will depend, in part, on our ability to realize the anticipated benefits and cost savings from combining the businesses of CVS Health and Aetna. Our ability to realize these anticipated benefits and cost savings is subject to certain risks, including:

- Our ability to successfully combine the businesses of CVS Health and Aetna;
- whether the combined businesses will perform as expected;
- the possibility that we paid more for Aetna than the value we will derive from the acquisition;
- the reduction of our cash available for operations and other uses and the incurrence of indebtedness to finance the acquisition; and
- the assumption of known and unknown liabilities of Aetna.

If we are not able to successfully combine the businesses of CVS Health and Aetna within the anticipated time frame, or at all, the anticipated cost savings and other benefits of the merger may not be realized fully or may take longer to realize than expected, the combined businesses may not perform as expected and the value of the shares of our common stock may be adversely affected.
We and Aetna have operated and, until completion of the merger will continue to operate, independently, and there can be no assurances that our respective businesses can be integrated successfully. It is possible that the integration process could result in the loss of key CVS Health or Aetna employees, the disruption of either company's or both companies' ongoing businesses or

in unexpected integration issues, higher than expected integration costs and an overall post-completion integration process that takes longer than originally anticipated. Specifically, issues that must be addressed in integrating the operations of Aetna and CVS Health in order to realize the anticipated benefits of the merger so the combined business performs as expected include, among other things:

- combining the companies' separate operational, financial, reporting and corporate functions;
- integrating the companies' technologies, products and services;
- identifying and eliminating redundant and underperforming operations and assets;
- harmonizing the companies' operating practices, employee development, compensation and benefit programs, internal controls and other policies, procedures and processes;
- addressing possible differences in business backgrounds, corporate cultures and management philosophies;
- consolidating the companies' corporate, administrative and information technology infrastructure;
- coordinating sales, distribution and marketing efforts;
- managing the movement of certain businesses and positions to different locations;
- maintaining existing agreements with customers, providers and vendors and avoiding delays in entering into new agreements with prospective customers, providers and vendors;
- operating in industry sectors in which we and our current management may have little or no experience;
- coordinating geographically dispersed organizations;
- consolidating offices of Aetna and CVS Health that are currently in or near the same location; and
- effecting potential actions that may be required in connection with obtaining regulatory approvals.

In addition, at times, the attention of certain members of each company's management and each company's resources may be focused on completion of the merger and the integration of the businesses of the two companies and diverted from day-to-day business operations, which may disrupt each company's ongoing business and the business of the combined company.

We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve the combined company's objectives.

We have limited experience operating an insurance and managed health care business, and will rely in large part on the existing management of Aetna to continue to manage the Aetna business following the merger. However, there is no assurance that we will be able to retain the services of such management. If we fail to retain the existing management of Aetna, our ability to realize the anticipated benefits of the transaction may be adversely affected.

We and Aetna may have difficulty attracting, motivating and retaining executives and other key employees in light of the merger.

As we will be operating in industry sectors for which our existing management team has little or no experience, our success after the transaction will depend in part on our ability to retain key executives and other employees of Aetna. Uncertainty about the effect of the merger on CVS Health and Aetna employees may have an adverse effect on each of us and Aetna separately and consequently the combined business. This uncertainty may impair our and/or Aetna's ability to attract, retain and motivate key personnel. Employee retention may be particularly challenging during the pendency of the merger, as employees of CVS Health and Aetna may experience uncertainty about their future roles in the combined business.

Additionally, Aetna's officers and employees may hold Aetna common shares, as well as Aetna stock appreciation rights, Aetna restricted stock units ("Aetna RSUs") and Aetna performance stock units ("Aetna PSUs") that are subject to accelerated vesting on a change in control, and, if the merger is completed, these officers and employees may be entitled to cash and/or the consideration payable under the merger agreement in respect of such Aetna common shares, stock appreciation rights, Aetna RSUs and Aetna PSUs. These payouts could also make retention of these officers and employees more difficult. Additionally, pursuant to employment agreements and/or other agreements or arrangements with Aetna, certain key employees of Aetna are entitled to receive severance payments upon a termination without cause and/or a resignation for "good reason" following completion of the merger. Under these agreements, certain key employees of Aetna potentially could resign from his or her employment following specified circumstances set forth in his or her applicable agreement, including an adverse change in his or her title, authority or responsibilities, compensation and benefits or primary office location.

Furthermore, if key employees of CVS Health or Aetna depart or are at risk of departing, including because of issues relating to the uncertainty and difficulty of integration, financial security or a desire not to become employees of the combined business, we may have to incur significant costs in retaining such individuals or in identifying, hiring and retaining replacements for departing employees and may lose significant expertise and talent relating to the business of Aetna, and our ability to realize the anticipated benefits of the merger may be materially and adversely affected. Accordingly, no assurance can be given that we

will be able to attract or retain key employees of Aetna to the same extent that Aetna has been able to attract or retain employees in the past.

Our and Aetna's business relationships may be subject to disruption due to uncertainty associated with the merger.

Parties with which we or Aetna do business may experience uncertainty associated with the merger, including with respect to current or future business relationships with us, Aetna or the combined business. Our and Aetna's business relationships may be subject to disruption as customers, providers, vendors and others may attempt to negotiate changes in existing business relationships or consider entering into business relationships with parties other than us, Aetna or the combined business. These disruptions could have a material adverse effect on the businesses, financial condition, results of operations or prospects of CVS Health, Aetna and/or the combined business, including a material adverse effect on our ability to realize the anticipated benefits of the merger. The risk and adverse effect of such disruptions could be exacerbated by a delay in completion of the merger or termination of the merger agreement.

The merger agreement contains provisions that may make it more difficult for us and Aetna to pursue alternatives to the merger.

The merger agreement contains provisions that make it more difficult for Aetna to sell its business to a party other than us, or for us to sell its business. These provisions include a general prohibition on each party soliciting any acquisition proposal. Further, there are only limited exceptions to each party's agreement that its board of directors will not withdraw or modify in a manner adverse to the other party the recommendation of its board of directors in favor of the approval and adoption of the merger agreement, in the case of Aetna, or the approval of the stock issuance, in our case, and the other party generally has a right to match any acquisition proposal that may be made. However, at any time prior to the approval and adoption of the merger agreement by Aetna shareholders, in the case of Aetna, or the approval of the stock issuance by CVS Health stockholders, in our case, such party's board of directors is permitted to take certain of these actions if it determines in good faith that the failure to take such action would be reasonably likely to be inconsistent with its fiduciary duties under applicable law.

While we believe these provisions are reasonable and not preclusive of other offers, these restrictions might discourage a third party that has an interest in acquiring all or a significant part of either Aetna or CVS Health from considering or proposing that acquisition, even if that party were prepared to pay consideration with a higher per-share value than the currently proposed merger consideration, in the case of Aetna, or that party were prepared to enter into an agreement that may be favorable to us or our stockholders, in our case. Furthermore, the termination fees described below may result in a potential competing acquirer proposing to pay a lower per-share price to acquire the applicable party than it might otherwise have proposed to pay because of the added expense of the termination fee that may become payable by such party in certain circumstances.

Failure to complete the merger could negatively impact our stock price and our future business and financial results.

If the merger is not completed for any reason, including as a result of Aetna shareholders failing to approve and adopt the merger agreement or CVS Health stockholders failing to approve the stock issuance, our ongoing business may be materially and adversely affected and, without realizing any of the benefits of having completed the merger, we would be subject to a number of risks, including the following:

- we may experience negative reactions from the financial markets, including negative impacts on the trading price of our common stock and other securities, and from our customers, providers, vendors, regulators and employees;
- we may be required to pay Aetna a termination fee of $2.1 billion if the merger agreement is terminated under certain circumstances;
- we will be required to pay certain transaction expenses and other costs incurred in connection with the merger, whether or not the merger is completed;
- the merger agreement places certain restrictions on the conduct of our businesses prior to completion of the merger, and such restrictions, the waiver of which is subject to the consent of Aetna, may prevent us from making certain acquisitions, taking certain other specified actions or otherwise pursuing business opportunities during the pendency of the merger that we would have made, taken or pursued if these restrictions were not in place; and
- matters relating to the merger (including arranging permanent financing and integration planning) will require substantial commitments of time and resources by our management and the expenditure of significant funds in the form of fees and expenses, which would otherwise have been devoted to day-to-day operations and other opportunities that may have been beneficial to us as an independent company.

There can be no assurance that the risks described above will not materialize. If any of those risks materialize, they may materially and adversely affect our businesses, financial condition, financial results, ratings, stock prices and/or bond prices.

In addition, we could be subject to litigation related to any failure to complete the merger or related to any proceeding to specifically enforce our obligation to perform our obligations under the merger agreement. If the merger is not completed, these risks may materialize and may materially and adversely affect our businesses, financial condition, financial results, ratings, stock prices and/or bond prices.

We and Aetna may be targets of securities class action and derivative lawsuits which could result in substantial costs and may delay or prevent the merger from being completed.

Securities class action lawsuits and derivative lawsuits are often brought against public companies that have entered into merger agreements. Even if the lawsuits are without merit, defending against these claims can result in substantial costs and divert management time and resources. An adverse judgment could result in monetary damages, which could have a negative impact on our and Aetna's respective liquidity and financial condition. Additionally, if a plaintiff is successful in obtaining an injunction prohibiting completion of the merger, then that injunction may delay or prevent the merger from being completed, which may adversely affect our and Aetna's respective business, financial position and results of operation. Since the filing with the SEC of the preliminary joint proxy statement/prospectus relating to the proposed merger, a number of class action lawsuits in connection with the merger have been filed against us, Aetna and Aetna's directors and officers. Neither we nor Aetna presently believe that there is any merit to any such lawsuit. We and Aetna intend to defend them vigorously.

Our indebtedness following completion of the merger will be substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility, and increase our borrowing costs. Downgrades in our ratings could adversely affect our business, cash flows, financial condition and operating results.

In order to complete the merger, we expect to incur acquisition-related debt financing of approximately $45.0 billion and assume Aetna's existing indebtedness of approximately $8.2 billion. Our substantially increased indebtedness and higher debt-to-equity ratio following completion of the merger in comparison to that of CVS Health prior to the merger will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and will increase our borrowing costs. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources will be greater than the amount of cash flows required to service the indebtedness of CVS Health or Aetna individually prior to the merger. The increased levels of indebtedness could also reduce funds available to fund our efforts to combine our business with Aetna and realize expected benefits of the merger and/or engage in investments in product development, capital expenditures, dividend payments, share repurchases and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

In addition, our credit ratings impact the cost and availability of future borrowings, and, as a result, our cost of capital. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or, following completion of the merger, obligations to the combined company's insureds. Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Following the announcement of the merger agreement, each of Standard & Poor's and Moody's placed certain of our debt, financial strength and other credit ratings under review for a possible downgrade. Following the announcement of the merger agreement, Standard & Poor's, A.M. Best and Fitch placed Aetna's debt, financial strength and other credit ratings under review with negative implications. Downgrades in our ratings could adversely affect our business, cash flows, financial condition and operating results. In addition, if the merger is completed and, in certain circumstances, Aetna's debt securities are rated below investment grade, this may constitute a change of control triggering event under the indentures governing such debt. Upon the occurrence of a change of control triggering event, Aetna, as the surviving corporation of the merger, would be required to offer to repurchase most of Aetna's outstanding notes at 101% of the principal amount thereof plus accrued and unpaid interest if any, to, but not including, the date of repurchase. However, it is possible that Aetna (or us) would not have sufficient funds at the time of the change of control triggering event to make the required repurchase of notes or that restrictions in other debt instruments would not allow such repurchases. We cannot provide any assurance that there will be sufficient funds available for Aetna (or us) to make any required repurchases of the notes upon a change of control triggering event.

We will incur significant transaction and integration-related costs in connection with the merger.

We expect to incur a number of non-recurring costs associated with the merger and combining the operations of the two companies. We will incur significant transaction costs related to the merger, including with respect to the financing for the cash consideration to be paid to Aetna shareholders. We also will incur significant integration-related fees and costs related to

formulating and implementing integration plans, including facilities and systems consolidation costs and employment-related costs. We continue to assess the magnitude of these costs, and additional unanticipated costs may be incurred in the merger and the integration of the two companies' businesses. Although we expect that the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of the businesses, should allow us to offset integration-related costs over time, this net benefit may not be achieved in the near term, or at all.

The merger may not be accretive, and may be dilutive, to our earnings per share, which may negatively affect the market price of shares of our common stock.

We currently project that the merger will result in a number of benefits, including enhanced competitive positioning and a platform from which to accelerate growth, and that it will be accretive to earnings per share in the second full year after the close of the transaction. This projection is based on preliminary estimates that may materially change. In addition, future events and conditions could decrease or delay the accretion that is currently projected or could result in dilution, including adverse changes in market conditions, additional transaction and integration-related costs and other factors such as the failure to realize some or all of the anticipated benefits of the merger. Any dilution of, decrease in or delay of any accretion to, our earnings per share could cause the price of shares of our common stock to decline or grow at a reduced rate.

The future results of the combined company may be adversely impacted if the combined company does not effectively manage its expanded operations following completion of the merger.

Following completion of the merger, the size of the combined company's business will be significantly larger than the current size of either our or Aetna's respective businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to implement an effective integration of the two companies and its ability to manage a combined business with significantly larger size and scope with the associated increased costs and complexity. There can be no assurances that the management of the combined company will be successful or that the combined company will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the merger.

Additional information concerning these risks, uncertainties and assumptions can be found in the section entitled "Risk Factors" beginning on page 62 of our preliminary joint proxy statement/prospectus filed February 9, 2018 with the SEC on Form S-4/A.

CVS Form 10-K 2016

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

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2016
OR
☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from to
Commission file number 001-01011

CVSHealth

CVS HEALTH CORPORATION

(Exact name of Registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Exchange Act:

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Exchange Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer, or a smaller reporting company. See definition of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $101,661,618,666 as of June 30, 2016, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 3, 2017, the registrant had 1,025,699,605 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

- Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2016 are incorporated by reference in our response to Items 7, 8 and 9 of Part II.
- Information contained in our Proxy Statement for the 2017 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

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PART I

Item 1. Business

Overview

CVS Health Corporation, together with its subsidiaries (collectively "CVS Health," the "Company," "we," "our" or "us"), is a pharmacy innovation company helping people on their path to better health. At the forefront of a changing health care landscape, the Company has an unmatched suite of capabilities and the expertise needed to drive innovations that will help shape the future of health care.

We are currently the only integrated pharmacy health care company with the ability to impact consumers, payors, and providers with innovative, channel-agnostic solutions to complex challenges managing costs and care. We have a deep understanding of their diverse needs through our unique integrated model, and we are bringing them innovative solutions that help increase access to quality care, deliver better health outcomes and lower overall health care costs.

Through more than 9,700 retail locations, more than 1,100 walk-in health care clinics, a leading pharmacy benefits manager with nearly 90 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services and a leading stand-alone Medicare Part D prescription drug plan, we enable people, businesses, and communities to manage health in more affordable, effective ways. We are delivering break-through products and services, from advising patients on their medications at our CVS Pharmacy ® locations, to introducing unique programs to help control costs for our clients at CVS Caremark ®, to innovating how care is delivered to our patients with complex conditions through CVS Specialty ™, to improving pharmacy care for the senior community through Omnicare ®, or by expanding access to high-quality, low-cost care at CVS MinuteClinic ®.

We have three reportable segments: Pharmacy Services, Retail/LTC and Corporate.

Pharmacy Services Segment

The Pharmacy Services Segment provides a full range of pharmacy benefit management ("PBM") solutions, as described more fully below, to our clients consisting primarily of employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans, plans offered on the public and private exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, through our SilverScript Insurance Company ("SilverScript") subsidiary, we are a national provider of drug benefits to eligible beneficiaries under the federal government's Medicare Part D program. The Pharmacy Services Segment operates under the CVS Caremark ® Pharmacy Services, Caremark ®, CVS Caremark ®, CarePlus CVS Pharmacy ™, CVS Specialty ™, Accordant ®, SilverScript ®, NovoLogix ®, Coram ®, Navarro ® Health Services and ACS Pharmacy names. As of December 31, 2016 , the Pharmacy Services Segment operated 23 retail specialty pharmacy stores, 13 specialty mail order pharmacies and four mail order dispensing pharmacies, and 84 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence, located in 41 states, Puerto Rico and the District of Columbia. During the year ended December 31, 2016 , our PBM filled or managed approximately 1.2 billion prescriptions (which equates to 1.6 billion prescriptions when counting 90-day prescriptions as three prescriptions).

Pharmacy Services Business Strategy - Our business strategy centers on providing innovative tools and strategies, as well as quality client service in order to help improve clinical outcomes for our clients' health benefit plan members while assisting our clients and their plan members in better managing overall health care costs. Our goal is to produce superior results for our clients and their plan members by leveraging our expertise in core PBM services, including: plan design offerings and administration, formulary management, Medicare Part D services, mail order, specialty pharmacy and infusion services, retail pharmacy network management services, prescription management systems, clinical services, disease management services and medical spend management.

In addition, as a fully integrated pharmacy services company, we are able to offer our clients and their plan members a variety of programs and tools, including plan design offerings, that benefit from our integrated systems and the ability of our almost 36,000 pharmacists, nurses, nurse practitioners and physician assistants to interact personally with the many plan members. Through our multiple member touch points (retail stores, mail order, infusion, long-term care and specialty pharmacies, retail clinics, digital resources and cost management tools), we seek to engage plan members in behaviors that help lower cost and improve health care outcomes. Examples of these programs and services include: Maintenance Choice ®, a program where eligible client plan members can elect to fill their maintenance prescriptions at our CVS Pharmacy retail stores for the same price as mail order; Pharmacy Advisor ®, a program that facilitates face-to-face and telephone counseling by our pharmacists to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to

identify gaps in care, adhere to their prescribed medications and manage their health conditions; compliance and persistency programs designed to help ensure that patients take their medications in the proper manner; enhanced disease management programs that are targeted at managing chronic disease states; Specialty Connect ®, our integrated specialty pharmacy offering which integrates specialty mail and retail capabilities, providing members with disease-state specific counseling from our experienced specialty pharmacists and the choice to bring their specialty prescriptions to a CVS Pharmacy location or submit it through our specialty mail order pharmacies; and an ExtraCare ® Health Card program which offers discounts to eligible plan members on certain over-the-counter health care products sold in our CVS Pharmacy stores. In addition, MinuteClinic ® is an important and differentiated part of the enterprise that offers certain capabilities to PBM clients and their members. For example, we offer plan-sponsored co-pay reductions to encourage use of MinuteClinic, thereby helping to reduce emergency room visits and to lower overall health care costs. Other ways we are working with our clients include partnerships with health plan clients sponsoring patient centered medical homes, biometric screenings for plan members, closing gaps in care, and onsite clinics at client corporate headquarters.

PBM Services - Our PBM solutions are described more fully below.

Plan Design Offerings and Administration - Our clients sponsor pharmacy benefit plans that facilitate the ability of eligible members in these plans to receive prescribed medications. We assist our clients in designing pharmacy benefit plans that help minimize the costs to the client while helping improve health outcomes. We also administer these benefit plans selected by our clients and assist them in monitoring the effectiveness of these plans through frequent, informal communications, their use of our proprietary software, as well as through a formal annual client review.

We make recommendations to our clients helping them to design benefit plans promoting the use of the lower cost, clinically appropriate drugs. We help our clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Our clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or “formularies”.

Formulary Management - We utilize an independent panel of doctors, pharmacists and other medical experts, referred to as our Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet our high standards of safety and efficacy for inclusion on one of our template formularies. Our formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate alternatives under the client’s pharmacy benefit plan, while helping to drive the lowest net cost for our clients that select one of our formularies. To help improve clinical outcomes for members and clients, we conduct ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products, as well as our clinical programs. Many of our clients choose to adopt one of our template formulary offerings as part of their plan design.

Medicare Part D Services - We participate in the administration of the drug benefit added to the Medicare program under Part D of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) through the provision of PBM services to those of our health plan clients and other clients that have qualified as a Medicare Part D prescription drug plans (“PDP”) or as a Medicare Advantage prescription drug plan (“MA-PD”) and by offering Medicare Part D pharmacy benefits through SilverScript, a PDP that has contracted with the United States Centers for Medicare and Medicaid Services (“CMS”). We also assist employer, union and other health plan clients that qualify for the retiree drug subsidy made available under the MMA by collecting and submitting eligibility and/or drug cost data to CMS in order for them to obtain the subsidy and offer Medicare Part D pharmacy benefits to such clients' retirees through SilverScript-sponsored Employer Group Waiver Plans (“EGWPs”).

Mail Order Pharmacy - As of December 31, 2016 , we operated four mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies via mail, telephone, fax, e-prescribing or the Internet. We also offer Maintenance Choice ®, a program in which eligible client plan members in most states can elect to fill their maintenance prescriptions at our CVS Pharmacy retail stores for the same price as mail order, and operate a network of smaller mail order specialty pharmacies described below. Our staff pharmacists review mail order prescriptions and refill requests with the assistance of our prescription management systems. This review may involve communications with the prescriber and, with the prescriber’s approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. These pharmacies have been awarded Mail Order Pharmacy accreditation from Utilization Review Accreditation Commission (“URAC”), a Washington DC-based health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy - Our specialty pharmacies support individuals who require complex and expensive drug therapies. As of December 31, 2016 , our specialty pharmacy operations included 13 specialty mail order pharmacies located throughout the United States that are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. These pharmacies have also been awarded Specialty Pharmacy accreditation from URAC. As of December 31, 2016 , the Company operated a network of 23 retail specialty pharmacy stores, which operate under the CarePlus CVS Pharmacy ™ and Navarro ® Health Services names. These stores average 1,100 square feet in size and sell prescription drugs and a limited assortment of front store items such as alternative medications, homeopathic remedies and vitamins. Through our affiliate Coram LLC and its subsidiaries (collectively, "Coram"), one of the nation's largest providers of comprehensive infusion services, we care for approximately 146,000 patients annually, providing specialty infusion and enteral nutrition services. Our Specialty Connect ® product, which integrates our specialty pharmacy mail and retail capabilities, provides members with disease-state specific counseling from our experienced specialty pharmacists and the choice to bring their specialty prescriptions to a CVS Pharmacy location. Whether submitted through our specialty mail order pharmacy or at a CVS Pharmacy, all prescriptions are filled through our specialty mail order pharmacies, so all revenue from this specialty prescription services program is recorded within the Pharmacy Services Segment. Members then can choose to pick up their medication at their local CVS Pharmacy, except in three states that do not allow retail pick-up, or have it sent to their home through the mail. Additionally, with the acquisition of Omnicare, Inc. ("Omnicare"), we expanded our specialty pharmacy to include the specialty pharmacy operations of Omnicare which operates under the name ACS Pharmacy.

Retail Pharmacy Network Management - We maintain a national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes our CVS Pharmacy locations) and 27,000 independent pharmacies, in the United States, Puerto Rico, District of Columbia, Guam and the Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to us from the point-of-sale. This data interfaces with our proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. We are also able to build client-specific networks and narrow networks to further drive savings for our clients.

Prescription Management Systems - We dispense prescription drugs both directly, through one of our mail order or specialty pharmacies, or through a network of retail pharmacies, described above. All prescriptions processed through our systems, whether they are filled through one of our mail order or specialty dispensing pharmacies or through a pharmacy in our retail network, are analyzed, processed and documented by our proprietary prescription management systems. These systems provide essential features and functionality to allow a plan member to use their prescription drug benefit. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists, by enhancing review of various items through automation, including, but not limited to, plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Clinical Services - We offer multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. Our programs are primarily designed to promote good health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that negatively impact member health and client pharmacy and medical spend. In this regard, we offer various utilization management, medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies.

Disease Management Programs - Our clinical services utilize advanced protocols and offer clients convenience in working with health care providers and other third parties. Our Accordant ® programs include integrated rare disease management programs, which cover diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis. The majority of these integrated programs are accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations. They have also been awarded Case Management Accreditation from URAC.

Medical Pharmacy Management - We offer a technology platform, NovoLogix ®, an online preauthorization tool that helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure appropriate clinical use of these drugs.

Pharmacy Services Information Systems - We currently operate and support a small number of claim adjudication platforms to support our Pharmacy Services Segment. However, the majority of our clients have migrated to one platform. These information systems incorporate architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to our PBM clients. Our Health Engagement Engine ™ technology and proprietary clinical algorithms help enable our mail and specialty pharmacists provide quality care, and our

enterprise digital strategy and integrated digital offerings help patients seamlessly manage mail, specialty and retail prescriptions.

Pharmacy Services Clients - Our clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on public and private exchanges, other sponsors of health benefit plans and individuals located throughout the United States. We provide pharmaceuticals to eligible members in benefit plans maintained by our clients and utilize our information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. We generate substantially all of our Pharmacy Services Segment net revenue from dispensing and managing prescription drugs to eligible members in benefit plans maintained by our clients. In 2016, net revenues from Aetna accounted for approximately 11.2% of our consolidated net revenues. In 2015 and 2014, no single PBM client accounted for 10% or more of our consolidated net revenues.

Pharmacy Services Seasonality - The majority of our Pharmacy Services Segment revenues are not seasonal in nature. However, our quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in plan sponsors sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP plan pay percentage or benefit ratio generally decreases and operating profit generally increases as the year progresses.

Pharmacy Services Competition - We believe the primary competitive factors in the industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (vii) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; and the quality, scope and costs of products and services offered to clients and their members, as well as operational excellence in delivering services. The Pharmacy Services Segment has a significant number of competitors offering PBM services including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs (e.g., Express Scripts, OptumRx, Humana, Prime Therapeutics and MedImpact).

Retail/LTC Segment

As of December 31, 2016 , the Retail/LTC Segment included 9,709 retail locations (of which 7,980 were our stores that operated a pharmacy and 1,674 were our pharmacies located within Target Corporation ("Target") stores), our online retail pharmacy websites, CVS.com ®, Navarro.com ™ and Onofre.com.br ™, 38 onsite pharmacy stores, our long-term care pharmacy operations and our retail health care clinics. The retail locations are in 49 states, the District of Columbia, Puerto Rico and Brazil operating primarily under the CVS Pharmacy ®, CVS ®, CVS Pharmacy y más ®, Longs Drugs ®, Navarro Discount Pharmacy ® and Drogaria Onofre ™ names. With the addition of the pharmacies of Target, we currently operate in all of the top 100 United States drugstore markets. The CVS Pharmacy retail drugstores sell prescription drugs and a wide assortment of over-the-counter and personal care products, beauty and cosmetic products, and general merchandise, which we refer to as "front store" products. The pharmacies within Target stores sell prescription drugs and over-the-counter drugs that are required to be held behind the counter. Existing retail stores range in size from approximately 5,000 to 30,000 square feet, although most new stores range in size from approximately 11,000 to 15,000 square feet and typically include a drive-thru pharmacy. The pharmacies within Target stores range in size from approximately 450 to 1,100 square feet. During 2016, our Retail/LTC Segment filled approximately 1.2 billion prescriptions (counting 90-day prescriptions as three prescriptions), and we held approximately 23.8% of the United States retail pharmacy market.

Our acquisition of Omnicare broadened our base of pharmacy care to an additional dispensing channel, long-term care pharmacy. Omnicare's long-term care ("LTC") operations include the distribution of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Omnicare also provides commercialization services under the name RxCrossroads ®. LTC is comprised of 152 spoke pharmacies that primarily handle new prescription orders, of which 32 are also hub pharmacies that use automation to support spoke pharmacies with refill prescriptions. LTC primarily operates under the Omnicare ® and NeighborCare ® names. With the addition of the LTC operations, we are continuing to enhance our service offerings to further address the needs of an aging population throughout the continuum of senior care.

Retail Pharmacy Business Strategy - Our integrated pharmacy services model has enhanced the ability of our retail pharmacy stores to expand customer access to care while helping to lower overall health care costs and improve health outcomes. In that regard, the role of our retail pharmacist is shifting from primarily dispensing prescriptions to also providing services, including flu vaccinations as well as face-to-face patient counseling with respect to adherence to drug therapies, closing gaps in care and

recommending more cost effective drug therapies. We also provide a broad assortment of quality merchandise at competitive prices using a retail format that emphasizes service, innovation and convenience. One of the keys to our strategy is technology, which allows us to focus on constantly improving service and exploring ways to provide more personalized product offerings and services. We are leveraging digital to empower our customers and patients by making the full breadth of health care and pharmacy services available to them anytime, anywhere. We are introducing digital tools to make it easier for people to save time and money and to live healthier lives. In 2016, we rolled out CVS Pay ™ nationwide, an end-to-end mobile payment solution that integrates payment, prescription pick-up and our ExtraCare ® loyalty program into one spot at checkout. We believe that continuing to innovate with new and unique products and services, using innovative marketing and adjusting our mix of merchandise to match our customers' needs and preferences is very important to our ability to continue to improve customer satisfaction.

Retail/LTC Products and Services - A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, beauty products and cosmetics, personal care products, convenience foods, photo finishing services, seasonal merchandise and greeting cards. The pharmacies within Target stores sell prescription drugs and over-the-counter drugs that are required to be held behind the counter. The LTC operations include distribution of pharmaceuticals and related consulting and ancillary services. We purchase our merchandise from numerous manufacturers and distributors. We believe that competitive sources are readily available for substantially all of the products we carry and the loss of any one supplier would not likely have a material effect on the business. Our clinics offer a variety of health care services by nurse practitioners and physician assistants.

Retail/LTC net revenues by major product group are as follows:

	Percentage of Net Revenues [1]		
	2016	2015	2014
Prescription drugs [2]	75.0%	72.9%	70.7%
Over-the-counter and personal care	10.0	10.9	11.0
Beauty/cosmetics	4.2	4.5	4.7
General merchandise and other	10.8	11.7	13.6
	100.0%	100.0%	100.0%

(1) Percentages are estimates based on store point-of-sale data for the stores and revenue system data for sales outside the stores.
(2) In 2016 and 2015, prescription drugs include LTC sales and sales in pharmacies within Target stores.

Pharmacy - Pharmacy revenues represented more than two-thirds of Retail Pharmacy revenues in each of 2016, 2015 and 2014. We believe that our pharmacy operations will continue to represent a critical part of our business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, pharmaceuticals being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, and Medicare Part D. We believe our pharmacy business benefits from our investment in both people and technology, as well as our innovative partnerships with health plans, PBMs and providers. Given the nature of prescriptions, people want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers need medication management programs and better information to help them get the most out of their health care dollars. To assist our customers with these needs, we have introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging them in behaviors that can help lower costs, improve health, and save lives. Examples include: our Patient Care Initiative, an enhanced medication adherence program; Maintenance Choice ®, a program where eligible client plan members can elect to fill their maintenance prescriptions at our retail pharmacy stores for the same price as mail order; Pharmacy Advisor ®, our program that facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions; Specialty Connect ®, our integrated specialty pharmacy offering which integrates specialty mail and retail capabilities, providing members with disease-state specific counseling from our experienced specialty pharmacists and the choice to bring their specialty prescriptions to a CVS Pharmacy location or submit it through our specialty mail order pharmacies; as well as ScriptSync ®, a service that enables patients with multiple medications to pick up their eligible maintenance prescriptions in a single monthly CVS Pharmacy visit . Maintenance Choice, Pharmacy Advisor, Specialty Connect and ScriptSync are all programs that demonstrate our ability to enhance the customer experience through our integrated enterprise products and services. Further evidencing our belief in the importance of pharmacy service is our continuing investment in technology, such as our Drug Utilization Review system that helps check for harmful interactions between prescription drugs and patient identified over-the-counter products, vitamins and herbal remedies; RxConnect, our proprietary pharmacy system that integrates our product delivery and clinical workflows as well as advanced patient safety functionality such as drug utilization review; our prescription refill program, ReadyFill ®; and our online retail businesses, CVS.com, Navarro.com and Onofre.com.br. In December 2015, we expanded our pharmacy offering with the

acquisition of the pharmacies within Target stores. Now that the system integration is complete, we will offer all the same pharmacy services available in our retail drugstores and online at our pharmacies within Target stores.

Front Store - Front store revenues benefited from our strategy to innovate with new and unique products and services, using innovative personalized marketing and adjusting our mix of merchandise to match our customers' needs and preferences. A key component of our front store strategy is our ExtraCare ® card program, which is helping us continue to build our loyal customer base. The ExtraCare program is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows us to balance our marketing efforts so we can reward our best customers by providing them automatic sale prices, customized coupons, ExtraBucks ® rewards and other benefits. We continue to launch and enhance new and exclusive brands to create unmatched offerings in beauty. Another component of our front store strategy is our unique product offerings, which include a full range of high-quality CVS Pharmacy ® and proprietary brand products that are only available through CVS Pharmacy stores. We currently carry approximately 7,000 CVS Pharmacy and proprietary brand products, which accounted for approximately 22.6% of our front store revenues during 2016. These products include expanded offerings of healthy foods and vitamins. Furthermore, we are tailoring certain groups of stores, such as suburban area stores, to better meet the needs of our customers. This includes the launch of CVS Curbside in late 2016. Developed in partnership with industry leader Curbside, customers can use the CVS Pharmacy app to have front store purchases delivered to their car when they pull up to our store.

MinuteClinic - As of December 31, 2016 , we operated 1,139 MinuteClinic ® locations in 33 states and the District of Columbia, of which 1,053 were located in our retail pharmacy stores, 79 were located in Target stores and seven were located in corporate campuses or other locations. We opened seven new clinics during 2016. Our clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions, provide wellness services and deliver vaccinations. Insurers value our clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. As a result, visits paid for by employers, health insurers or other third parties accounted for approximately 91% of MinuteClinic's total revenues in 2016. MinuteClinic is collaborating with our Pharmacy Services Segment to help meet the needs of CVS Caremark's client plan members by offering programs that can improve member health and lower costs. MinuteClinic is now affiliated with more than 70 major health systems and continues to build a platform that supports primary care.

Long-term Care - Through our Omnicare business, we provide the distribution of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. LTC's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. We provide pharmacy consulting, including monthly patient drug therapy evaluations, assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. We also provide pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Onsite Pharmacies - We also operate a limited number of small pharmacies located at client sites, typically under the CarePlus ®, CarePlus CVS Pharmacy ™ or CVS Pharmacy ® name, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Retail Pharmacy Drugstore Development - The addition of new stores has played, and will continue to play, a key role in our continued growth and success. Our store development program focuses on three areas: entering new markets, adding stores within existing markets and relocating stores to more convenient sites. During 2016, we opened 130 new and acquired retail stores, relocated 50 stores and closed 46 stores. During the last five years, we opened more than 1,100 new and relocated stores, and acquired 1,841 stores including the pharmacies acquired from Target. We believe that continuing to grow our store base and locating stores in more accessible markets are essential components to compete effectively in the current health care environment. As a result, we believe that our store development program is an integral part of our ability to maintain our leadership position given the changing health care landscape and to meet the increasing needs of our customers.

Retail/LTC Information Systems - We have continued to invest in information systems to enable us to deliver exceptional customer service, enhance safety and quality, and expand our patient care services while lowering operating costs. Leveraging our retail pharmacy fulfillment system, RxConnect and our proprietary WeCARE Workflow, supports our pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating our clinical programs. This solution delivers improved efficiency and enhances the customer experience, as well as providing a framework to accommodate the evolution of pharmacy practice and the expansion of our clinical programs. Our Health Engagement Engine ™ technology and proprietary clinical algorithms enable us to help identify opportunities for our pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including adherence issues, gaps in care and management

of certain chronic health conditions. Our digital strategy empowers the consumer to navigate their pharmacy experience and manage their condition through our on-line and mobile tools that offer utility and convenience. This includes the ability to schedule an appointment at MinuteClinic, get next-in line alerts or health reminders and appointment updates via text messages. Our integrated digital offerings help patients seamlessly manage retail, mail and specialty prescriptions dispensed by a CVS Pharmacy or long-term care location and enhance front store personalization to drive value for customers. We experienced strong adoption of our digital solutions with our mobile app receiving critical acclaim for ease of use and our text message program experiencing significant growth. LTC's Digital Technology suite, Omniview ®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers - The success of our retail drugstore and long-term care businesses is dependent upon our ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Pharmacy benefit managers, managed care organizations, government-funded health care programs, commercial employers and other third party payors accounted for 98.9% of our 2016 pharmacy revenues. No single Retail/LTC payor accounts for 10% or more of our annual consolidated net revenues.

Retail/LTC Seasonality - The majority of our revenues, particularly pharmacy revenues, are generally not seasonal in nature. However, retail front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and retail front store revenues are affected by the timing and severity of the cough, cold and flu season. For additional information, we refer you to "Risks related to the seasonality of our business" in Item 1A. Risk Factors.

Retail/LTC Competition - The retail drugstore business is highly competitive. We believe that we compete principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the markets we serve, we compete with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Wal-Mart), independent pharmacies, restrictive pharmacy networks, membership clubs, Internet companies, and retail health clinics (including urgent care centers), as well as other mail order pharmacies.

LTC pharmaceutical services are highly regional or local in nature and within a given geographic area of operation, highly competitive. Our largest competitor nationally is PharMerica. We also compete with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state medicaid programs or in separate legislation, which may increase the competition that we face in providing services to long-term care facility residents in these states.

Corporate Segment

Our Corporate Segment provides management and administrative services to support the overall operations of the Company. The Corporate Segment consists of certain aspects of our executive management, corporate relations, legal, compliance, human resources, information technology and finance departments.

Generic Sourcing Venture

In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

We fund the growth of our business through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on our working capital practices, we refer you to the caption "Management's Discussion and Analysis - Liquidity and Capital Resources" in our Annual Report to Stockholders for the year ended December 31, 2016, which section is incorporated by reference herein. The majority of our non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government-funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of our consolidated pharmacy revenues, typically settle in less than 30 days. With the exception of our Medicare Part D services, the remainder of our consolidated pharmacy revenues are paid in cash, or with debit or credit cards. As a provider of Medicare Part D services, we contract annually with CMS. Utilization of

services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS may take several quarters which impacts our working capital from year to year.

Colleague Development

As of December 31, 2016, we employed approximately 250,000 colleagues, which included approximately 36,000 pharmacists, nurses, nurse practitioners and physician assistants. The total included approximately 92,000 part-time colleagues who work less than 30 hours per week. To deliver the highest levels of service to our customers, we devote considerable time and attention to our people and service standards. We emphasize attracting and training knowledgeable, friendly and helpful associates to work in our organization.

Intellectual Property

We have registered and/or applied to register a variety of our trademarks and service marks used throughout our business, as well as domain names, and rely on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect our proprietary rights. We regard our intellectual property as having significant value in our Pharmacy Services and Retail/LTC segments. We are not aware of any facts that could materially impact our continuing use of any of our intellectual property.

Government Regulation

Overview - Much of our business is subject to federal and state laws and regulations. In addition, many of our PBM clients and our payors in the Retail/LTC Segment, including insurers, Medicare Part D plans, Managed Medicaid plans and managed care organizations ("MCOs"), are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, our LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which we are subject. The application of these complex legal and regulatory requirements to the detailed operation of our business creates areas of uncertainty. Further, there are numerous proposed health care laws and regulations at the federal and state levels, some of which could adversely affect our business if they are enacted. We are unable to predict what federal or state legislation or regulatory initiatives may be enacted in the future relating to our business or the health care industry in general, or what effect any such legislation or regulations might have on our business. Any failure or alleged failure to comply with applicable laws and regulations as summarized below, or any adverse applications of, or changes in, the laws and regulations affecting our business, could have a material adverse effect on our operating results and/or financial condition. See Item 3, "Legal Proceedings" for further information.

Although we believe that we are in material compliance with existing laws and regulations applicable to our various business lines, we cannot give any assurances that our business, financial condition and results of operations will not be materially adversely affected, or that we will not be required to materially change our business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to our business, the pharmacy services, retail pharmacy, long-term care or retail clinic industry or to the health care industry generally; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services, retail pharmacy, long-term care or retail clinic industry or of the health care industry generally; (iv) institution of government enforcement actions against us; (v) adverse developments in any pending *qui tam* lawsuit against us, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against us; or (vi) adverse developments in other pending or future legal proceedings against us or affecting the pharmacy services, retail pharmacy, long-term care or retail clinic industry or the health care industry generally.

Laws and Regulations Related to Each Operating Segment of Our Business

Laws Related to Reimbursement by Government Programs - We are subject to various state and federal laws concerning our submission of claims for reimbursement by Medicare, Medicaid and other government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, multiples damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act ("FCA"), the federal Anti-Kickback statute, various state false claims acts and anti-kickback statutes, the federal "Stark Law" and related state laws. In particular, the FCA prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. As part of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "ACA"), the federal Anti-Kickback Statute was amended in 2010 to provide that any claim for government reimbursement violates the FCA where it results from a

violation of the Anti-Kickback Statute. Most states have enacted false claims laws analogous to the FCA, and both federal and state false claims laws permit private individuals to file *qui tam* or "whistleblower" lawsuits on behalf of the federal or state government. Further, the federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The 21st Century Cures Act ("Cures Act"), enacted in December 2016, among other things shifted payment for Medicare Part B durable medical equipment ("DME") infused drugs from one pricing benchmark to another as of January 1, 2017. This change, depending upon the particular drug, is expected to cause both increases and decreases in reimbursement, although the overall impact is expected to be negative. In addition, the change in presidential administration has caused uncertainty regarding the implementation of the Cures Act, meaning that the full impact of this new law on the Company is uncertain.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other government-sponsored health care programs.

Antitrust and Unfair Competition - The Federal Trade Commission ("FTC") has authority under Section 5 of the Federal Trade Commission Act ("FTCA") to investigate and prosecute practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various state and federal antitrust and unfair competition laws challenging, among other things: (i) brand drug pricing practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that we appear to have actual or potential market power in a relevant market or CVS Pharmacy or CVS Specialty plays a unique or expanded role in a PBM product offering, our business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties.

Privacy and Confidentiality Requirements - Many of our activities involve the receipt, use and disclosure by us of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, we use and disclose de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have recently incorporated these requirements into state laws.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA") impose extensive requirements on the way in which health plans, health care providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of the American Recovery and Reinvestment Act of 2009, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. It also extended HIPAA privacy and security requirements and penalties directly to business associates. In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA.

Finally, the Health Insurance Marketplaces (formerly known as the "exchanges") are required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Health Insurance Marketplace has implemented for itself or non-Health Insurance Marketplace entities, which include insurers offering plans through the Health Insurance Marketplaces and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the FTCA, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws. These laws have been the basis for investigations, lawsuits and multi-state settlements relating to, among other matters, the marketing

of loyalty programs and health care services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs and disclosures related to how personal data is used and protected.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, Medicare Part D prescription drug plans, expired products, environmental and safety matters, marketing and advertising practices, PBM, long term care and pharmacy operations and various other business practices. These agreements may contain certain ongoing reporting, monitoring or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - Our business is subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in our stores, distribution centers and other facilities. Governmental agencies on the federal, state and local levels have, in recent years, increasingly focused on the retail and health care sectors' compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

Health Reform Legislation - Passed in 2010, ACA affects virtually every aspect of health care in the country. In addition to establishing the framework for every individual to have health coverage, ACA enacted a number of significant health care reforms. Many of these reforms affect the coverage and plan designs that are provided by our health plan clients. As a result, these reforms impact a number of our services and business practices. Some significant ACA provisions are still being finalized (e.g., nondiscrimination in health programs and activities, excise tax on high-cost employer-sponsored health coverage) and all or parts of ACA may be repealed or replaced, so the full impact of ACA on our Company is still uncertain.

Pharmacy and Professional Licensure and Regulation - We are subject to a variety of intersecting state and federal statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians and nurses; registration of facilities with the United States Drug Enforcement Administration ("DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the United States Food and Drug Administration ("FDA"), the Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of local, state and federal agencies, with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the United States Department of Justice, the United States Department of Health and Human Services ("HHS") and others. Many of these agencies have broad enforcement powers, conduct audits on a regular basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Laws and Regulations Related to Our Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect our business as a whole, we are subject to federal, state and local statutes and regulations governing the operation of our Pharmacy Services Segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation seeking to regulate PBM activities in a comprehensive manner has been introduced or enacted in a number of states. This legislation could adversely impact our ability to conduct business on commercially reasonable terms in states where the legislation is in effect.

In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM or specialty pharmacy services. Moreover, any standards established by these organizations could also impact our health plan clients and/or the services we provide to them.

Medicare Part D - The Medicare Part D program, which makes prescription drug coverage available to eligible Medicare beneficiaries through private insurers, regulates all aspects of the provision of Medicare drug coverage, including enrollment, formularies, pharmacy networks, marketing, and claims processing. The Medicare Part D program has undergone significant legislative and regulatory changes since its inception, and continues to attract a high degree of legislative and regulatory scrutiny. The applicable government rules and regulations continue to evolve. CMS has imposed restrictions and issued new requirements to protect Medicare Part D beneficiaries and has used its authority to sanction and impose civil monetary penalties on plans for non-compliance.

Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the ability to limit access to a pharmacy provider network or remove network providers. For example, certain "any willing provider" legislation may require us or our clients to admit a non-participating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively impact the services and economic benefits achievable through a limited pharmacy provider network.

Also, a majority of states now have some form of legislation affecting our ability (and the health plans' ability) to conduct audits of network pharmacies regarding claims submitted to us for payment. These laws could negatively impact our ability to recover overpayments in health care payments stemming from pharmacy audits. Lastly, several states have passed legislation regulating our ability to manage and establish maximum allowable costs ("MAC") for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively impact our ability to establish MAC prices for generic drugs.

Contract Audits - We are subject to audits of many of our contracts, including our PBM client contracts, our PBM rebate contracts, our PBM network contracts, our contracts relating to Medicare Part D and the agreements our pharmacies enter into with other payors. Because some of our contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these agreements are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - We have a contractual arrangement with carriers for the Federal Employee Health Benefits Program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the Federal Employees Health Benefits Act ("FEHBA") and as part of the Federal Employees Health Benefits Program. These arrangements subjects us to certain aspects of FEHBA, and other federal regulations, such as the Federal Employees Health Benefits Acquisition Regulation, that otherwise are not applicable to us.

State Insurance Laws - PDPs and our PBM service contracts, including those in which we assume certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state

departments of insurance are increasing their oversight of PBM activities due to legislation passing in several states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a few states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code. Additionally, some states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

As a PDP, SilverScript is subject to state insurance laws limited to licensure and solvency. In addition, PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

ERISA Regulation - The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, we assist plan sponsors in the administration of the prescription drug portion of their health benefit plans in accordance with the plan designs adopted by the plan sponsors. We do not believe that the conduct of our business subjects us to the fiduciary obligations of ERISA, except when we have specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan, and with respect to the Contraceptive Coverage Mandate, one of the health reforms presently included in ACA.

In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state exchanges. Additionally, NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect our ability to develop and administer formularies, networks and other plan design features on behalf of our insurer, MCO and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Managed Care Reform - In addition to health reforms enacted by ACA, proposed legislation has been considered at the state level, and legislation has been enacted in several states, aimed primarily at providing additional rights and access to drugs to individuals enrolled in managed care plans. This legislation may impact the design and implementation of prescription drug benefit plans sponsored by our PBM health plan clients and/or the services we provide to them. Both the scope of the managed care reform proposals considered by state legislatures and reforms enacted by states to date vary greatly, and the scope of future legislation that may be enacted is uncertain.

Disease Management Services Regulation - We provide disease management programs to PBM plan members for rare medical conditions and arrange for them to receive disease management programs for common medical conditions. State laws regulate the practice of medicine, the practice of pharmacy and the practice of nursing. Clinicians engaged in a professional practice in connection with the provision of disease management services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as preferred provider organizations, third party administrators and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

Laws and Regulations Related to Our Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect our business as a whole, we are subject to federal, state and local statutes and regulations governing the operation of our Retail/LTC Segment specifically. Among these are the following:

Specific FDA Regulation - The FDA generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, medical devices (including mobile medical devices), cosmetics, dietary supplements and certain food items.

Retail Clinics - States regulate retail clinics operated by nurse practitioners or physician assistants through physician oversight, lab licensing and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of our owned and managed retail clinics.

Available Information

CVS Health Corporation is a Delaware corporation. Our corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. Our common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about CVS Health is available through the Company's Web site at *http://www.cvshealth.com* . Our financial press releases and filings with the United States Securities and Exchange Commission ("SEC") are available free of charge within the Investors section of our Web site at *http://www.cvshealth.com/investors* . In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that Web site is *http://www.sec.gov.*

Item 1A. Risk Factors

Our business is subject to various industry, economic, regulatory and other risks and uncertainties. Our business, financial condition, results of operations, cash flows and prospects could be materially adversely affected by any one or more of the following risk factors and by additional risks and uncertainties not presently known to us or that we currently deem to be immaterial:

Risks of declining gross margins in the PBM, retail pharmacy and LTC pharmacy industries.

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, enhanced service offerings and/or higher service levels. In that regard, we maintain contractual relationships with generic pharmaceutical manufacturers and brand name pharmaceutical manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more pharmaceutical manufacturers, or if the discounts or rebates provided by pharmaceutical manufacturers decline, our business and financial results could be adversely affected. Further, competitive pressures in the PBM industry have resulted in our clients sharing in a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. Market dynamics and regulatory changes have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could negatively impact our future profitability. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to patent term extensions, purchase discount and rebate arrangements with pharmaceutical manufacturers, or to formulary management or other PBM services could also reduce the discounts or rebates we receive. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, could adversely impact our profitability.

Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have also been affected by the margin pressures described above, including client demands for lower prices, generic pricing and network reimbursement pressure. In addition, as competition increases in the markets in which we operate, a significant increase in general pricing pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive. A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates could adversely affect our margins, including the shift in pharmacy mix towards 90-day prescriptions at retail and the shift in pharmacy mix towards Medicare Part D prescriptions.

Finally, the margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements. These actions could also adversely affect the margins of our LTC business.

Efforts to reduce reimbursement levels and alter health care financing practices.

The continued efforts of health maintenance organizations, managed care organizations, PBMs, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, as well as litigation and other legal proceedings relating to how drugs are priced, may impact our profitability. In particular, increased utilization of generic pharmaceuticals (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail, specialty, LTC and mail order pharmacies for generic drugs, causing a reduction in the generic profit rate. Historically, the effect of this trend on generic profitability has been mitigated by our efforts to negotiate reduced acquisition costs of generic pharmaceuticals with manufacturers. However, in recent years, there has been significant consolidation within the generic manufacturing industry, and it is possible that this and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic pharmaceuticals and diminish our ability to negotiate reduced acquisition costs. Any inability to offset increased costs or to modify our activities to lessen the impact could have a significant adverse effect on our results of operations.

In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and audits at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are continuing at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices. For example, we anticipate that federal and state governments will continue to review and assess alternative health care delivery systems, payment methodologies and operational requirements for health care providers, including LTC facilities and pharmacies. A change in the composition of pharmacy prescription volume toward programs offering lower reimbursement rates could negatively impact our profitability. Any action taken to repeal or replace all or significant parts of ACA could also impact our profitability, though it is unclear at this time what the full effects will be.

ACA made several significant changes to Medicaid rebates and to reimbursement. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for multi-source (i.e., generic) drugs. This change has negatively affected our reimbursement. In addition, ACA made other changes that affect the coverage and plan designs that are or will be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum medical loss ratio to avoid having to pay rebates to enrollees. These ACA changes may not affect our business directly, but they could indirectly impact our services and/or business practices.

A highly competitive business environment.

Each of our retail pharmacy, LTC pharmacy, retail health clinic and pharmacy services operations currently operates in a highly competitive and evolving health care environment.

The competitive success of our retail pharmacy business, as well as our specialty pharmacy operations with non-Caremark payors, is derived by their ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. As a pharmacy retail business, we compete with other drugstore chains, supermarkets, on-line and other discount retailers, independent pharmacies, membership clubs, convenience stores and mass merchants, some of which are aggressively expanding into markets we serve. We also face competition from other retail health clinics, as well as other mail order pharmacies and PBMs. Competition may also come from other sources in the future. Changes in market dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and the exclusion from new narrow or restricted networks, could materially and adversely impact us.

We could also be adversely affected if we fail to identify or effectively respond to changes in market dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the United States, a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy operations focuses on complex and high-cost medications that serve a relatively limited universe of patients, the future growth of this business depends to a significant extent upon expanding our ability to access key drugs and successfully penetrate key treatment categories.

The competitive success of our LTC pharmacy operations is dependent upon our ability to compete in each geographic region where we have operations. In the geographic regions we serve, we compete with PharMerica Corporation, our largest

competitor, as well as with numerous local and regional institutional pharmacies, pharmacies owned by LTC facilities and local retail pharmacies.

The competitive success of our pharmacy services business is impacted by its ability to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. Competitors in the PBM industry (e.g., Express Scripts, OptumRx, Prime Therapeutics, MedImpact and Humana), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Competition may also come from other sources in the future. In addition, changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could adversely affect our claims volume and/or our competitiveness generally.

Competitors in each of our business areas may offer services and pricing terms that we may not be willing or able to offer. Strong competition in the PBM marketplace has generated greater client demand for lower pricing, increased revenue sharing and enhanced product and service offerings. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings, particularly in a rapidly changing health care industry, we may be unable to remain competitive.

Changes in U.S. policy, laws and regulations, including reform of the United States health care system.

The results of the November 2016 elections have generated uncertainty with respect to, and could result in, significant changes in legislation, regulation and government policy that could significantly impact our business and the health care and retail industries. While it is not possible to predict whether and when any such changes will occur or what form any such changes may take (including through the use of Executive Orders), specific proposals discussed during and after the election that could have a material adverse effect on our business, liquidity and results of operations include, but are not limited to, immigration policies, the repeal of all or part of ACA and other significant changes to health care system legislation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries.

The repeal of all or part of the ACA, significant changes to Medicaid funding or even significant destabilization of the Health Insurance Marketplaces could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Even if ACA remains, significant provisions of ACA have not yet been finalized (e.g., nondiscrimination in health programs and activities, excise tax on high-cost employer-sponsored health coverage) and it is uncertain whether or in what form these provisions will be finalized. We cannot predict the effect, if any, a repeal of all or part of ACA, the implementation or failure to implement the outstanding provisions of ACA, or the enactment of new health care system legislation to replace current legislation may have on our retail pharmacy, LTC pharmacy and pharmacy services operations.

In addition, much of the branded and generic drug product that we sell in our retail, mail and specialty pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the disallowance of tax deductions for imported merchandise or the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material impact on our business, liquidity and results of operations. In addition, other countries may change their business and trade policies and such changes as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations could adversely affect our business.

Finally, comprehensive tax reform is likely to be considered in the current political environment. We expect that tax reform, if enacted, could have a significant impact on the Company. Current proposals aim to lower the U.S. corporate tax rate from 35% to as low as 15% or 20%, but generally broaden the base to which the lower tax rate would apply. Many aspects of tax reform plans remain unknown though, and no proposed legislation has been filed. We cannot say with certainty if tax reform will be enacted, or how it would impact the Company.

Risks related to compliance with a broad and complex regulatory framework.

Our business is subject to numerous federal, state and local laws and regulations. See “Business - Government Regulation.” In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and enforcement activity at both the federal and state levels. Further, uncertainties exist regarding the application of many of these legal requirements to our business. In addition, it is possible that all, or certain provision of the current health care reform legislation may be modified, repealed or otherwise invalidated. Changes in these laws and regulations and the related interpretations and enforcement practices may require extensive system and operating changes that may be difficult to

implement. Untimely compliance or noncompliance with applicable laws and regulations could adversely affect the continued operation of our business, including, but not limited to: imposition of civil or criminal penalties; significant fines or monetary penalties; suspension or disgorgement of payments from government programs; loss of required government certifications or approvals; loss of authorizations to participate in or exclusion from government reimbursement programs, such as the Medicare and Medicaid programs; or loss of registrations or licensure. The regulations to which we are subject include, but are not limited to: the laws and regulations described in the Government Regulation section; accounting standards; financial disclosure; securities laws and regulations; federal anti-trust laws; tax laws and regulations and their possible reform; laws and regulations relating to the protection of the environment and health and safety matters, including those governing exposure to, and the management and disposal of, hazardous materials and wastes; and laws and regulations of the FTC, the FCC, and the Consumer Product Safety Commission, as well as state regulatory authorities, governing the sale, advertisement and promotion of products that we sell, such as Boards of Pharmacy. The FDA, DEA and various states regulate the distribution of pharmaceuticals and controlled substances. We are required to hold valid DEA and state-level registrations and licenses, meet various security and operating standards and comply with the federal and various states' controlled substances acts and their accompanying regulations governing the sale, marketing, packaging, holding and distribution of controlled substances. The DEA, FDA and state regulatory authorities have broad enforcement powers, including the ability to suspend our registrations and licenses, seize or recall products and impose significant criminal, civil and administrative sanctions for violations of these laws and regulations. In addition, our business interests outside of the United States are subject to the Foreign Corrupt Practices Act and other applicable domestic and international laws and regulations. We are also subject to the terms of various government agreements and mandates, including those described in the Government Regulation section. In that regard, our business, financial position and results of operations could be adversely affected by existing and new government legislative, regulatory action and enforcement activity, including, without limitation, any one or more of the following:

- federal and state laws and regulations concerning the submission of claims for reimbursement by Medicare, Medicaid and other government programs, whether at retail, mail, specialty or LTC;
- federal and state laws and regulations governing the purchase, distribution, tracking, management, compounding, dispensing and reimbursement of prescription drugs and related services, whether at retail, mail, specialty or LTC, and applicable registration or licensing requirements;
- heighted enforcement of controlled substances regulations;
- the effect of the expiration of patents covering brand name drugs and the introduction of generic products;
- the frequency and rate of approvals by the FDA of new brand name and generic drugs, or of over-the-counter status for brand name drugs;
- rules and regulations issued pursuant to HIPAA and the HITECH Act; and other federal and state laws affecting the collection, use, disclosure and transmission of health or other personal information, such as federal laws on information privacy precipitated by concerns about information collection through the Internet, state security breach laws and state laws limiting the use and disclosure of prescriber information;
- health care fraud and abuse laws regulations;
- consumer protection laws affecting our health care services, our loyalty programs, our drug discount card programs, the products we sell, the informational calls we make and/or the marketing of our goods and services;
- federal, state and local environmental, health and safety laws and regulations applicable to our business, including the management of hazardous substances, storage and transportation of hazardous materials, and various recordkeeping disclosure and procedure requirements promulgated by the Occupational Safety and Health Administration that may apply to our operations;
- health care reform, managed care reform and plan design legislation;
- laws against the corporate practice of medicine;
- FDA regulation affecting the retail, LTC, specialty or PBM industry;
- government regulation of the development, administration, review and updating of formularies and drug lists including requirements and/or limitations around formulary tiering and patient cost sharing;
- state laws and regulations related to increased oversight of PBM activities by state departments of insurance pharmacy reimbursement for generics and pharmacy audits;
- drug pricing legislation, including "most favored nation" pricing;
- federal and state laws and regulations establishing or changing prompt payment requirements for payments to retail pharmacies;
- impact of network access legislation or regulations, including "any willing provider" laws, on our ability to manage pharmacy networks;
- ERISA and related regulations;
- administration of Medicare Part D, including legislative changes and/or CMS rulemaking and interpretation;
- Medicare and Medicaid regulations applicable to our business, in particular our LTC pharmacies and those of our client's facilities;

- ongoing compliance with consent decrees, corporate integrity agreements, corrective action plans and other agreements with government agencies;
- insurance licensing and other insurance regulatory requirements applicable to offering Medicare Part D programs and services or other health care services; and
- direct regulation of pharmacies or PBMs by regulatory and quasi-regulatory bodies.

The possibility of client losses and/or the failure to win new business.

Our PBM business generates net revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM's client base typically is subject to renewal each year. In some cases, however, PBM clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Our clients are generally well informed and organized, can easily move between our competitors and often seek competing bids prior to expiration of their contracts. In addition, the reputational impact of a service-related incident could negatively affect our business. These factors, together with the impact of competitive pressures, could make it difficult for us to attract new clients, retain existing clients and cross-sell additional services. Further, the PBM industry has been affected by consolidation activity that may continue in the future. In the event one or more of our PBM clients is acquired by an entity that is not also our client, we may be unable to retain all or a portion of the acquired business. These circumstances, either individually or in the aggregate, could result in an adverse effect on our business and financial results. Therefore, we continually face challenges in competing for new PBM business and retaining or renewing our existing PBM business. With respect to our LTC business, reimbursement from skilled nursing facilities for prescriptions we dispense is determined pursuant to our agreements with those skilled nursing facilities. The termination of these agreements generally causes our ability to provide services to any of the residents of that facility to cease, resulting in the loss of revenue from any source for those residents. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to us as the present terms.

Additionally, with respect to our retail and LTC pharmacy businesses, reimbursement under Medicare Part D, as well as reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their pharmacy benefit manager representatives. The loss of those agreements, or a material change in the terms of those agreements, could negatively impact the Company. In addition, restricted networks that exclude our retail or specialty pharmacies negatively impact those businesses.

Risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription products.

The profitability of our business is dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription pharmaceuticals as well as lower-priced generic alternatives to existing brand name products, as the sale of generic alternatives normally yield higher gross margins than brand name equivalents. In addition, inflation in the price of the brand name drugs can affect utilization, particularly given the increase in high deductible health plans. Accordingly, our business could be impacted by a slowdown or delay in the number or magnitude of new and successful prescription pharmaceuticals and/or generic alternatives, as well as the pricing of brand name drugs.

The health of the economy in general and in the markets we serve.

Our business is affected by the economy and consumer confidence in general, including various economic factors, inflation and changes in consumer purchasing power, preferences and/or spending patterns. It is possible that an unfavorable, uncertain or volatile economic environment will cause a decline in drug and health care services utilization and dampen demand for pharmacy benefit management services as well as consumer demand for products sold in our retail stores. Further economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms and our ability to execute sale-leaseback transactions under acceptable terms. These changes in conditions could result in an adverse effect on our business and financial results. This could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments.

The failure or disruption of our information technology systems, our information security systems and our infrastructure to support our business and to protect the privacy and security of sensitive customer and business information.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, ExtraCare customer loyalty program, finance, human resource and other processes. Throughout our operations, we receive, retain and transmit certain confidential information, including PII that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks. Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches including credit card or personally identifiable information breaches, coordinated cyber attacks, vandalism, catastrophic events and human error. Although we deploy a layered approach to address information security threats and vulnerabilities, including ones from a cyber security standpoint, designed to protect confidential information against data security breaches, a compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our business, financial position, and results of operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

Risks relating to the market availability, suppliers and safety profiles of prescription drugs that we purchase and sell.

We dispense significant volumes of brand-name and generic drugs from our retail, LTC, specialty and mail-order pharmacies and through our PBM's network of retail pharmacies. When increased safety risk profiles or manufacturing or other supply issues of specific drugs or classes of drugs occur, or drugs become subject to greater restrictions as controlled substances, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced.

Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can result in lower prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our volumes, net revenues, profitability and cash flows may decline as a result of such regulatory rulings or market changes.

Further, we acquire a substantial amount of our mail and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers are often short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the agreement and may allow the supplier to distribute through channels other than ours. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could have a material adverse effect on our business, financial condition and results of operations. Moreover, many products distributed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages.

A disruption in our business operations could occur as a result of contamination of drugs, a failure to maintain necessary shipment and storage conditions, errors in mail order processing, the unavailability of prescription drugs provided by suppliers, labor disruptions or other unanticipated disruptions at our mail order facilities, call centers, data centers or corporate facilities, among other factors. Such disruption could reduce our ability to process and dispense prescriptions and provide products and services to our customers.

In the event any products we distribute are in limited supply for significant periods of time, our financial condition and results of operations could be materially and adversely affected.

Regulatory and business changes relating to our participation in Medicare Part D.

Medicare Part D has resulted in increased utilization and puts pressure on pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of ACA and changes to the retiree drug subsidy rules, our PBM clients could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that impacts the profitability of our Medicare Part D business; if changes to the regulations impact our ability to retain fees from third parties including network pharmacies; if the government alters Medicare program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if Congress acts to reduce reinsurance thresholds from 80% to 20%; if we fail to design and maintain programs that are attractive to Medicare participants; if CMS imposes restrictions on our Medicare Part D business as a result of audits or other regulatory actions; if we fail to successfully implement corrective action or other remedial measures sufficient to prevent or remove any applicable restrictions that may be imposed by CMS; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare Part D's competitive bidding process, our Medicare Part D services and the ability to expand our Medicare Part D services could be negatively impacted.

Possible changes in industry pricing benchmarks and drug pricing generally.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace Average Wholesale Price ("AWP") or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, pharmaceutical purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs ("FFS Medicaid") are expected to establish pharmacy network payments on the basis of Actual Acquisition Cost ("AAC") by April 1, 2017. This move to an AAC basis in FFS Medicaid could have an impact in reimbursement practices in other commercial and government segments. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish pharmaceutical pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with pharmaceutical manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have an adverse effect on our results of operations. Additionally, any future changes in drug prices could be significantly different than our projections. The effect of these possible changes on our business cannot be predicted at this time.

Product liability, product recall or personal injury issues could damage our reputation; failure to maintain adequate liability insurance coverage.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of pharmaceuticals could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the products or pharmaceuticals we sell or services we provide. Our business involves the provision of professional services including by pharmacists, nurses and nurse practitioners that exposes us to professional liability claims. Should a product or other liability issue arise, the coverage limits under our insurance programs and the indemnification amounts available to us may not be adequate to protect us against claims. We also may not be able to maintain this insurance on acceptable terms in the future. Damage to our reputation in the event of a product liability or personal injury issue or judgment against us or a product recall could have a significant adverse effect on our business, financial condition and results of operations.

Relationship with our retail and specialty pharmacy customers and the demand for our products and services, including propriety brands.

The success of our business depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in our markets, an inability to expand the products being purchased by our clients and customers, or the

failure or inability to obtain or offer particular categories of products could negatively affect our relationship with our clients and customers and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks and mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. Any failure to adequately address some or all of these risks could have an adverse effect on our business, results of operations and financial condition. Additionally, an increase in the sales of our proprietary brands may negatively affect our sales of products owned by our suppliers which, consequently, could adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our financial performance and erode customer loyalty.

Moreover, customer expectations and new technology advances from our competitors have required that our business evolve so that we are able to engage with our retail customers not only face-to-face in our stores but also online and via mobile and social media. Our customers are using computers, tablets, mobile phones and other electronic devices to shop in our stores and online, as well as to provide public reactions concerning each facet of our operation. If we fail to keep pace with dynamic customer expectations and new technology developments, our ability to compete and maintain customer loyalty could be adversely affected.

Finally, our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs), that serve a relatively limited universe of patients. As a result, the future growth of our specialty pharmacy business is dependent largely upon expanding our base of drugs or penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our business, financial condition and results of operations.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these companies are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our results of operations.

We may be unable to successfully integrate companies acquired by us.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company may also be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems, while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disruption of management’s attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and

- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays encountered in the integration process, could have a material adverse effect on our business and results of operation. Furthermore, these acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or geographic markets, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

Our outstanding debt and associated payment obligations could, among other things, limit our ability to make incremental investments in our business.

Our current debt service costs associated with our increased debt levels may dampen incremental investments in our business and limit our flexibility to respond to industry changes and market conditions. In addition, our debt level and related debt service obligations could make it more difficult or expensive for us to obtain any required future financing for working capital, capital expenditures, acquisitions or other purposes. Moreover, we may be unable to refinance existing indebtedness or otherwise access the capital markets for any reason, whether due to market conditions or otherwise. These circumstances could have a material adverse effect on our business operations and financial condition.

Risks related to the seasonality of our business.

Although the majority of our revenues, particularly pharmacy revenues, are generally not seasonal in nature, front store revenues tend to be higher during the December holiday season. Uncharacteristic or extreme weather conditions can adversely impact consumer shopping patterns as well. This could lead to lost sales, as well as increased snow removal and other costs, thereby negatively affecting our short-term results of operations. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season, which is susceptible to large fluctuations from year to year, and our quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. See “Business - Pharmacy Services Seasonality.”

Risks related to litigation and other legal proceedings.

Pharmacy services, retail pharmacy and LTC pharmacy are highly regulated and litigious industries. We are currently subject to various litigation matters, investigations, audits, inspections, government inquiries, and regulatory and legal proceedings. Litigation, and particularly securities and collective or class action litigation, is often expensive and disruptive. Further, under the *qui tam* or “whistleblower” provisions of the federal and various state false claims acts, private citizens may bring lawsuits alleging that a violation of the federal anti-kickback statute or similar laws has resulted in the submission of “false” claims to federal and/or state health care programs, including Medicare and Medicaid. Litigation related to our provision of professional services in our pharmacies, specialty pharmacies, clinics and LTC facilities has also increased as we expand our services along the continuum of health care. We cannot predict the outcome of any of these matters, and the costs incurred may be substantial regardless of outcome. Our business, financial condition and results of operations may be adversely affected, or we may be required to materially change our business practices, as a result of such proceedings. We refer you to Item 3, “Legal Proceedings” for additional information.

The foregoing is not a comprehensive listing of all possible risks and there can be no assurance that we have correctly identified and appropriately assessed all factors affecting the business. As such, we refer you to “Management’s Discussion and Analysis of Financial Condition and Results of Operations,” which includes our “Cautionary Statement Concerning Forward-Looking Statements” at the end of such section, of our Annual Report to Stockholders for the year ended December 31, 2016, which section is incorporated by reference herein.

Item 1B. Unresolved Staff Comments

There are no unresolved SEC Staff Comments.

Item 2. Properties

We lease most of our stores under long-term leases that vary as to rental amounts, expiration dates, renewal options and other rental provisions. For additional information on the amount of our rental obligations for our leases, we refer you to Note 6 “Leases” in our Annual Report to Stockholders for the year ended December 31, 2016 , which section is incorporated by reference herein.

As of December 31, 2016 , we owned approximately 5% of our 8,035 retail stores. Net selling space for our retail stores was approximately 79.2 million square feet as of December 31, 2016 . Approximately 20% of our store base was opened or significantly remodeled within the last five years.

We lease 1,674 retail pharmacies and 79 clinics in Target stores located in 47 states and the District of Columbia.

We own nine distribution centers located in Alabama, California, Hawaii, New York, Rhode Island, South Carolina, Tennessee and Texas and lease 11 additional distribution facilities located in Arizona, Florida, Indiana, Michigan, New Jersey, Pennsylvania, Texas, Virginia and Brazil. The 20 distribution centers total approximately 9.6 million square feet as of December 31, 2016 .

As of December 31, 2016 , we owned five and leased 147 LTC pharmacies in 43 states and owned one LTC repackaging facility in Kentucky.

As of December 31, 2016 , we owned one mail service dispensing pharmacy located in Texas and leased three additional mail order dispensing pharmacies located in Hawaii, Illinois and Pennsylvania; we leased call centers located in Missouri, Pennsylvania, Tennessee and Texas; we leased 38 onsite pharmacy stores and 23 specialty pharmacy stores, and leased 13 specialty mail order pharmacies; we leased 84 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence.

We own our corporate offices located in Woonsocket, Rhode Island, which totals approximately one million square feet. In addition, we lease corporate offices in Scottsdale, Arizona, Northbrook, Illinois, Cincinnati, Ohio, Monroeville, Pennsylvania, Irving, Texas, and Sao Paulo, Brazil.

In connection with certain business dispositions completed between 1991 and 1997, we continue to guarantee lease obligations for approximately 87 former stores. We are indemnified for these guarantee obligations by the respective purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information, we refer you to Note 11 “Commitments and Contingencies” in our Annual Report to Stockholders for the year ended December 31, 2016, which section is incorporated by reference herein.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company’s anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space.

The following is a breakdown by state, District of Columbia, Puerto Rico and Brazil of our retail stores, pharmacies and clinics in Target stores, LTC hub and spoke pharmacies, onsite pharmacy stores, specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies and branches and centers of excellence for infusion and enteral services as of December 31, 2016 :

	Retail Stores	Pharmacies within Target	LTC Hub & Spoke Pharmacies	Onsite Pharmacy Stores	Specialty Pharmacy Stores	Specialty Mail Order Pharmacies	Mail Order Dispensing Pharmacies	Infusion & Enteral Services Locations	Total
United States:									
Alabama	159	22	2	1	1	—	—	1	186
Alaska	—	3	—	—	—	—	—	—	3
Arizona	152	45	2	—	1	1	—	3	204
Arkansas	15	8	2	—	—	—	—	1	26
California	878	250	9	—	3	1	—	8	1,149
Colorado	—	39	3	—	1	—	—	1	44
Connecticut	153	20	1	1	—	—	—	1	176
Delaware	17	3		—	—	—	—	—	20
District of Columbia	59	1	—	—	1	—	—	—	61
Florida	756	121	6	1	2	2	—	7	895
Georgia	312	42	2	3	1	—	—	1	361
Hawaii	63	6	—	—	1	—	1	—	71
Idaho	—	2	1	—	—	—	—	1	4
Illinois	282	88	7	1	—	1	1	2	382
Indiana	303	30	4	—	—	—	—	3	340
Iowa	20	18	2	—	—	—	—	1	41
Kansas	40	14	2	—	—	1	—	2	59
Kentucky	68	9	9	—	—	—	—	—	86
Louisiana	119	15	3	—	—	—	—	1	138
Maine	22	5	1	—	—	—	—	1	29
Maryland	182	39	2	5	—	—	—	1	229
Massachusetts	357	39	2	2	2	1	—	1	404
Michigan	250	51	4	1	—	1	—	2	309
Minnesota	61	74	6	1	—	—	—	2	144
Mississippi	52	5	1	1	—	—	—	1	60
Missouri	95	33	6	1	—	—	—	1	136
Montana	14	2	1	—	—	—	—	—	17
Nebraska	19	11	1	—	—	—	—	1	32
Nevada	87	15	2	—	—	—	—	2	106
New Hampshire	40	9	1	—	—	—	—	—	50
New Jersey	293	45	3	4	—	1	—	1	347
New Mexico	19	6	1	—	—	—	—	1	27
New York	487	73	7	—	1	—	—	7	575
North Carolina	314	49	4	2	1	1	—	3	374
North Dakota	6	—	—	—	—	—	—	—	6
Ohio	320	59	7	1	—	—	—	4	391
Oklahoma	62	15	2	—	—	—	—	1	80
Oregon	—	18	2	—	1	—	—	1	22
Pennsylvania	410	64	6	3	1	1	1	2	488
Puerto Rico	24	—	—	—	—	1	—	—	25
Rhode Island	63	4	1	—	1	—	—	1	70
South Carolina	191	19	3	1	1	—	—	2	217
South Dakota	—	3	1	—	—	—	—	—	4
Tennessee	135	27	3	1	—	1	—	3	170
Texas	684	133	10	3	2	—	1	5	838
Utah	12	13	2	—	—	—	—	1	28
Vermont	10	—	—	—	—	—	—	—	10
Virginia	283	58	7	4	1	—	—	2	355

Washington	8	30	4	—	1	—	—	2	45
West Virginia	51	6	2	—	—	—	—	—	59
Wisconsin	51	33	5	1	—	—	—	1	91
Wyoming	—	—	—	—	—	—	—	2	2
Total United States	7,998	1,674	152	38	23	13	4	84	9,986
Brazil	37	—	—	—	—	—	—	—	37
Total	8,035	1,674	152	38	23	13	4	84	10,023

Item 3. Legal Proceedings

I. Legal Proceedings

We refer you to the Note 11 “Commitments and Contingencies” contained in the “Notes to the Consolidated Financial Statements” of our Annual Report to Stockholders for the year ended December 31, 2016 , which section is incorporated by reference herein.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of certain environmental legal proceedings if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. The Company is in the process of negotiating with United States Environmental Protection Agency, Region 2 and the United States Department of Justice to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with three retail pharmacy locations in Puerto Rico. These proceedings are not material to the Company's business or financial position.

Item 4. Mine Safety Disclosures

Not applicable.

Executive Officers of the Registrant

Executive Officers of the Registrant

The following sets forth the name, age and biographical information for each of our executive officers as of February 9, 2017 . In each case the officer's term of office extends to the date of the board of directors meeting following the next annual meeting of stockholders of the Company. Previous positions and responsibilities held by each of the executive officers over the past five years are indicated below:

Lisa G. Bisaccia , age 60, Executive Vice President of CVS Health Corporation since March 2015 and Chief Human Resources Officer of CVS Health Corporation since January 2010; Senior Vice President of CVS Health Corporation from January 2010 through February 2015; Vice President, Human Resources of CVS Pharmacy, Inc. from September 2004 through December 2009. Ms. Bisaccia is also a member of the Board of Directors of Aramark, a leading global provider of food, facilities and uniform services.

Eva C. Boratto , age 50, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since July 2013; Senior Vice President of PBM Finance from July 2010 through June 2013; Vice President, U.S. Market Finance Leader of Merck & Co., Inc. from June 2009 through June 2010.

Troyen A. Brennan, M.D ., age 62, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna, Inc. from February 2006 through November 2008.

David M. Denton , age 51, Executive Vice President and Chief Financial Officer of CVS Health Corporation since January 2010; Senior Vice President and Controller/Chief Accounting Officer of CVS Health Corporation from March 2008 until December 2009; Senior Vice President, Financial Administration of CVS Health Corporation and CVS Pharmacy, Inc. from April 2007 to March 2008. Mr. Denton is also a member of the Board of Directors of Coach, Inc., a leading retailer of premium bags and luxury accessories.

Helena B. Foulkes , age 52, Executive Vice President of CVS Health Corporation and President of CVS Pharmacy since January 2014; Executive Vice President and Chief Health Care Strategy and Marketing Officer of CVS Health Corporation from March 2011 through December 2013; Executive Vice President and Chief Marketing Officer of CVS Health Corporation from January 2009 through February 2011. Ms. Foulkes is also a member of the Board of Directors of The Home Depot, Inc., a leading home improvement retailer.

Stephen J. Gold , age 57, Executive Vice President of CVS Health Corporation since March 2015 and Chief Information Officer of CVS Health Corporation since July 2012; Senior Vice President of CVS Health Corporation from July 2012 through February 2015; Senior Vice President and Chief Information Officer of Avaya, Inc. from May 2010 through June 2012; Executive Vice President, Chief Information Officer and Chief Technology Officer of GSI Commerce, Inc. from February 2005 through April 2010.

J. David Joyner , age 52, Executive Vice President of CVS Health Corporation since March 2011 and Executive Vice President of Sales and Account Services, CVS Caremark since March 2004.

Robert O. Kraft , age 46, Executive Vice President of CVS Health Corporation and President - Omnicare since August 2015; Senior Vice President and Chief Financial Officer of Omnicare from September 2012 through August 2015; Senior Vice President - Finance of Omnicare from November 2010 through September 2012; PricewaterhouseCoopers LLP from September 1992 to November 2010, where he was a partner. Mr. Kraft is also a member of the Board of Directors of Medpace Holdings, Inc. a global clinical contract research organization providing Phase I-IV clinical development services to the biotechnology, pharmaceutical and medical device industries.

Larry J. Merlo, age 61, President and Chief Executive Officer of CVS Health Corporation since March 2011; President and Chief Operating Officer of CVS Health Corporation from May 2010 through March 2011; President of CVS Pharmacy from January 2007 through August 2011; Executive Vice President of CVS Health Corporation from January 2007 through May 2010; also a director of CVS Health Corporation since May 2010.

Thomas M. Moriarty , age 53, Executive Vice President and General Counsel of CVS Health Corporation since October 2012 and Chief Strategy Officer since March 2014; General Counsel of Celgene Corporation, a global biopharmaceutical company, from May 2012 through September 2012; General Counsel and Corporate Secretary of Medco

Health Solutions, Inc. (“Medco”), a pharmacy benefit management company, from March 2008 through April 2012; also President of Global Pharmaceutical Strategies of Medco from March 2011 through April 2012; Senior Vice President, Pharmaceutical Strategies and Solutions of Medco from September 2007 through March 2011.

Jonathan C. Roberts , age 61, Executive Vice President of CVS Health Corporation and President of CVS Caremark since September 2012; Executive Vice President of CVS Health Corporation and Chief Operating Officer of CVS Caremark from October 2010 through August 2011; Executive Vice President, Rx Purchasing, Pricing and Network Relations of CVS Health Corporation from January 2009 through October 2010.

Andrew J. Sussman, M.D. , age 51, Executive Vice President of CVS Health Corporation since March 2015, Associate Chief Medical Officer of CVS Health Corporation since March 2011 and President of CVS MinuteClinic since September 2009; Senior Vice President of CVS Health Corporation from March 2011 through March 2015; Executive Vice President and Chief Operating Officer of the University of Massachusetts Memorial Medical Center, the major teaching affiliate of UMass Medical School, from May 2004 through August 2009.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Our common stock is listed on the New York Stock Exchange under the symbol "CVS." The table below sets forth the high and low closing prices of our common stock on the New York Stock Exchange Composite Tape and the quarterly cash dividends declared per share of common stock during the periods indicated.

		First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2016	High	$ 104.05	$ 106.10	$ 98.06	$ 88.80	$ 106.10
	Low	$ 89.65	$ 93.21	$ 88.99	$ 73.53	$ 73.53
	Cash dividends per common share	$ 0.425	$ 0.425	$ 0.425	$ 0.425	$ 1.70
2015	High	$ 104.56	$ 106.47	$ 113.45	$ 105.29	$ 113.45
	Low	$ 94.16	$ 98.74	$ 95.12	$ 91.56	$ 91.56
	Cash dividends per common share	$ 0.350	$ 0.350	$ 0.350	$ 0.350	$ 1.40

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Company's Board of Directors. As of February 3, 2017 , there were 22,164 registered shareholders according to the records maintained by our transfer agent.

The following share repurchase programs were authorized by the Company's Board of Directors:

In billions Authorization Date	Authorized	Remaining
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 15.0
December 15, 2014 ("2014 Repurchase Program")	$ 10.0	$ 3.2
December 17, 2013 ("2013 Repurchase Program")	$ 6.0	$ —

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2016 and 2014 Repurchase Programs may be modified or terminated by the Board of Directors at any time.

Pursuant to the authorization under the 2014 Repurchase Program, effective August 29, 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion . Upon payment of the $3.6 billion purchase price on January 6, 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares at a price of $80.34 per share, which were placed into treasury stock in January 2017. At the conclusion of the ASRs, the Company may receive additional shares equal to the remaining 20% of the $3.6 billion notional amount. The ultimate number of shares the Company may receive will fluctuate based on changes in the daily volume-weighted average price of the Company's stock over a period beginning on January 6, 2017 and ending on or before July 6, 2017. If the mean daily volume-weighted average price of the Company's common stock, less a discount (the "forward price"), during the ASRs falls below $80.34 per share, the Company will receive a higher number of shares from Barclays. If the forward price rises above $80.34 per share, the Company will either receive fewer shares from Barclays or, potentially have an obligation to Barclays which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASRs, the maximum number of shares that could be received or delivered is 90.1 million .

Pursuant to the authorization under the 2014 Repurchase Program, effective December 11, 2015, the Company entered into a $725 million fixed dollar ASR with Barclays. Upon payment of the $725 million purchase price on December 14, 2015, the Company received a number of shares of its common stock equal to 80% of the $725 million notional amount of the ASR or approximately 6.2 million shares. The initial 6.2 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in December 2015. The ASR was accounted for as an initial treasury stock transaction of $580 million and a forward contract of $145 million. The forward contract was classified as an equity instrument and was recorded

within capital surplus on the consolidated balance sheet. On January 28, 2016, the Company received 1.4 million shares of common stock, representing the remaining 20% of the $725 million notional amount of the ASR, thereby concluding the ASR. The remaining 1.4 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in January 2016 and the forward contract was reclassified from capital surplus to treasury stock.

Pursuant to the authorization under the 2013 Repurchase Program, effective January 2, 2015, the Company entered into a $2.0 billion fixed dollar ASR agreement with J.P. Morgan Chase Bank ("JP Morgan"). Upon payment of the $2.0 billion purchase price on January 5, 2015, the Company received a number of shares of its common stock equal to 80% of the $2.0 billion notional amount of the ASR agreement or approximately 16.8 million shares, which were placed into treasury stock in January 2015. On May 1, 2015, the Company received approximately 3.1 million shares of common stock, representing the remaining 20% of the $2.0 billion notional amount of the ASR, thereby concluding the ASR. The remaining 3.1 million shares of common stock delivered to the Company by JP Morgan were placed into treasury stock in May 2015. The ASR was accounted for as an initial treasury stock transaction of $1.6 billion and a forward contract of $0.4 billion . The forward contract was classified as an equity instrument and was initially recorded within capital surplus on the consolidated balance sheet and was reclassified to treasury stock upon the settlement of the ASR in May 2015.

In the ASR transactions described above, the initial repurchase of the shares and delivery of the remainder of the shares to conclude the ASR, resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

During the year ended December 31, 2016, the Company repurchased an aggregate of 47.5 million shares of common stock for approximately $4.5 billion under the 2014 Repurchase Program. As of December 31, 2016, there remained an aggregate of approximately $18.2 billion available for future repurchases under the 2016 and 2014 Repurchase Programs, $3.6 billion of which was used for the ASR effective January 6, 2017 described previously. As of December 31, 2015, the 2013 Repurchase Program was complete.

Fiscal Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs
October 1, 2016 through October 31, 2016	—	$ —	—	$ 3,691,002,299
November 1, 2016 through November 30, 2016	5,425,000	$ 75.11	5,425,000	$ 18,283,540,767
December 1, 2016 through December 31, 2016	700,000	$ 75.91	700,000	$ 18,230,407,177
	6,125,000		6,125,000	

Item 6. Selected Financial Data

The selected consolidated financial data of CVS Health Corporation as of and for the periods indicated in the five-year period ended December 31, 2016 have been derived from the consolidated financial statements of CVS Health Corporation. The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated elsewhere herein.

In millions, except per share amounts	2016	2015	2014	2013	2012
Statement of operations data:					
Net revenues	$ 177,526	$ 153,290	$ 139,367	$ 126,761	$ 123,120
Gross profit	28,857	26,528	25,367	23,783	22,488
Operating expenses	18,519	17,074	16,568	15,746	15,278
Operating profit	10,338	9,454	8,799	8,037	7,210
Interest expense, net	1,058	838	600	509	557
Loss on early extinguishment of debt	643	—	521	—	348
Income tax provision	3,317	3,386	3,033	2,928	2,436
Income from continuing operations	5,320	5,230	4,645	4,600	3,869
Income (loss) from discontinued operations, net of tax	(1)	9	(1)	(8)	(7)
Net income	5,319	5,239	4,644	4,592	3,862
Net (income) loss attributable to noncontrolling interest	(2)	(2)	—	—	2
Net income attributable to CVS Health	$ 5,317	$ 5,237	$ 4,644	$ 4,592	$ 3,864
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 4.93	$ 4.65	$ 3.98	$ 3.78	$ 3.05
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ 0.01	$ —	$ (0.01)	$ (0.01)
Net income attributable to CVS Health	$ 4.93	$ 4.66	$ 3.98	$ 3.77	$ 3.04
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 4.91	$ 4.62	$ 3.96	$ 3.75	$ 3.02
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ 0.01	$ —	$ (0.01)	$ (0.01)
Net income attributable to CVS Health	$ 4.90	$ 4.63	$ 3.96	$ 3.74	$ 3.02
Cash dividends per common share	$ 1.70	$ 1.40	$ 1.10	$ 0.90	$ 0.65
Balance sheet and other data:					
Total assets [(1)]	$ 94,462	$ 92,437	$ 73,202	$ 70,550	$ 65,474
Long-term debt	$ 25,615	$ 26,267	$ 11,630	$ 12,767	$ 9,079
Total shareholders' equity	$ 36,834	$ 37,203	$ 37,963	$ 37,938	$ 37,653
Number of stores (at end of year)	9,750	9,681	7,866	7,702	7,508

(1) As of January 1, 2016, the Company early adopted Accounting Standard Update No. 2015-17, *Income Taxes* (Topic 740) issued by the Financial Accounting Standards Board in November 2015. The effect of the retrospective adoption on the Company's historical consolidated balance sheets is a reduction in current assets and deferred income taxes of $1.2 billion , $985 million , $902 million and $693 million as of December 31, 2015, 2014, 2013 and 2012, respectively.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

We refer you to "Management's Discussion and Analysis of Financial Condition and Results of Operations," which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section of our Annual Report to Stockholders for the year ended December 31, 2016 , which section is incorporated by reference herein.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

As of December 31, 2016 , the Company did not have any interest rate, foreign currency exchange rate or commodity derivative instruments in place and believes that as of December 31, 2016 its exposure to interest rate risk (inherent in the Company's debt portfolio), foreign currency exchange rate risk and commodity price risk is not material.

Item 8. Financial Statements and Supplementary Data

We refer you to the "Consolidated Statements of Income," "Consolidated Statements of Comprehensive Income," "Consolidated Balance Sheets," "Consolidated Statements of Shareholders' Equity," "Consolidated Statements of Cash Flows," "Notes to Consolidated Financial Statements," and "Report of Independent Registered Public Accounting Firm" of our Annual Report to Stockholders for the year ended December 31, 2016 , which sections are incorporated by reference herein.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of disclosure controls and procedures: The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2016 , have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its subsidiaries would be made known to such officers on a timely basis.

Internal control over financial reporting: We refer you to "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm" of our Annual Report to Stockholders for the fiscal year ended December 31, 2016 , which are incorporated by reference herein, for management's report on the Company's internal control over financial reporting and the Independent Registered Public Accounting Firm's report with respect to the effectiveness of internal control over financial reporting.

Changes in internal control over financial reporting: On August 18, 2015, the Company completed its acquisition of Omnicare and on December 16, 2015, the Company completed its acquisition of the pharmacies and clinics of Target. During the three months ended December 31, 2016, the Company completed the process of integrating the applicable internal controls for each business into its internal control over financial reporting for the rest of the Company. Other than the foregoing, there have been no changes in our internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Securities Exchange Act Rule 13a-15 or Rule 15d-15 that occurred in the three months ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

No events have occurred during the fourth quarter that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

We refer you to our Proxy Statement for the 2017 Annual Meeting of Stockholders under the captions “Committees of the Board,” “Code of Conduct,” “Director Nominations,” “Audit Committee Report,” “Biographies of our Board Nominees,” and “Section 16(a) Beneficial Ownership Reporting Compliance,” which sections are incorporated by reference herein. Biographical information on our executive officers is contained in Part I of this Annual Report on Form 10-K.

Item 11. Executive Compensation

We refer you to our Proxy Statement for the 2017 Annual Meeting of Stockholders under the captions “Executive Compensation and Related Matters,” including “Compensation Discussion & Analysis” and “Management Planning and Development Committee Report,” which sections are incorporated by reference herein.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

We refer you to our Proxy Statement for the 2017 Annual Meeting of Stockholders under the captions “Share Ownership of Directors and Certain Executive Officers,” and “Share Ownership of Principal Stockholders” which sections are incorporated by reference herein, for information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the Company’s common stock that may be issued upon the exercise of options, warrants and rights under all of our equity compensation plans as of December 31, 2016 .

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1]	Weighted average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1]
Equity compensation plans approved by stockholders	23,275	$ 68.60	17,645
Equity compensation plans not approved by stockholders	—	—	—
Total	23,275	$ 68.60	17,645

(1) Shares in thousands.

Item 13. Certain Relationships and Related Transactions and Director Independence

We refer you to our Proxy Statement for the 2017 Annual Meeting of Stockholders under the caption “Independence Determinations for Directors” and “Certain Transactions with Directors and Officers,” which sections are incorporated by reference herein.

Item 14. Principal Accountant Fees and Services

We refer you to our Proxy Statement for the 2017 Annual Meeting of Stockholders under the caption “Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm,” which section is incorporated by reference herein.

PART IV

Item 15. Exhibits and Financial Statement Schedules

A. Documents filed as part of this report:

1. Financial Statements:

The following financial statements are incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2016, as provided in Item 8 hereof:

2. Financial Statement Schedules

All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

B. Exhibits

Exhibits marked with an asterisk (*) are hereby incorporated by reference to exhibits or appendices previously filed by the Registrant as indicated in brackets following the description of the exhibit.

Exhibit	Description
2.1*	Agreement and Plan of Merger dated as of November 1, 2006 among, the Registrant, Caremark Rx, Inc. and Twain MergerSub Corp. (incorporated by reference to Exhibit 2.1 to the Registrant's Registration Statement No. 333-139470 on Form S-4 filed December 19, 2006).
2.2*	Amendment No. 1 dated as of January 16, 2007 to the Agreement and Plan of Merger dated as of November 1, 2006 among the Registrant, Caremark Rx, Inc. and Twain Merger Sub Corp. (incorporated by reference to Exhibit 2.2 to the Registrant's Registration Statement No. 333-139470 on Form S-4/A filed January 16, 2007).
2.3*	Waiver Agreement dated as of January 16, 2007 between the Registrant and Caremark Rx, Inc. with respect to the Agreement and Plan Merger dated as of November 1, 2006 by and between Registrant and Caremark Rx, Inc (incorporated by reference to Exhibit 2.3 to the Registrant's Registration Statement No. 333-139470 on Form S-4/A filed January 16, 2007).
2.4*	Amendment to Waiver Agreement, dated as of February 12, 2007, between Registrant and Caremark Rx, Inc. (incorporated by reference to Exhibit 99.2 to the Registrant's Current Report on Form 8-K dated February 13, 2007; Commission File No. 001-01011).
2.5*	Amendment to Waiver Agreement, dated as of March 8, 2007, between Registrant and Caremark Rx, Inc. (incorporated by reference to Exhibit 99.2 to the Registrant's Current Report on Form 8-K dated March 8, 2007; Commission File No. 001-01011).
2.6*	Agreement and Plan of Merger dated as of August 12, 2008, among the Registrant, Longs Drug Stores Corporation and Blue MergerSub Corp. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated August 13, 2008; Commission File No. 001-01011).
2.7*	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated May 21, 2015; Commission File No. 001-01011).

3.1*	Amended and Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1 of Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1996; Commission File No. 001-01011).
3.1A*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation, effective May 13, 1998 (incorporated by reference to Exhibit 4.1A to Registrant's Registration Statement No. 333-52055 on Form S-3/A dated May 18, 1998).
3.1B*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K dated March 22, 2007; Commission File No. 001-01011).
3.1C*	Certificate of Merger dated May 9, 2007 (incorporated by reference to Exhibit 3.1C to Registrant's Quarterly Report on Form 10-Q dated November 1, 2007; Commission File No. 001-01011).
3.1D*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K dated May 13, 2010; Commission File No. 001-01011).
3.1E*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report On Form 8-K dated May 10, 2012; Commission File No. 001-01011).
3.1F*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report On Form 8-K dated May 13, 2013; Commission File No. 001-01011).
3.1G*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report on Form 8-K dated September 3, 2014 (Commission File No. 001-01011)).
3.2*	By-laws of the Registrant, as amended and restated (incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K dated January 26, 2016; Commission File No. 001-01011).
4	Pursuant to Regulation S-K, Item 601(b)(4)(iii)(A), no instrument which defines the rights of holders of long-term debt of the Registrant and its subsidiaries is filed with this report. The Registrant hereby agrees to furnish a copy of any such instrument to the Securities and Exchange Commission upon request.
4.1*	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant on Form 8-B dated November 4, 1996; Commission File No. 001-01011).
10.1*	Stock Purchase Agreement dated as of October 14, 1995 between The TJX Companies, Inc. and Melville Corporation, as amended November 17, 1995 (incorporated by reference to Exhibits 2.1 and 2.2 to Melville's Current Report on Form 8-K dated December 4, 1995; Commission File No. 001-01011).
10.2*	Stock Purchase Agreement dated as of March 25, 1996 between Melville Corporation and Consolidated Stores Corporation, as amended May 3, 1996 (incorporated by reference to Exhibits 2.1 and 2.2 to Melville's Current Report on Form 8-K dated May 5, 1996; Commission File No. 001-01011).
10.3*	Distribution Agreement dated as of September 24, 1996 among Melville Corporation, Footstar, Inc. and Footstar Center, Inc. (incorporated by reference to Exhibit 99.1 to Melville's Current Report on Form 8-K dated October 28, 1996; Commission File No. 001-01011).
10.4*	Tax Disaffiliation Agreement dated as of September 24, 1996 among Melville Corporation, Footstar, Inc. and certain subsidiaries named therein (incorporated by reference to Exhibit 99.2 to Melville's Current Report on Form 8-K dated October 28, 1996; Commission File No. 001-01011).
10.5*	Stockholder Agreement dated as of December 2, 1996 between the Registrant, Nashua Hollis CVS, Inc. and Linens 'n Things, Inc. (incorporated by reference to Exhibit 10(i)(6) to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1997; Commission File No. 001-01011).
10.6*	Tax Disaffiliation Agreement dated as of December 2, 1996 between the Registrant and Linens 'n Things, Inc. and certain of their respective affiliates (incorporated by reference to Exhibit 10(i)(7) to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1997; Commission File No. 001-01011).

10.7*	Four Year Credit Agreement dated as of May 12, 2011 by and among the Registrant, the lenders party thereto, Barclays Capital and JP Morgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and the Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2011; Commission File No. 001-01011).
10.8*	Amendment No. 1, dated as of November 22, 2011, to the Credit Agreement dated as of May 12, 2011 by and among the Registrant, the Lenders party thereto, the Co-Syndication Agents and Co-Documentation Agents named therein, and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2011; Commission File No. 001-01011).
10.9*	Credit Agreement dated as of May 23, 2013, by and among the Registrant, the lenders party thereto, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of New York Mellon, as Administrative Agent. (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2013 (Commission File No. 001-01011).
10.10*	Amendment No. 2, dated as of May 23, 2013, to the Credit Agreement dated as of May 12, 2011, by and among the Registrant, the lenders party thereto, Barclays Capital and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of New York Mellon, as Administrative Agent, as previously amended by Amendment No. 1, dated as of November 22, 2011 (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2013 (Commission File No. 001-01011).
10.11*	Second Amended and Restated Credit Agreement, dated as of July 24, 2014, by and among the Registrant, the lenders party thereto, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014 (Commission File No. 001-01011).
10.12*	Five Year Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2015 (Commission File No. 001-01011).
10.13	Credit Agreement dated as of January 3, 2017, by and among the Registrant, the lenders party thereto, and Barclays Bank PLC, as Administrative Agent.
10.14*	The Registrant's Supplemental Retirement Plan for Select Senior Management I as amended and restated in December 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009; Commission File No. 001-01011).
10.15*	The Registrant's 1996 Directors Stock Plan, as amended and restated November 5, 2002 (incorporated by reference to Exhibit 10.18 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 28, 2002; Commission File No. 001-01011).
10.16*	The Registrant's 1997 Incentive Compensation Plan as amended through December 2008 (incorporated by reference to Exhibit 10.8 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009; Commission File No. 001-01011).
10.17*	Caremark Rx, Inc. 2004 Incentive Stock Plan (incorporated by reference to Exhibit 99.2 of the Registrant's Registration Statement No. 333-141481 on Form S-8 filed March 22, 2007; Commission File No. 011-01011).
10.18*	The Registrant's Deferred Stock Compensation Plan, as amended (incorporated by reference to Exhibit 10.17 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.19	The Registrant's Deferred Compensation Plan, as amended.

10.20*	The Registrant's 2010 Incentive Compensation Plan, as amended through January 15, 2013 (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 27, 2015; Commission File No. 001-01011).
10.21*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 10.20 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.22	The Registrant's 2016 Management Incentive Plan.
10.23	The Registrant's 2016 Executive Incentive Plan.
10.24*	The Registrant's Long-Term Incentive Plan (incorporated by reference to Exhibit 10.21 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011).
10.25	The Registrant's Partnership Equity Program, as amended.
10.26*	The Registrant's Severance Plan for Non-Store Employees amended as of January 2015 (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.27	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended.
10.28*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the year ended December 31, 2013; Commission File No. 001-01011).
10.29*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.30*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.31*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.32*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.33*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.34*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.35*	Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008; Commission File No. 001-01011).
10.36*	Amendment dated December 21, 2012 to the Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).

10.37	Form of Non-Qualified Stock Option Agreement between the Registrant and the Registrant's President and Chief Executive Officer.
10.38	Form of Restricted Stock Unit Agreement between the Registrant and the Registrant's President and Chief Executive Officer.
10.39*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated January 20, 2015; Commission File No. 001-01011).
10.40*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Financial Officer (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010; Commission File No. 001-01011).
10.41*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Financial Officer (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.42*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and President of CVS Caremark (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.43*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and President of CVS Caremark (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.44	Restricted Stock Unit Agreement dated April 1, 2016 between the Registrant and the Registrant's Executive Vice President and President of CVS Caremark.
10.45	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and the Registrant's Executive Vice President and President of CVS Caremark.
10.46*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and President of CVS Pharmacy (incorporated by reference to Exhibit 10.43 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.47*	Amendment dated as of December 31, 2012 to the Change in Control Agreement between the Registrant and the Registrant's Executive Vice President and President of CVS Pharmacy (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.48*	Change in Control Agreement dated October 1, 2012 between the Registrant and the Registrant's Executive Vice President, Chief Strategy Officer and General Counsel (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
10.49*	Restrictive Covenant Agreement dated June 1, 2014 between the Registrant and the Registrant's Executive Vice President, Chief Strategy Officer and General Counsel (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
13	Portions of the 2016 Annual Report to Stockholders of CVS Health Corporation, which are specifically designated in this Form 10-K as being incorporated by reference.
21	Subsidiaries of the Registrant.
23	Consent of Ernst & Young LLP.

31.1	Certification by the Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification by the Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification by the Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification by the Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the year ended December 31, 2016 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Income, (ii) the Consolidated Balance Sheets, (iii) the Consolidated Statements of Cash Flows and (iv) related notes.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Annual Report on Form 10-K to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS HEALTH CORPORATION

Date: February 9, 2017

By: /s/ DAVID M. DENTON

David M. Denton

Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ RICHARD M. BRACKEN **Richard M. Bracken**	Director	February 9, 2017
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 9, 2017
/s/ EVA C. BORATTO **Eva C. Boratto**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 9, 2017
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 9, 2017
/s/ DAVID M. DENTON **David M. Denton**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 9, 2017
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 9, 2017
/s/ DAVID W. DORMAN **David W. Dorman**	Chairman of the Board and Director	February 9, 2017
Anne M. Finucane	Director	
/s/ LARRY J. MERLO **Larry J. Merlo**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 9, 2017
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 9, 2017
/s/ RICHARD J. SWIFT **Richard J. Swift**	Director	February 9, 2017
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 9, 2017
/s/ TONY L. WHITE **Tony L. White**	Director	February 9, 2017

EXECUTION VERSION

Exhibit 10.13

CREDIT AGREEMENT

by and among

CVS HEALTH CORPORATION,

THE LENDERS PARTY HERETO,

and

BARCLAYS BANK PLC,
as Administrative Agent

Dated as of January 3, 2017

BARCLAYS BANK PLC,
as Sole Lead Arranger and Sole Bookrunner

008330-0373-Active.20553774

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EXHIBITS

Exhibit	A	List of Commitments
Exhibit	B	Form of Note
Exhibit	C	Form of Borrowing Request
Exhibit	D	Form of Opinion of Counsel to the Borrower
Exhibit	E	Form of Assignment and Assumption

CREDIT AGREEMENT , dated as of January 3, 2017, by and among ***CVS HEALTH CORPORATION*** , a Delaware corporation (the *" **Borrower** "*), the lenders party hereto from time to time (each a *" **Lender** "* and, collectively, the *" **Lenders** "*), and ***BARCLAYS BANK PLC*** (*" **Barclays** ")* , as administrative agent for the Lenders (in such capacity, the *" **Administrative Agent** "*).

1. *DEFINITIONS AND PRINCIPLES OF CONSTRUCTION*

1.1 Definitions

When used in any Loan Document (as defined below), each of the following terms shall have the meaning ascribed thereto unless the context otherwise specifically requires:

"ABR Advances" : the Revolving Credit Loans (or any portions thereof) at such time as they (or such portions) are made or are being maintained at a rate of interest based upon the Alternate Base Rate.

"Acquisition" : with respect to any Person, the purchase or other acquisition by such Person, by any means whatsoever, of (a) stock of, or other equity securities of, any other Person if, immediately thereafter, such other Person would be either a consolidated subsidiary of such Person or otherwise under the control of such Person, or (b) any business, going concern or division or segment thereof, or all or substantially all of the assets thereof; *provided* that no redemption, retirement, purchase or acquisition by any Person of the stock or other equity securities of such Person shall be deemed to constitute an Acquisition.

"Administrative Agent" : as defined in the preamble.

"Administrative Questionnaire" : an Administrative Questionnaire in a form supplied by the Administrative Agent.

"Affiliate" : with respect to any Person at any time and from time to time, any other Person (other than a wholly-owned subsidiary of such Person) which, at such time (a) controls such Person, (b) is controlled by such Person or (c) is under common control with such Person. The term *"* control *"* , as used in this definition with respect to any Person, means the power, whether direct or indirect through one or more intermediaries, to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting securities or other interests, by contract or otherwise.

"Aggregate Commitment Amount" : at any time, the sum of the Commitment Amounts of the Lenders at such time under this Agreement. The Aggregate Commitment Amount on the Effective Date is $2,500,000,000.

"Aggregate Credit Exposure" : at any time, the sum at such time of the aggregate Committed Credit Exposure of the Lenders at such time under this Agreement.

"Agreement" : this Credit Agreement, as the same may be amended, amended and restated, supplemented or otherwise modified from time to time.

"Alternate Base Rate" : for any day, a rate per annum equal to the greatest of (1) the Prime Rate in effect on such day, (1) 0.50% plus the Federal Funds Effective Rate (rounded, if necessary, to the nearest l/100th of 1% or, if there is no nearest 1/100th of 1%, then to the next higher 1/100th of 1%) in effect on such day, and (1) the Eurodollar Rate in effect on such day for a one month interest period commencing on such day (or if such day is not a Domestic Business Day, the immediately preceding Domestic Business Day), calculated in the manner provided in the definition of "Eurodollar Rate", plus 1%. Any change in the Alternate Base Rate due to a change in the Prime Rate, the Federal Funds Effective Rate or the Eurodollar Rate shall be effective from and including the effective date of such change in the Prime Rate, the Federal Funds Effective Rate or the Eurodollar Rate, respectively. If for any reason the Administrative Agent shall determine (which determination shall be conclusive absent clearly demonstrable error) that it is unable to ascertain the Federal Funds Effective Rate for any reason, including the inability or failure of the Administrative Agent to obtain sufficient quotations in accordance with the terms hereof, the Alternate Base Rate shall be determined without regard to clause (b) until the circumstances giving rise to such inability no longer exist.

"Anti-Corruption Laws" : all laws, rules, and regulations of any jurisdiction applicable to the Borrower or the Subsidiaries from time to time concerning or relating to bribery or corruption.

"Applicable Margin" : (i) with respect to the unpaid principal balance of ABR Advances, the applicable percentage set forth below in the column entitled "ABR Advances", (ii) with respect to the unpaid principal balance of Eurodollar Advances, the applicable percentage set forth below in the column entitled "Eurodollar Advances", and (iii) with respect to the Facility Fee, the applicable percentage set forth below in the column entitled "Facility Fee", in each case opposite the applicable Pricing Level:

Pricing Level	ABR Advances	Eurodollar Advances	Facility Fee
Pricing Level I	0.000%	0.795%	0.080%
Pricing Level II	0.000%	0.900%	0.100%
Pricing Level III	0.000%	1.000%	0.125%
Pricing Level IV	0.100%	1.100%	0.150%
Pricing Level V	0.300%	1.300%	0.200%
Pricing Level VI	0.500%	1.500%	0.250%

Decreases in the Applicable Margin resulting from a change in Pricing Level shall become effective upon the delivery by the Borrower to the Administrative Agent of a notice pursuant to Section 7.7(d) . Increases in the Applicable Margin resulting from a change in Pricing Level shall become effective on the effective date of any downgrade or withdrawal in the rating by Moody's or S&P of the senior unsecured long term debt rating of the Borrower.

"Approved Fund" : any Person (other than a natural person) that is (or will be) engaged in making, purchasing, holding or otherwise investing in commercial loans and similar extensions of credit in the ordinary course of its business that is administered or managed by a Lender, (1) an Affiliate of a Lender or (1) an entity or an Affiliate of an entity that administers or manages a Lender.

"Assignment and Assumption" : an assignment and assumption entered into by a Lender and an assignee (with the consent of any party whose consent is required by Section 11.7(b)), and accepted by the Administrative Agent, in substantially the form of Exhibit E or any other form approved by the Administrative Agent.

"Bail-In Action" : the exercise of any Write-Down and Conversion Powers by the applicable EEA Resolution Authority in respect of any liability of an EEA Financial Institution.

"Bail-In Legislation" : with respect to any EEA Member Country implementing Article 55 of Directive 2014/59/EU of the European Parliament and of the Council of the European Union, the implementing law for such EEA Member Country from time to time which is described in the EU Bail-In Legislation Schedule.

"Barclays" : as defined in the preamble.

"Benefited Lender" : as defined in Section 11.9(b) .

"Borrower" : as defined in the preamble.

"Borrower Materials" : as defined in Section 7.7 .

"Borrowing Date" : in respect of Revolving Credit Loans, any Domestic Business Day or Eurodollar Business Day, as the case may be, on which the Lenders shall make Revolving Credit Loans pursuant to a Borrowing Request.

"Borrowing Request" : a request for Revolving Credit Loans in the form of Exhibit C .

"Change of Control" : any of the following:

(i) any Person or group (as such term is used in Section 13(d)(3) of the Securities Exchange Act of 1934, as amended), (a) shall have or acquire beneficial ownership of securities having 35% or more of the ordinary voting power of the Borrower or (b) shall possess, directly or indirectly, the power to direct or cause the direction of the management and policies of the Borrower, whether through the ownership of voting securities, by contract or otherwise; or

(ii) the Continuing Directors shall cease for any reason to constitute a majority of the board of directors of the Borrower then in office.

"Commitment" : in respect of any Lender, such Lender's undertaking to make Revolving Credit Loans, subject to the terms and conditions hereof, in an aggregate outstanding principal amount not to exceed the Commitment Amount of such Lender.

"Commitment Amount" : at any time and with respect to any Lender, the amount set forth adjacent to such Lender's name under the heading *"* Commitment Amount *"* in Exhibit A at such time or, in the event that such Lender is not listed on Exhibit A , the *"* Commitment Amount *"* which such Lender shall have assumed from another Lender in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7 .

"Commitment Percentage" : at any time and with respect to any Lender, a fraction the numerator of which is such Lender's Commitment Amount at such time, and the denominator of which is the Aggregate Commitment Amount at such time.

"Commitment Period" : the period commencing on the Effective Date and ending on the Commitment Termination Date, or on such earlier date as all of the Commitments shall have been terminated in accordance with the terms hereof.

"Commitment Reduction Date" : as defined in Section 2.6(c) .

"Commitment Termination Date" : the earlier of (i) December 31, 2017 and (ii) the date on which the Loans shall become due and payable, whether by acceleration, notice of intention to prepay or otherwise.

"Committed Credit Exposure" : with respect to any Lender at any time, the outstanding principal balance of such Lender's Revolving Credit Loans.

"Compensatory Interest Payment" : as defined in Section 3.4(c) .

"Consolidated" : the Borrower and the Subsidiaries on a consolidated basis in accordance with GAAP.

"Contingent Obligation" : as to any Person (the *"* secondary obligor *"*), any obligation of such secondary obligor (a) guaranteeing or in effect guaranteeing any return on any investment made by another Person, or (b) guaranteeing or in effect guaranteeing any Indebtedness, lease, dividend or other obligation (*"* primary obligation *"*) of any other Person (the *"* primary obligor *"*) in any manner, whether directly or indirectly, including any obligation of such secondary obligor, whether or not contingent, (i) to purchase any such primary obligation or any Property constituting direct or indirect security therefor, (ii) to advance or supply funds (A) for the purchase or payment of any such primary obligation or (B) to maintain working capital or equity capital of the primary obligor or otherwise to maintain the net worth or solvency of the primary obligor, (iii) to purchase Property, securities or services primarily for the purpose of assuring the beneficiary of any such primary obligation of the ability of the primary obligor to make payment of such primary obligation, (iv) otherwise to assure or hold harmless the beneficiary of such primary obligation against loss in respect thereof, and (v) in respect of the Indebtedness of any partnership in which such secondary obligor is a general partner, except to the extent that such Indebtedness of such partnership is nonrecourse to such secondary obligor and its separate Property; *provided* that the term *"* Contingent Obligation *"* shall not include the indorsement of instruments for deposit or collection in the ordinary course of business.

"Continuing Director" : any member of the board of directors of the Borrower who (i) is a member of that board of directors on the Effective Date or (ii) was nominated for election by the board of directors a majority of whom were directors on the Effective Date or whose election or nomination for election was previously approved by one or more of such directors.

"Control Person" : as defined in Section 3.6 .

"Convert" , *"Conversion"* and *"Converted"* : each, a reference to a conversion pursuant to Section 3.3 of one Type of Revolving Credit Loan into another Type of Revolving Credit Loan.

"Costs" : as defined in Section 3.6 .

"Credit Exposure" : with respect to any Lender at any time, the Committed Credit Exposure of such Lender at such time under this Agreement.

"Credit Parties" means the Administrative Agent and the Lenders.

"Default" : any of the events specified in Section 9.1 , whether any requirement for the giving of notice, the lapse of time, or both, or any other condition, has been satisfied.

" *Defaulting Lender* ": any Lender, as reasonably determined by the Administrative Agent, that has (1) failed to fund any portion of its Loans within two Domestic Business Days of the date required to be funded by it hereunder, unless such Lender notifies the Administrative Agent and the Borrower in writing that such failure is the result of such Lender's determination that one or more conditions precedent to funding (each of which conditions precedent, together with any applicable default, shall be specifically identified in such writing) has not been satisfied, (1) notified the Borrower or any Credit Party in writing that it does not intend to comply with any of its funding obligations under this Agreement or has made a public statement to the effect that it does not intend to comply with its funding obligations under this Agreement or generally under other agreements in which it commits to extend credit, unless such writing or public statement relates to such Lender's obligation to fund a Loan hereunder and states that such position is based on such Lender's determination that a condition precedent to funding (which condition precedent, together with any applicable default, shall be specifically identified in such writing or public statement) cannot be satisfied, (1) failed, two Domestic Business Days after written request by the Administrative Agent (based on the reasonable belief that it may not fulfill its funding obligation), to confirm that it will comply with the terms of this Agreement relating to its obligations to fund prospective Loans; *provided* that such Lender shall cease to be a Defaulting Lender under this clause (c) upon receipt by the Administrative Agent of such confirmation, (1) otherwise failed to pay over to the Administrative Agent or any other Lender any other amount required to be paid by it hereunder within two Domestic Business Days of the date when due, unless the subject of a good faith dispute, or (1) (1) become or is insolvent or has a parent company that has become or is insolvent, (1) become the subject of a bankruptcy or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment or has a parent company that has become the subject of a bankruptcy

or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment or (iii) become or has had a direct or indirect parent become the subject of a Bail-In Action; *provided* that a Lender shall not qualify as a Defaulting Lender solely as a result of the acquisition or maintenance of an ownership interest in such Lender or its parent company, or of the exercise of control over such Lender or any Person controlling such Lender, by a Governmental Authority or instrumentality thereof so long as such ownership interest does not result in or provide such Lender with immunity from the jurisdiction of courts within the United States of America or from the enforcement of judgments or writs of attachment on its assets or permit such Lender (or such Governmental Authority) to reject, repudiate, disavow or disaffirm any agreements made by such Lender.

"Disposition" : with respect to any Person, any sale, assignment, transfer or other disposition by such Person by any means, of:

(a) the stock of, or other equity interests of, any other Person,

(b) any business, operating entity, division or segment thereof, or

(c) any other Property of such Person, other than (i) the sale of inventory (other than in connection with bulk transfers), (ii) the disposition of equipment and (iii) the sale of cash investments.

"Dividend Restrictions" : as defined in Section 8.7(b) .

"Dollar" or "$" : lawful currency of the United States of America.

"Domestic Business Day" : any day other than a Saturday, Sunday or a day which in New York City is a legal holiday or a day on which banking institutions are authorized or required by law or other governmental action to close.

"EEA Financial Institution" : (a) any credit institution or investment firm established in any EEA Member Country which is subject to the supervision of an EEA Resolution Authority, (b) any entity established in an EEA Member Country which is a parent of an institution described in clause (a) of this definition, or (c) any financial institution established in an EEA Member Country which is a subsidiary of an institution described in clauses (a) or (b) of this definition and is subject to consolidated supervision with its parent.

"EEA Member Country" : any of the member states of the European Union, Iceland, Liechtenstein, and Norway.

"EEA Resolution Authority" : any public administrative authority or any person entrusted with public administrative authority of any EEA Member Country (including any delegee) having responsibility for the resolution of any EEA Financial Institution.

"Effective Date" : as defined in Section 5 .

" *Eligible Assignee* ": a Person that is a permitted assignee under Section 11.7(b) that has received the consent of each party whose consent is required under Section 11.7(b) .

"Employee Benefit Plan" : an employee benefit plan, within the meaning of Section 3(3) of ERISA, maintained, sponsored or contributed to by the Borrower, any Subsidiary or any ERISA Affiliate.

"Environmental Laws" : all laws, rules, regulations, codes, ordinances, orders, decrees, judgments, injunctions, notices or binding agreements issued, promulgated or entered into by any Governmental Authority, relating in any way to the environment, preservation or reclamation of natural resources, the management, release or threatened release of any Hazardous Material or to health and safety matters.

"Environmental Liability" : as to any Person, any liability, contingent or otherwise (including any liability for damages, costs of environmental remediation, fines, penalties or indemnities), of such Person directly or indirectly resulting from or based upon (1) violation of any Environmental Law, (1) the generation, use, handling, transportation, storage, treatment or disposal of any Hazardous Materials, (1) exposure to any Hazardous Materials, (1) the release or threatened release of any Hazardous Materials into the environment or (1) any contract, agreement or other consensual arrangement pursuant to which liability is assumed or imposed with respect to any of the foregoing.

"ERISA" : the Employee Retirement Income Security Act of 1974, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"ERISA Affiliate" : when used with respect to an Employee Benefit Plan, ERISA, the PBGC or a provision of the Internal Revenue Code pertaining to employee benefit plans, any Person that is a member of any group of organizations within the meaning of Sections 414(b) or (c) of the Internal Revenue Code or, solely with respect to the applicable provisions of the Internal Revenue Code, Sections 414(m) or (o) of the Internal Revenue Code, of which the Borrower or any Subsidiary is a member.

"EU Bail-In Legislation Schedule" : the EU Bail-In Legislation Schedule published by the Loan Market Association (or any successor Person), as in effect from time to time.

"Eurodollar Advance" : a portion of the Revolving Credit Loans selected by the Borrower to bear interest during a Eurodollar Interest Period selected by the Borrower at a rate per annum based upon a Eurodollar Rate determined with reference to such Eurodollar Interest Period, all pursuant to and in accordance with Section 2.1 or Section 3.3 .

"Eurodollar Business Day" : any Domestic Business Day, other than a Domestic Business Day on which banks are not open for dealings in Dollar deposits in the interbank eurodollar market.

"Eurodollar Interest Period" : the period commencing on any Eurodollar Business Day selected by the Borrower in accordance with Section 2.3 or Section 3.3 and ending one, two, three or six months thereafter, as selected by the Borrower in accordance with either such Sections, subject to the following:

(i) if any Eurodollar Interest Period would otherwise end on a day which is not a Eurodollar Business Day, such Eurodollar Interest Period shall be extended to the immediately succeeding Eurodollar Business Day unless the result of such extension would be to carry the end of such Eurodollar Interest Period into another calendar month, in which event such Eurodollar Interest Period shall end on the Eurodollar Business Day immediately preceding such day; and

(ii) if any Eurodollar Interest Period shall begin on the last Eurodollar Business Day of a calendar month (or on a day for which there is no numerically corresponding day in the calendar month at the end of such Eurodollar Interest Period), such Eurodollar Interest Period shall end on the last Eurodollar Business Day of such latter calendar month.

" *Eurodollar Rate* ": with respect to any Eurodollar Advance or any ABR Advance, to the extent such ABR Advance is based on a Eurodollar Rate, for any Interest Period, an interest rate per annum equal to (a) the LIBO Rate for such Interest Period multiplied by (b) the Statutory Reserve Rate.

"Event of Default" : any of the events specified in Section 9.1 , *provided* that any requirement for the giving of notice, the lapse of time, or both, or any other condition has been satisfied.

"Excluded Taxes" : with respect to the Administrative Agent, any Lender or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, (a) Taxes imposed on or measured by its net income (however denominated), and franchise Taxes, in each case, (i) imposed on it by the jurisdiction (or any political subdivision thereof) under the laws of which it is organized or in which its principal office is located or, in the case of any Lender, in which its applicable lending office is located, or (ii) that are Other Connection Taxes, (b) any branch profits Taxes imposed by the United States of America or that are Other Connection Taxes, (c) in the case of a Lender (other than an assignee pursuant to a request by the Borrower under Section 3.13), any withholding Tax that (i) is imposed on amounts payable to such Lender at the time such Lender becomes a party hereto (or designates a new lending office), (ii) is attributable to such Lender's failure or inability (other than as a result of a Regulatory Change) to comply with Section 3.10 , except to the extent that such Lender (or its assignor, if any) was entitled, at the time of designation of a new lending office (or assignment), to receive additional amounts from the Borrower with respect to such withholding Tax pursuant to Section 3.10 , or (iii) is attributable to such Lender's failure or inability (other than as a result of a Regulatory Change, except for a Regulatory Change relating to the implementation of FATCA) to comply with Section 3.10 and (d) any Taxes imposed under FATCA.

"Existing 2013 Credit Agreement" : the Credit Agreement, dated as of May 23, 2013, by and among the Borrower, the lenders party thereto from time to time, Barclays Bank PLC and

JPMorgan Chase Bank, N.A., as co-syndication agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as co-documentation agents, and The Bank of New York Mellon, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 2014 Credit Agreement" : the Second Amended and Restated Credit Agreement, dated as of July 24, 2014, by and among the Borrower, the lenders party thereto from time to time, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as co-syndication agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as co-documentation agents, and The Bank of New York Mellon, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 2015 Credit Agreement" : the Credit Agreement, dated as of July 1, 2015, by and among the Borrower, the lenders party thereto from time to time, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as co-syndication agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as co-documentation agents, and The Bank of New York Mellon, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Expiration Date" : the first date, occurring on or after the date the Commitments shall have terminated or been terminated in accordance herewith, upon which there shall be no Loans outstanding.

"Facility Fee" : as defined in Section 3.11 .

"FATCA" : Sections 1471 through 1474 of the Internal Revenue Code, as of the date of this Agreement (or any amended or successor version that is substantively comparable and not materially more onerous to comply with), any current or future regulations or official interpretations thereof, any agreements entered into pursuant to Section 1471(b)(1) of the Internal Revenue Code, any applicable intergovernmental agreements with respect thereto, and any treaty, law, regulations, or other official guidance enacted in any other jurisdiction relating to such intergovernmental agreement.

"Federal Funds Effective Rate" : for any day, the rate calculated by the Federal Reserve Bank of New York based on such day's federal funds transactions by depository institutions (as determined in such manner as the Federal Reserve Bank of New York shall set forth on its public website from time to time) and published on the next succeeding Business Day by the Federal Reserve Bank of New York as the federal funds effective rate; provided, that if the Federal Funds Effective Rate for any day is less than zero, the Federal Funds Effective Rate for such day will be deemed to be zero.

"Fees" : as defined in Section 3.2(a) .

"Financial Statements" : as defined in Section 4.13 .

"Foreign Lender" : any Lender that is not a United States person within the meaning of Section 7701(a)(30) of the Internal Revenue Code.

"GAAP" : generally accepted accounting principles set forth in the opinions and pronouncements of the Accounting Principles Board and the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board or such other principles as may be approved by a significant segment of the accounting profession, which are applicable to the circumstances as of the date of determination, consistently applied.

"Governmental Authority" : any foreign, federal, state, municipal or other government, or any department, commission, board, bureau, agency, public authority or instrumentality thereof, or any court, arbitrator, regulatory body or central bank (including any supra-national bodies such as the European Union or the European Central Bank).

"Hazardous Materials" : all explosive or radioactive substances or wastes and all hazardous or toxic substances, wastes or other pollutants, including petroleum or petroleum distillates, asbestos or asbestos containing materials, polychlorinated biphenyls, radon gas, infectious or medical wastes and all other substances or wastes of any nature regulated pursuant to any Environmental Law.

"Highest Lawful Rate" : as to any Lender, the maximum rate of interest, if any, which at any time or from time to time may be contracted for, taken, charged or received on the Loans or the Notes or which may be owing to such Lender pursuant to this Agreement under the laws applicable to such Lender and this Agreement.

"Indebtedness" : as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) indebtedness with respect to any conditional sale or other title retention agreement, (d) indebtedness arising under acceptance facilities and the amount available to be drawn under all letters of credit (excluding for purposes of Section 8.1 and Section 8.9 letters of credit obtained in the ordinary course of business by the Borrower or any Subsidiary) issued for the account of such Person and, without duplication, all drafts drawn thereunder to the extent such Person shall not have reimbursed the issuer in respect of the issuer's payment of such drafts, (e) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, (f) all indebtedness described in (a) - (e) above secured by any Lien on any Property owned by such Person even though such Person shall not have assumed or otherwise become liable for the payment thereof (other than carriers', warehousemen's, mechanics', repairmen's or other like non-consensual Liens arising in the ordinary course of business), and (g) Contingent Obligations in respect of any indebtedness described in items (a) - (f) above; *provided* that, for purposes of this definition, Indebtedness shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"Indemnified Liabilities" : as defined in Section 11.5 .

"Indemnified Person" : as defined in Section 11.10(a) .

"Indemnified Taxes" : Taxes other than Excluded Taxes and Other Taxes.

"Information" : as defined in Section 11.14(b) .

"Intangible Assets" : at any date, the value, as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP, of: (i) all trade names, trademarks, licenses, patents, copyrights, service marks, goodwill and other like intangibles, (ii) organizational and development costs, (iii) deferred charges (other than prepaid items, such as insurance, taxes, interest, commissions, rents, pensions, compensation and similar items and tangible assets being amortized), and (iv) unamortized debt discount and expense, less unamortized premium.

"Intercompany Debt" : (i) Indebtedness of the Borrower to one or more of the Subsidiaries of the Borrower and (ii) Indebtedness of one or more of the Subsidiaries of the Borrower to the Borrower or any one or more of the other Subsidiaries of the Borrower.

"Intercompany Disposition" : a Disposition by the Borrower or any of the Subsidiaries of the Borrower to the Borrower or to any of the other Subsidiaries of the Borrower.

"Interest Payment Date" : (i) as to any ABR Advance, the last day of each March, June, September and December, commencing on the first of such days to occur after such ABR Advance is made or any Eurodollar Advance is converted to an ABR Advance, (ii) [reserved], (iii) as to any Eurodollar Advance in respect of which the Borrower has selected a Eurodollar Interest Period of one, two or three months, the last day of such Eurodollar Interest Period, (iv) [reserved] and (v) as to any Eurodollar Advance in respect of which the Borrower has selected an Interest Period greater than three months or 90 days, as the case may be, the last day of the third month or the 90th day, as the case may be, of such Interest Period and the last day of such Interest Period.

"Interest Period" : a Eurodollar Interest Period.

"Internal Revenue Code" : the Internal Revenue Code of 1986, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"Interpolated Rate" : in relation to the LIBO Screen Rate, the rate which results from interpolating on a linear basis between:

(a) the applicable LIBO Screen Rate for the longest period (for which that LIBO Screen Rate is available) which is less than the Interest Period of that Loan; and

(b) the applicable LIBO Screen Rate for the shortest period (for which that LIBO Screen Rate is available) which exceeds the Interest Period of that Loan,

each as of approximately 11:00 a.m. (London, England time) two Business Days prior to the commencement of such Interest Period of that Loan.

"Lender" and *"Lenders"* : as defined in the preamble.

"LIBO Rate" : (i) the rate per annum determined by the Administrative Agent to be the offered rate which appears on the page of the Reuters Screen which displays the London interbank offered rate administered by ICE Benchmark Administration Limited (such page currently being the LIBOR01 page) (the " *LIBO Screen Rate* ") for deposits (for delivery on the first day of such Interest Period) with a term equivalent to such Interest Period in Dollars, determined as of approximately 11:00 a.m. (London, England time), two Business Days prior to the commencement of such Interest Period, or (ii) in the event the rate referenced in the preceding clause (i) does not appear on such page or service or if such page or service shall cease to be available, the rate determined by the Administrative Agent to be the offered rate on such other page or other service which displays the LIBO Screen Rate for deposits (for delivery on the first day of such Interest Period) with a term equivalent to such Interest Period in Dollars, determined as of approximately 11:00 a.m. (London, England time) two Business Days prior to the commencement of such Interest Period; *provided* that if LIBO Screen Rates are quoted under either of the preceding clauses (i) or (ii), but there is no such quotation for the Interest Period elected, the LIBO Screen Rate shall be equal to the Interpolated Rate; and *provided* , *further* , that if any such rate determined pursuant to the preceding clauses (i) or (ii) is less than zero, the Eurodollar Rate will be deemed to be zero.

"LIBO Screen Rate" : has the meaning assigned to it in the definition of *"LIBO Rate"*.

"Lien" : any mortgage, pledge, hypothecation, assignment, lien, deposit arrangement, charge, encumbrance or other security arrangement or security interest of any kind, or the interest of a vendor or lessor under any conditional sale agreement, capital lease or other title retention agreement.

"Loan" : a Revolving Credit Loan.

"Loan Documents" : this Agreement and, upon the execution and delivery thereof, the Notes, if any.

"Loans" : the Revolving Credit Loans.

"Margin Stock" : any *"* margin stock *"* , as said term is defined in Regulation U of the Board of Governors of the Federal Reserve System, as the same may be amended or supplemented from time to time.

"Material Adverse" : with respect to any change or effect, a material adverse change in, or effect on, as the case may be, (i) the financial condition, operations, business, or Property of the Borrower and the Subsidiaries taken as a whole, (ii) the ability of the Borrower to perform its obligations under the Loan Documents, or (iii) the ability of the Administrative Agent or any Lender to enforce the Loan Documents.

"Moody's" : Moody's Investors Service, Inc., or any successor thereto.

"Multiemployer Plan" : a Pension Plan which is a multiemployer plan as defined in Section 4001(a)(3) of ERISA.

"Net Tangible Assets" : at any date, the total assets as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP, less (i) all current liabilities (due within one year) as shown on such balance sheet and (ii) Intangible Assets and liabilities relating thereto.

"Note" : with respect to each Lender that has requested one, a promissory note evidencing such Lender's Loans payable to the order of such Lender (or, if required by such Lender, to such Lender and its registered assigns), substantially in the form of Exhibit B .

" *Other Connection Taxes* ": with respect to the Administrative Agent, any Lender or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, Taxes imposed as a result of a present or former connection between such recipient and the jurisdiction imposing such Tax (other than connections arising from such recipient having executed, delivered, become a party to, performed its obligations under, received payments under, received or perfected a security interest under, engaged in any other transaction pursuant to, enforced any Loan Document, or sold or assigned an interest in any Loan or Loan Document).

"Other Taxes" : all present or future stamp, court or documentary Taxes or any other excise or property Taxes, charges or similar levies arising from any payment made hereunder or under any other Loan Document or from the execution, delivery or enforcement of, or otherwise with respect to, this Agreement or any other Loan Document, except any such Taxes that are Other Connection Taxes imposed with respect to an assignment (other than an assignment made pursuant to Section 3.13).

"Participant" : as defined in Section 11.7(d) .

"Participant Register" : as defined in Section 11.7(d) .

"Patriot Act" : as defined in Section 11.20 .

"PBGC" : the Pension Benefit Guaranty Corporation established pursuant to Subtitle A of Title IV of ERISA, or any Governmental Authority succeeding to the functions thereof.

"Pension Plan" : at any time, any Employee Benefit Plan (including a Multiemployer Plan) subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, the funding requirements of which are, or at any time within the six years immediately preceding the time in question were, in whole or in part, the responsibility of the Borrower, any Subsidiary or an ERISA Affiliate.

"Person" : any individual, firm, partnership, limited liability company, joint venture, corporation, association, business trust, joint stock company, unincorporated association, trust, Governmental Authority or any other entity, whether acting in an individual, fiduciary, or other capacity, and for the purpose of the definition of *"* ERISA Affiliate *"* , a trade or business.

"Platform" : as defined in Section 7.7 .

"Pricing Level" : Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV, Pricing Level V or Pricing Level VI, as the case may be.

"Pricing Level I" : any time when the senior unsecured long term debt rating of the Borrower by (x) S&P is A or higher or (y) Moody's is A2 or higher.

"Pricing Level II" : any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is A- or higher or (y) Moody's is A3 or higher and (ii) Pricing Level I does not apply.

"Pricing Level III" : any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB+ or higher or (y) Moody's is Baa1 or higher and (ii) neither Pricing Level I nor Pricing Level II applies.

"Pricing Level IV" : any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB or higher or (y) Moody's is Baa2 or higher and (ii) none of Pricing Level I, Pricing Level II or Pricing Level III applies.

"Pricing Level V" : any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB- or higher or (y) Moody's is Baa3 or higher and (ii) none of Pricing Level I, Pricing Level II, Pricing Level III or Pricing Level IV applies.

"Pricing Level VI" : any time when none of Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV or Pricing Level V applies.

Notwithstanding each definition of Pricing Level set forth above, if at any time the senior unsecured long term debt ratings of the Borrower by S&P and Moody's differ by more than one equivalent rating level, then the applicable Pricing Level shall be determined based upon the lower such rating adjusted upwards to the next higher rating level.

"Prime Rate" : the rate of interest last quoted by The Wall Street Journal as the "Prime Rate" in the U.S. or, if The Wall Street Journal ceases to quote such rate, the highest per annum interest rate published by the Board of Governors of Federal Reserve System in Federal Reserve Statistical Release H.15 (519) (Selected Interest Rates) as the "bank prime loan" rate or, if such rate is no longer quoted therein, any similar rate quoted therein (as reasonably determined by the Administrative Agent) or any similar release by the Board of Governors of Federal Reserve System (as reasonably determined by the Administrative Agent).

"Proceeding" : as defined in Section 11.10(a) .

"Prohibited Transaction" : a transaction that is prohibited under Section 4975 of the Internal Revenue Code or Section 406 of ERISA and not exempt under Section 4975 of the Internal Revenue Code, Section 408 of ERISA or any applicable administrative exemptions.

"Property" : in respect of any Person, all types of real, personal or mixed property and all types of tangible or intangible property owned or leased by such Person.

"Regulatory Change" : the occurrence, after the date hereof, of any of the following: (a) the adoption or taking effect of any law, rule, regulation or treaty, (b) any change in any law, rule, regulation or treaty or in the administration, interpretation or application thereof by any Governmental Authority or (c) the making or issuance of any request, guideline or directive (whether or not having the force of law) by any Governmental Authority; *provided* that, notwithstanding anything herein to the contrary, (i) the Dodd-Frank Wall Street Reform and Consumer Protection Act and all requests, rules, guidelines or directives thereunder or issued in connection therewith and (ii) all requests, rules, guidelines or directives promulgated by the Bank for International Settlements, the Basel Committee on Banking Supervision (or any successor or similar authority) or the United States or foreign regulatory authorities, in each case, pursuant to Basel III, in the case of each of clauses (i) and (ii), shall be deemed to be a "Regulatory Change", regardless of the date enacted, adopted or issued, but only if any such requirements are generally applicable to (and for which reimbursement is generally being sought by the Lenders in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this definition), as determined by the Lenders in their respective reasonable discretion.

"Register" : as defined in Section 11.7(c) .

"Related Parties" : with respect to any specified Person, such Person's Affiliates and the respective directors, officers, employees, agents and advisors of such Person and such Person's Affiliates.

"Replaced Lender" : as defined in Section 3.13 .

"Replacement Lender" : as defined in Section 3.13 .

"Reportable Event" : with respect to any Pension Plan, (a) any event set forth in Sections 4043(c) (other than a Reportable Event as to which the 30 day notice requirement is waived by the PBGC under applicable regulations), 4062(e) or 4063(a) of ERISA, or the regulations thereunder, (b) an event requiring the Borrower, any Subsidiary or any ERISA Affiliate to provide security to a Pension Plan under Section 401(a)(29) of the Internal Revenue Code, or (c) the failure to make any payment required by Section 412(m) of the Internal Revenue Code.

"Required Lenders" : (a) at any time prior to the Commitment Termination Date or such earlier date as all of the Commitments shall have terminated or been terminated in accordance herewith, Lenders having Commitment Amounts equal to or more than 51% of the Aggregate Commitment Amount, and (b) at all other times, Lenders having Credit Exposure equal to or more than 51% of the Aggregate Credit Exposure.

"Restricted Payment" : with respect to any Person, any of the following, whether direct or indirect: (a) the declaration or payment by such Person of any dividend or distribution on any class of stock of such Person, other than a dividend payable solely in shares of that class of stock to the holders of such class, (b) the declaration or payment by such Person of any distribution on any other type or class of equity interest or equity investment in such Person, and (c) any redemption, retirement, purchase or acquisition of, or sinking fund or other similar payment in respect of, any class of stock of, or other type or class of equity interest or equity investment in, such Person.

"Restrictive Agreement" : as defined in Section 8.7 .

"Revolving Credit Loan" and *"Revolving Credit Loans"* : as defined in Section 2.1(a) .

"Sanctioned Country" : at any time, a country or territory which is the subject or target of any Sanctions.

"Sanctioned Person" : at any time, (a) any Person listed in any Sanctions-related list of designated Persons maintained by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State, (b) any Person operating, organized or resident in a Sanctioned Country or (c) any Person controlled by any such Person or Persons described in the foregoing clauses (a) or (b).

"Sanctions" : economic or financial sanctions or trade embargoes imposed, administered or enforced from time to time by the U.S. government, including those administered by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State.

"S&P" : Standard & Poor's Ratings Services, a Standard & Poor's Financial Services LLC business, or any successor thereto.

"Special Counsel" : such counsel as the Administrative Agent may engage from time to time.

"Statutory Reserve Rate" : a fraction (expressed as a decimal), the numerator of which is the number one and the denominator of which is the number one minus the aggregate of the maximum reserve percentages (including any marginal, special, emergency or supplemental reserves) expressed as a decimal established by the Board of Governors of the Federal Reserve System to which the Administrative Agent is subject for eurocurrency funding (currently referred to as "Eurocurrency liabilities" in Regulation D of the Board of Governors of the Federal Reserve System, as amended). Such reserve percentages shall include those imposed pursuant to said Regulation D. Eurodollar Loans shall be deemed to constitute eurocurrency funding and to be subject to such reserve requirements without benefit of or credit for proration, exemptions or offsets that may be available from time to time to any Lender under said Regulation D or any comparable regulation. The Statutory Reserve Rate shall be adjusted automatically on and as of the effective date of any change in any reserve percentage.

"Subsidiary" : at any time and from time to time, any corporation, partnership, limited liability company, joint venture or other business entity of which the Borrower and/or any Subsidiary of the Borrower, directly or indirectly at such time, either (a) in respect of a corporation, owns or controls more than 50% of the outstanding stock having ordinary voting power to elect a majority of the board of directors or similar managing body, irrespective of whether a class or classes shall or might have voting power by reason of the happening of any contingency, or (b) in respect of a partnership, limited liability company, joint venture or other business entity, is entitled to share in more than 50% of the profits and losses, however determined.

"Taxes" : all present or future taxes, levies, imposts, duties, deductions, withholdings, assessments, fees or other charges imposed by any Governmental Authority, including any interest, additions to tax or penalties applicable thereto.

"Termination Event" : with respect to any Pension Plan, (a) a Reportable Event, (b) the termination of a Pension Plan under Section 4041(c) of ERISA, or the filing of a notice of intent to terminate a Pension Plan under Section 4041(c) of ERISA, or the treatment of a Pension Plan amendment as a termination under Section 4041(e) of ERISA (except an amendment made after such Pension Plan satisfies the requirement for a standard termination under Section 4041(b) of ERISA), (c) the institution of proceedings by the PBGC to terminate a Pension Plan under Section 4042 of ERISA, or (d) the appointment of a trustee to administer any Pension Plan under Section 4042 of ERISA.

"Total Capitalization" : at any date, the sum of the Borrower's Consolidated Indebtedness and shareholders' equity on such date, determined in accordance with GAAP.

"Type" : with respect to any Revolving Credit Loan, the characteristic of such Loan as an ABR Advance or a Eurodollar Advance, each of which constitutes a Type of Revolving Credit Loan.

"Unqualified Amount" : as defined in Section 3.4(c) .

"Upstream Dividends" : as defined in Section 8.7(a) .

"U.S. Lender" : as defined in Section 3.10(e) .

"United States Tax Compliance Certificate" : as defined in Section 3.10(e)(iii) .

" *Write-Down and Conversion Powers* ": with respect to any EEA Resolution Authority, the write-down and conversion powers of such EEA Resolution Authority from time to time under the Bail-In Legislation for the applicable EEA Member Country, which write-down and conversion powers are described in the EU Bail-In Legislation Schedule.

1.2 *Principles of Construction*

(a) All capitalized terms defined in this Agreement shall have the meanings given to such capitalized terms herein when used in the other Loan Documents or in any certificate, opinion

or other document made or delivered pursuant hereto or thereto, unless otherwise expressly provided therein.

(b) Unless otherwise expressly provided herein, the word *"fiscal"* when used herein shall refer to the relevant fiscal period of the Borrower. As used in the Loan Documents and in any certificate, opinion or other document made or delivered pursuant thereto, accounting terms not defined in Section 1.1 , and accounting terms partly defined in Section 1.1 , to the extent not defined, shall have the respective meanings given to them under GAAP as in effect from time to time; *provided* that, if the Borrower notifies the Administrative Agent that the Borrower requests an amendment to any provision hereof to eliminate the effect of any change occurring after the date hereof in GAAP or in the application thereof on the operation of such provision (or if the Administrative Agent notifies the Borrower that the Required Lenders request an amendment to any provision hereof for such purpose), regardless of whether any such notice is given before or after such change in GAAP or in the application thereof, then such provision shall be interpreted on the basis of, and any accounting term related thereto shall have the respective meaning given to it under, GAAP as in effect and applied immediately before such change shall have become effective until such notice shall have been withdrawn or such provision amended in accordance herewith.

(c) The words *"hereof"* , *"herein"* , *"hereto"* and *"hereunder"* and similar words when used in each Loan Document shall refer to such Loan Document as a whole and not to any particular provision of such Loan Document, and Section, schedule and exhibit references contained therein shall refer to Sections thereof or schedules or exhibits thereto unless otherwise expressly provided therein.

(d) All references herein to a time of day shall mean the then applicable time in New York, New York, unless otherwise expressly provided herein.

(e) Section headings have been inserted in the Loan Documents for convenience only and shall not be construed to be a part thereof. Unless the context otherwise requires, words in the singular number include the plural, and words in the plural include the singular.

(f) Whenever in any Loan Document or in any certificate or other document made or delivered pursuant thereto, the terms thereof require that a Person sign or execute the same or refer to the same as having been so signed or executed, such terms shall mean that the same shall be, or was, duly signed or executed by (i) in respect of any Person that is a corporation, any duly authorized officer thereof, and (ii) in respect of any other Person (other than an individual), any analogous counterpart thereof.

(g) The words "include" and "including", when used in each Loan Document, shall mean that the same shall be included "without limitation", unless otherwise specifically provided.

2. AMOUNT AND TERMS OF LOANS

2.1 *Revolving Credit Loans*

(a) Subject to the terms and conditions hereof, each Lender severally (and not jointly) agrees to make loans denominated in Dollars under this Agreement (each a *"Revolving Credit Loan"* and, collectively with each other Revolving Credit Loan of such Lender and/or with each Revolving Credit Loan of each other Lender, the *"Revolving Credit Loans"*) to the Borrower from time to time during the Commitment Period, during which period the Borrower may borrow, prepay and reborrow in accordance with the provisions hereof. Immediately after making each Revolving Credit Loan, the Aggregate Credit Exposure will not exceed the Aggregate Commitment Amount. With respect to each Lender, at the time of the making of any Revolving Credit Loan, the sum of (I) the principal amount of such Lender's Revolving Credit Loan constituting a part of the Revolving Credit Loans to be made and (II) the aggregate principal balance of all other Revolving Credit Loans (exclusive of Revolving Credit Loans which are repaid with the proceeds of, and simultaneously with the incidence of, the Revolving Credit Loans to be made) then outstanding from such Lender, will not exceed the Commitment of such Lender at such time. At the option of the Borrower, indicated in a Borrowing Request, Revolving Credit Loans may be made as ABR Advances or Eurodollar Advances.

(b) The aggregate outstanding principal balance of all Revolving Credit Loans shall be due and payable on the Commitment Termination Date or on such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6 .

2.2 *[Reserved]*

2.3 *Notice of Borrowing Revolving Credit Loans*

The Borrower agrees to notify the Administrative Agent, which notification shall be irrevocable, no later than (a) 11:00 A.M. on the proposed Borrowing Date in the case of Revolving Credit Loans to consist of ABR Advances and (b) 11:00 A.M. at least three Eurodollar Business Days (or in the case of Eurodollar Advances to be made on the Effective Date, one Eurodollar Business Day) prior to the proposed Borrowing Date in the case of Revolving Credit Loans to consist of Eurodollar Advances. Each such notice shall specify (i) the aggregate amount requested to be borrowed under the Commitments, (ii) the proposed Borrowing Date, (iii) whether a borrowing of Revolving Credit Loans is to be of ABR Advances or Eurodollar Advances, and the amount of each thereof and (iv) the Eurodollar Interest Period for such Eurodollar Advances. Each such notice shall be promptly confirmed by delivery to the Administrative Agent of a Borrowing Request. Each Eurodollar Advance to be made on a Borrowing Date, when aggregated with all amounts to be Converted to Eurodollar Advances on such date and having the same Interest Period as such Eurodollar Advance, shall equal no less than $10,000,000, or an integral multiple of $1,000,000 in excess thereof. Each ABR Advance made on each Borrowing Date shall equal no less than $5,000,000 or an integral multiple of $500,000 in excess thereof. The Administrative Agent shall promptly notify each Lender (by telephone or otherwise, such notification to be confirmed by fax, email or other writing) of each such Borrowing Request. Subject to its receipt of each such notice from the Administrative Agent and subject to the terms and conditions hereof, each Lender shall make immediately available funds available to the Administrative Agent at the address therefor set forth in Section 11.2 not later than 1:00 P.M. on each Borrowing Date in an amount equal to such

Lender's Commitment Percentage of the Revolving Credit Loans requested by the Borrower on such Borrowing Date.

2.4 *[Reserved]*

2.5 *Use of Proceeds*

The Borrower agrees that the proceeds of the Loans shall be used solely for its general corporate purposes (including the repurchase of equity interests of the Borrower), but not inconsistent with this Section 2.5. Notwithstanding anything to the contrary contained in any Loan Document, the Borrower further agrees that no part of the proceeds of any Loan will be used, directly or indirectly, and whether immediately, incidentally or ultimately (i) for a purpose which violates any law, rule or regulation of any Governmental Authority, including the provisions of Regulations U or X of the Board of Governors of the Federal Reserve System, as amended, or any provision of this Agreement, including, without limitation, the provisions of Section 4.9 and (ii) to make a loan to any director or executive officer of the Borrower or any Subsidiary.

2.6 *Termination or Reduction of Commitments*

(a) *Termination on Commitment Termination Date* . Unless previously terminated, the Commitments shall terminate on the Commitment Termination Date.

(b) *Voluntary Termination or Reductions* . At the Borrower's option and upon at least one Domestic Business Day's prior irrevocable notice to the Administrative Agent, the Borrower may (i) terminate the Commitments at any time, or (ii) permanently reduce the Aggregate Commitment Amount in part at any time and from time to time, *provided* that (1) each such partial reduction shall be in an amount equal to at least $5,000,000 or an integral multiple of $1,000,000 in excess thereof, and (2) immediately after giving effect to each such reduction, the Aggregate Commitment Amount shall equal or exceed the Aggregate Credit Exposure, and *provided* , *further* that a notice of termination of the Commitments delivered by the Borrower may state that such notice is conditioned upon the effectiveness of other credit facilities (such notice to specify the proposed effective date), in which case such notice may be revoked by the Borrower (by notice to the Administrative Agent on or prior to such specified effective date) if such condition is not satisfied and the Borrower shall indemnify the Lenders in accordance with Section 3.5 , if applicable.

(c) *Mandatory Termination and Reduction* . Prior to the Commitment Termination Date, the Aggregate Commitment Amount shall be automatically and permanently reduced on the dates set forth below (each such date, a *"Commitment Reduction Date"*) in the amounts set forth below opposite such dates:

Commitment Reduction Date	Amount of Reduction of Aggregate Commitment Amount
March 31, 2017	$750,000,000
June 30, 2017	$750,000,000
September 30, 2017	$500,000,000

provided that if on any Commitment Reduction Date, immediately after giving effect to any such reduction described in this clause (c), the Aggregate Credit Exposure would exceed the Aggregate Commitment Amount, the Borrower shall, no later than the applicable Commitment Reduction Date, prepay Loans in accordance with the terms of Section 2.7 in an aggregate principal amount sufficient to cause the Aggregate Commitment Amount to equal or exceed the Aggregate Credit Exposure.

(d) *In General* . Each reduction of the Aggregate Commitment Amount shall be made by reducing each Lender's Commitment Amount by a sum equal to such Lender's Commitment Percentage of the amount of such reduction.

2.7 *Prepayments of Loans*

(a) *Voluntary Prepayments* . The Borrower may prepay Revolving Credit Loans , in whole or in part, without premium or penalty, but subject to Section 3.5 at any time and from time to time, by notifying the Administrative Agent, which notification shall be irrevocable, at least two Eurodollar Business Days, in the case of a prepayment of Eurodollar Advances, or one Domestic Business Day, in the case of a prepayment of ABR Advances, prior to the proposed prepayment date specifying (i) the Loans to be prepaid, (ii) the amount to be prepaid, and (iii) the date of prepayment. Upon receipt of each such notice, the Administrative Agent shall promptly notify each Lender thereof. Each such notice given by the Borrower pursuant to this Section 2.7 shall be irrevocable, *provided* that, if a notice of prepayment is given in connection with a conditional notice of termination of the Commitments as contemplated by Section 2.6 , then such notice of prepayment may be revoked if such notice of termination is revoked in accordance with Section 2.6 , and the Borrower shall indemnify the Lenders in accordance with Section 3.5 . Each partial prepayment under this Section 2.7 shall be (A) in the case of Eurodollar Advances, in a minimum amount of $5,000,000 or an integral multiple of $1,000,000 in excess thereof, and (B) in the case of ABR Advances, $1,000,000 or an integral multiple of $100,000 in excess thereof.

(b) *In General* . Simultaneously with each prepayment hereunder, the Borrower shall prepay all accrued interest on the amount prepaid through the date of prepayment and indemnify the Lenders in accordance with Section 3.5 .

2.8 *[Reserved]*

2.9 *[Reserved]*

2.10 *[Reserved]*

2.11 *Notes*

Any Lender may request that the Loans made by it be evidenced by a Note. In such event, the Borrower shall prepare, execute and deliver to such Lender a Note payable to such Person or, if requested by such Person, such Person and its registered assigns. Thereafter, all Loans evidenced by such Note and interest thereon shall at all times (including after assignment pursuant to Section 11.7) be represented by a Note in like form payable to the payee named therein and its registered assigns.

2.12 *[Reserved]*

2.13 *Defaulting Lenders*

Notwithstanding any provision of this Agreement to the contrary, if any Lender becomes a Defaulting Lender, then the following provisions shall apply for so long as such Lender is a Defaulting Lender:

(a) Facility Fees shall cease to accrue on the unfunded portion of the Commitment of such Defaulting Lender pursuant to Section 3.11 ;

(b) the Commitment and Committed Credit Exposure of such Defaulting Lender shall not be included in determining whether all Lenders or the Required Lenders have taken or may take any action hereunder (including any consent to any amendment or waiver pursuant to Section 11.1); *provided* that any waiver, amendment or modification requiring the consent of all Lenders or each affected Lender which affects such Defaulting Lender differently than other affected Lenders, an increase, or extension of the Commitment Period, of the Commitment of a Defaulting Lender, a reduction in the principal amount owed to such Defaulting Lender (other than by payment thereof) or an extension of the final maturity thereof, or a modification of this clause shall require the consent of such Defaulting Lender;

(c) [reserved];

(d) [reserved];

(e) any amount payable to such Defaulting Lender hereunder (whether on account of principal, interest, fees or otherwise and including any amount that would otherwise be payable to such Defaulting Lender pursuant to Section 11.9 but excluding Section 3.13) shall, in lieu of being distributed to such Defaulting Lender, be retained by the Administrative Agent in a segregated account and, subject to any applicable requirements of law, be applied at such time or times as may be determined by the Administrative Agent (2) first , to the payment of any amounts owing by such Defaulting Lender to the Administrative Agent hereunder, (2) second , [reserved], (2) third , [reserved], (2) fourth , to the funding of any Revolving Credit Loan in respect of which such Defaulting Lender has failed to fund its portion thereof as required by this Agreement, as determined by the Administrative Agent, (2) fifth , if so determined by the Administrative Agent

and the Borrower, held in such account as cash collateral for future funding obligations of the Defaulting Lender in respect of any Revolving Credit Loans under this Agreement, (2) sixth , to the payment of any amounts owing to the Lenders as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by any Lender against such Defaulting Lender as a result of such Defaulting Lender's breach of its obligations under this Agreement, (2) seventh , to the payment of any amounts owing to the Borrower as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by the Borrower against such Defaulting Lender as a result of such Defaulting Lender's breach of its obligations under this Agreement, and (2) eighth , to such Defaulting Lender or as otherwise directed by a court of competent jurisdiction; *provided* that if such payment is (x) a prepayment of the principal amount of any Revolving Credit Loan and (y) made at a time when the conditions set forth in Section 6 are satisfied or waived, such payment shall be applied solely to prepay the Revolving Credit Loans of all non-Defaulting Lenders pro rata prior to being applied to the prepayment of any Loans owed to any Defaulting Lender; and

(f) The Borrower shall have the right at any time during which a Lender is a Defaulting Lender to replace such Defaulting Lender pursuant to Section 3.13 .

3. PROCEEDS, PAYMENTS, CONVERSIONS, INTEREST, YIELD PROTECTION AND FEES

3.1 *Disbursement of the Proceeds of the Loans*

The Administrative Agent shall disburse the proceeds of the Loans at its office specified in Section 11.2 by crediting to the Borrower the funds received from each Lender. Unless the Administrative Agent shall have received prior notice from a Lender (by telephone or otherwise, such notice to be confirmed by fax, email or other writing) that such Lender will not make available to the Administrative Agent such Lender's Commitment Percentage of the Revolving Credit Loans to be made by it on a Borrowing Date, the Administrative Agent may assume that such Lender has made such amount available to the Administrative Agent on such Borrowing Date in accordance with this Section 3.1 , *provided* that, in the case of a Revolving Credit Loan, such Lender received notice thereof from the Administrative Agent in accordance with the terms hereof, and the Administrative Agent may, in reliance upon such assumption, make available to the Borrower on such Borrowing Date a corresponding amount. If and to the extent such Lender shall not have so made such amount available to the Administrative Agent, such Lender and the Borrower severally agree to pay to the Administrative Agent, forthwith on demand, such corresponding amount (to the extent not previously paid by the other), together with interest thereon for each day from the date such amount is made available to the Borrower until the date such amount is paid to the Administrative Agent, at a rate per annum equal to, in the case of the Borrower, the applicable interest rate set forth in Section 3.4(a) and, in the case of such Lender, the Federal Funds Effective Rate from the date such payment is due until the third day after such date and, thereafter, at the Federal Funds Effective Rate *plus* 2%. Any such payment by the Borrower shall be without prejudice to its rights against such Lender. If such Lender shall pay to the Administrative Agent such corresponding amount, such amount so paid shall constitute such Lender's Loan as part of such Loans for purposes of this Agreement, which Loan shall be deemed to have been made by such Lender on the Borrowing Date applicable to such Loans.

3.2 *Payments*

(a) Each payment, including each prepayment, of principal and interest on the Loans and of the Facility Fee (collectively, together with all of the other fees to be paid to the Administrative Agent and the Lenders in connection with the Loan Documents, the *"Fees"*), and of all of the other amounts to be paid to the Administrative Agent and the Lenders in connection with the Loan Documents shall be made by the Borrower to the Administrative Agent at its office specified in Section 11.2 without setoff, deduction or counterclaim in funds immediately available in New York by 1:00 P.M. on the due date for such payment. The failure of the Borrower to make any such payment by such time shall not constitute a default hereunder, *provided* that such payment is made on such due date, but any such payment made after 1:00 P.M. on such due date shall be deemed to have been made on the next Domestic Business Day or Eurodollar Business Day, as the case may be, for the purpose of calculating interest on amounts outstanding on the Loans. If the Borrower has not made any such payment prior to 1:00 P.M., the Borrower hereby authorizes the Administrative Agent to deduct the amount of any such payment from such account(s) as the Borrower may from time to time designate in writing to the Administrative Agent, upon which the Administrative Agent shall apply the amount of such deduction to such payment. Promptly upon receipt thereof by the Administrative Agent, each payment of principal and interest on the Revolving Credit Loans shall be remitted by the Administrative Agent in like funds as received to each Lender (a) first, pro rata according to the amount of interest which is then due and payable to the Lenders, and (b) second, pro rata according to the amount of principal which is then due and payable to the Lenders. Each payment of the Facility Fee payable to the Lenders shall be promptly transmitted by the Administrative Agent in like funds as received to each Lender pro rata according to such Lender's Commitment Amount or, if the Commitments shall have terminated or been terminated, according to the outstanding principal amount of such Lender's Revolving Credit Loans.

(b) If any payment hereunder or under the Loans shall be due and payable on a day which is not a Domestic Business Day or Eurodollar Business Day, as the case may be, the due date thereof (except as otherwise provided in the definition of Eurodollar Interest Period) shall be extended to the next Domestic Business Day or Eurodollar Business Day, as the case may be, and (except with respect to payments in respect of the Facility Fee) interest shall be payable at the applicable rate specified herein during such extension.

3.3 *Conversions; Other Matters*

(a) The Borrower may elect at any time and from time to time to Convert one or more Eurodollar Advances to an ABR Advance by giving the Administrative Agent at least one Domestic Business Day's prior irrevocable notice of such election, specifying the amount to be so Converted. In addition, the Borrower may elect at any time and from time to time to Convert an ABR Advance to any one or more new Eurodollar Advances or to Convert any one or more existing Eurodollar Advances to any one or more new Eurodollar Advances by giving the Administrative Agent no later than 10:00 a.m. at least two Eurodollar Business Days' prior irrevocable notice, in the case of a Conversion to Eurodollar Advances, of such election, specifying the amount to be so Converted and the initial Interest Period relating thereto, *provided* that any Conversion of an ABR Advance to Eurodollar Advances shall only be made on a Eurodollar Business Day. The

Administrative Agent shall promptly provide the Lenders with notice of each such election. Each Conversion of Loans from one Type to another shall be made pro rata according to the outstanding principal amount of the Loans of each Lender. ABR Advances and Eurodollar Advances may be Converted pursuant to this Section 3.3 in whole or in part, *provided* that the amount to be Converted to each Eurodollar Advance, when aggregated with any Eurodollar Advance to be made on such date in accordance with Section 2.1 and having the same Interest Period as such first Eurodollar Advance, shall equal no less than $10,000,000 or an integral multiple of $1,000,000 in excess thereof.

(b) Notwithstanding anything in this Agreement to the contrary, the Borrower shall not have the right to elect to Convert any existing ABR Advance to a new Eurodollar Advance or to Convert any existing Eurodollar Advance to a new Eurodollar Advance if (i) a Default or Event of Default under Section 9.1(a) , Section 9.1(b) , Section 9.1(h), Section 9.1(i) or Section 9.1(j) shall then exist, or (ii) any other Event of Default shall then exist and the Administrative Agent shall have notified the Borrower at the request of the Required Lenders that no ABR Advance or Eurodollar Advance may be Converted to a new Eurodollar Advance. In such event, such ABR Advance shall be automatically continued as an ABR Advance or such Eurodollar Advance shall be automatically Converted to an ABR Advance on the last day of the Interest Period applicable to such Eurodollar Advance. The foregoing shall not affect any other rights or remedies that the Administrative Agent or any Lender may have under this Agreement or any other Loan Document.

(c) Each Conversion shall be effected by each Lender by applying the proceeds of each new ABR Advance or Eurodollar Advance, as the case may be, to the existing Advance (or portion thereof) being Converted (it being understood that such Conversion shall not constitute a borrowing for purposes of Section 4 or Section 6).

(d) Notwithstanding any other provision of any Loan Document:

(i) if the Borrower shall have failed to elect a Eurodollar Advance under Section 2.3 or this Section 3.3 , as the case may be, in connection with any borrowing of new Revolving Credit Loans or expiration of an Interest Period with respect to any existing Eurodollar Advance, the amount of the Revolving Credit Loans subject to such borrowing or such existing Eurodollar Advance shall thereafter be an ABR Advance until such time, if any, as the Borrower shall elect a new Eurodollar Advance pursuant to this Section 3.3 ,

(ii) the Borrower shall not be permitted to select a Eurodollar Advance the Interest Period in respect of which ends later than the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6 , and

(iii) the Borrower shall not be permitted to have more than 15 Eurodollar Advances, in the aggregate, outstanding at any one time, it being understood and agreed that each borrowing of Eurodollar Advances pursuant to a single Borrowing Request shall constitute the making of one Eurodollar Advance for the purpose of calculating such limitation.

3.4 *Interest Rates and Payment Dates*

(a) *Prior to Maturity* . Except as otherwise provided in Section 3.4(b) and Section 3.4(c) , the Loans shall bear interest on the unpaid principal balance thereof at the applicable interest rate or rates per annum set forth below:

LOANS	RATE
Revolving Credit Loans constituting ABR Advances	Alternate Base Rate applicable thereto *plus* the Applicable Margin.
Revolving Credit Loans constituting Eurodollar Advances	Eurodollar Rate applicable thereto *plus* the Applicable Margin.

(b) *After Maturity, Late Payment Rate* . After maturity, whether by acceleration, notice of intention to prepay or otherwise, the outstanding principal balance of each Loan shall bear interest at the applicable interest rate on such Loan *plus* 2% per annum until paid (whether before or after the entry of any judgment thereon). Any payment of principal or interest on the Loans, Fees or other amounts payable by the Borrower under the Loan Documents not paid on the date when due and payable shall bear interest, in the case of principal or interest on a Loan, at the applicable interest rate on such Loan *plus* 2% per annum and, in the case of any Fees or other amounts, at the Alternate Base Rate *plus* the Applicable Margin *plus* 2% per annum, in each case from the due date thereof until the date such payment is made (whether before or after the entry of any judgment thereon).

(c) *Highest Lawful Rate* . Notwithstanding anything to the contrary contained in this Agreement, at no time shall the interest rate payable to any Lender on any of its Loans, together with the Fees and all other amounts payable hereunder to such Lender to the extent the same constitute or are deemed to constitute interest, exceed the Highest Lawful Rate. If in respect of any period during the term of this Agreement, any amount paid to any Lender hereunder, to the extent the same shall (but for the provisions of this Section 3.4) constitute or be deemed to constitute interest, would exceed the maximum amount of interest permitted by the Highest Lawful Rate during such period (such amount being hereinafter referred to as an *"Unqualified Amount"*), then (i) such Unqualified Amount shall be applied or shall be deemed to have been applied as a prepayment of the Loans of such Lender, and (ii) if, in any subsequent period during the term of this Agreement, all amounts payable hereunder to such Lender in respect of such period which constitute or shall be deemed to constitute interest shall be less than the maximum amount of interest permitted by the Highest Lawful Rate during such period, then the Borrower shall pay to such Lender in respect of such period an amount (each a *"Compensatory Interest Payment"*) equal to the lesser of (x) a sum which, when added to all such amounts, would equal the maximum amount of interest permitted by the Highest Lawful Rate during such period, and (y) an amount equal to the aggregate sum of all Unqualified Amounts *less* all other Compensatory Interest Payments.

(d) *General* . Interest shall be payable in arrears on each Interest Payment Date, on the Commitment Termination Date and, to the extent provided in Section 2.7(b) , upon each

prepayment of the Loans. Any change in the interest rate on the Loans resulting from an increase or a decrease in the Alternate Base Rate or any reserve requirement shall become effective as of the opening of business on the day on which such change shall become effective. The Administrative Agent shall, as soon as practicable, notify the Borrower and the Lenders of the effective date and the amount of each change in the Prime Rate, but any failure to so notify shall not in any manner affect the obligation of the Borrower to pay interest on the Loans in the amounts and on the dates set forth herein. Each determination by the Administrative Agent of the Alternate Base Rate and the Eurodollar Rate pursuant to this Agreement shall be conclusive and binding on the Borrower absent manifest error. The Borrower acknowledges that to the extent interest payable on the Loans is based on the Alternate Base Rate, such rate is only one of the bases for computing interest on loans made by the Lenders, and by basing interest payable on ABR Advances on the Alternate Base Rate, the Lenders have not committed to charge, and the Borrower has not in any way bargained for, interest based on a lower or the lowest rate at which the Lenders may now or in the future make extensions of credit to other Persons. All interest (other than interest calculated with reference to the Prime Rate) shall be calculated on the basis of a 360-day year for the actual number of days elapsed, and all interest determined with reference to the Prime Rate shall be calculated on the basis of a 365/366-day year for the actual number of days elapsed.

3.5 *Indemnification for Loss*

Notwithstanding anything contained herein to the contrary, if: (i) the Borrower shall fail to borrow a Eurodollar Advance or if the Borrower shall fail to Convert a Eurodollar Advance after it shall have given notice to do so in which it shall have requested a Eurodollar Advance pursuant to Section 2.3 or Section 3.3 , as the case may be, (ii) [reserved], (iii) a Eurodollar Advance shall be terminated for any reason prior to the last day of the Interest Period applicable thereto, (iv) any repayment or prepayment of the principal amount of a Eurodollar Advance is made for any reason on a date which is prior to the last day of the Interest Period applicable thereto, (v) the Borrower shall have revoked a notice of prepayment or notice of termination of the Commitments that was conditioned upon the effectiveness of other credit facilities pursuant to Section 2.6 or Section 2.7 , or (vi) a Eurodollar Advance is assigned other than on the last day of the Interest Period applicable thereto as a result of a replacement of a Lender pursuant to clause (x) or (z) of Section 3.13 , then the Borrower agrees to indemnify each Lender against, and to pay on demand directly to such Lender the amount (calculated by such Lender using any method chosen by such Lender which is customarily used by such Lender for such purpose for borrowers similar to the Borrower) equal to any loss or expense suffered by such Lender as a result of such failure to borrow or Convert, or such termination, repayment, prepayment or revocation, including any loss, cost or expense suffered by such Lender in liquidating or employing deposits acquired to fund or maintain the funding of such Eurodollar Advance or redeploying funds prepaid or repaid, in amounts which correspond to such Eurodollar Advance and any reasonable internal processing charge customarily charged by such Lender in connection therewith for borrowers similar to the Borrower.

3.6 *Reimbursement for Costs, Etc.*

If at any time or from time to time there shall occur a Regulatory Change and any Lender shall have reasonably determined that such Regulatory Change (i) shall have had or will thereafter have the effect of reducing (A) the rate of return on such Lender's capital or liquidity or the capital or liquidity of any Person directly or indirectly owning or controlling such Lender (each a *"Control Person"*), or (B) the asset value (for capital or liquidity purposes) to the such Lender or such Control Person, as applicable, of the Loans, or any participation therein, in any case to a level below that which such Lender or such Control Person could have achieved or would thereafter be able to achieve but for such Regulatory Change (after taking into account such Lender's or such Control Person's policies regarding capital), (ii) will impose, modify or deem applicable any reserve, asset, special deposit or special assessment requirements on deposits obtained in the interbank eurodollar market in connection with the Loan Documents (excluding, with respect to any Eurodollar Advance, any such requirement which is included in the determination of the rate applicable thereto), or (iii) will subject such Lender or such Control Person, as applicable, to any tax (documentary, stamp or otherwise) with respect to this Agreement or any Note (except, in the case of clause (iii) above, for any Indemnified Taxes, Excluded Taxes or Other Taxes) then, in each such case, within ten days after demand by such Lender, the Borrower shall pay to such Lender or such Control Person, as the case may be, such additional amount or amounts as shall be sufficient to compensate such Lender or such Control Person, as the case may be, for any such reduction, reserve or other requirement, tax, loss, cost or expense (excluding general administrative and overhead costs) (collectively, *"Costs"*) attributable to such Lender's or such Control Person's compliance during the term hereof with such Regulatory Change, but only if such Costs are generally applicable to (and for which reimbursement is generally being sought by such Lender or such Control Person, as applicable, in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this Section 3.6), as determined by such Lender in its reasonable discretion. Each Lender may make multiple requests for compensation under this Section 3.6 .

Notwithstanding the foregoing, the Borrower will not be required to compensate any Lender for any Costs under this Section 3.6 arising prior to 45 days preceding the date of demand, unless the applicable Regulatory Change giving rise to such Costs

is imposed retroactively. In the case of retroactivity, such notice shall be provided to the Borrower not later than 45 days from the date that such Lender learned of such Regulatory Change. The Borrower's obligation to compensate such Lender shall be contingent upon the provision of such timely notice (but any failure by such Lender to provide such timely notice shall not affect the Borrower's obligations with respect to (i) Costs incurred from the date as of which such Regulatory Change became effective to the date that is 45 days after the date such Lender reasonably should have learned of such Regulatory Change and (ii) Costs incurred following the provision of such notice).

3.7 *Illegality of Funding*

Notwithstanding any other provision hereof, if any Lender shall reasonably determine that any law, regulation, treaty or directive, or any change therein or in the interpretation or application thereof, shall make it unlawful for such Lender to make or maintain any Eurodollar Advance as contemplated by this Agreement, such Lender shall promptly notify the Borrower and the Administrative Agent thereof, and (a) the commitment of such Lender to make such Eurodollar Advances or Convert ABR Advances to such Eurodollar Advances shall forthwith be suspended, (b) such Lender shall fund its portion of each requested Eurodollar Advance as an ABR Advance and (c) such Lender's Loans then outstanding as such Eurodollar Advances, if any, shall be Converted automatically to an ABR Advance on the last day of the then current Interest Period applicable thereto or at such earlier time as may be required. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7 and such Lender shall have obtained actual knowledge that it is once again legal for such Lender to make or maintain Eurodollar Advances, such Lender shall promptly notify the Administrative Agent and the Borrower thereof and, upon receipt of such notice by each of the Administrative Agent and the Borrower, such Lender's commitment to make or maintain Eurodollar Advances shall be reinstated. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7 , such suspension shall not otherwise affect such Lender's Commitment.

3.8 *[Reserved]*

3.9 *Certificates of Payment and Reimbursement*

Each Lender agrees, in connection with any request by it for payment or reimbursement pursuant to Section 3.5 or Section 3.6 , to provide the Borrower with a certificate, signed by an officer of such Lender, setting forth a description in reasonable detail of any such payment or reimbursement and the applicable Section of this Agreement pursuant to and in accordance with which such request is made. Each determination by each Lender of such payment or reimbursement shall be conclusive absent manifest error.

3.10 *Taxes; Net Payments*

(a) Payments Free of Taxes . Any and all payments by or on account of any obligation of the Borrower hereunder or under any other Loan Document shall be made free and clear of and without reduction or withholding for any Indemnified Taxes or Other Taxes, *provided* that if any withholding agent shall be required by applicable law to deduct any Indemnified Taxes (including any Other Taxes) from such payments, then (i) the sum payable shall be increased as necessary so that after making all required deductions (including deductions applicable to additional sums payable under this Section 3.10) the Administrative Agent or the applicable Lender, as the case may be, receives an amount equal to the sum it would have received had no such deductions for Indemnified Taxes or Other Taxes been made, (ii) such withholding agent shall make such deductions and (iii) such withholding agent shall timely pay the full amount deducted to the relevant Governmental Authority in accordance with applicable law.

(b) Payment of Other Taxes by the Borrower . Without limiting the provisions of paragraph (a) above, the Borrower shall timely pay any Other Taxes to the relevant Governmental Authority in accordance with applicable law.

(c) Indemnification by the Borrower . The Borrower shall indemnify the Administrative Agent and each Lender, within 30 days after demand therefor, for the full amount of any Indemnified Taxes imposed on or with respect to any payment made by or on account of any obligation of the Borrower under any Loan Document or Other Taxes (including Indemnified Taxes or Other Taxes imposed or asserted on or attributable to amounts payable under this Section 3.10) paid by the Administrative Agent or such Lender, as the case may be, and, without duplication, any penalties, interest and reasonable expenses arising therefrom or with respect thereto, whether or not such Indemnified Taxes or Other Taxes were correctly or legally imposed or asserted by the relevant Governmental Authority. A certificate as to the amount of such payment or liability delivered to the Borrower by such Lender (with a copy to the Administrative Agent), or by the Administrative Agent on its own behalf or on behalf of such Lender, shall be conclusive absent manifest error. After any Lender learns of the imposition of any Indemnified Taxes or Other Taxes, such Lender will as soon as reasonably practicable notify the Borrower thereof; *provided* that the failure to provide Borrower with such notice shall not release the Borrower from its indemnification obligations under this Section 3.10 .

(d) Evidence of Payments . As soon as practicable after any payment of Indemnified Taxes or Other Taxes by the

Borrower to a Governmental Authority, the Borrower shall deliver to the Administrative Agent the original or a certified copy of a receipt issued by such Governmental Authority evidencing such payment, a copy of the return reporting such payment or other evidence of such payment reasonably satisfactory to the Administrative Agent.

(e) Status of Lenders . Any Lender that is entitled to an exemption from or reduction of withholding Tax under the law of the jurisdiction in which the Borrower is resident for Tax purposes, or any treaty to which such jurisdiction is a party, with respect to payments hereunder or under any other Loan Document shall deliver to the Borrower (with a copy to the Administrative Agent), at the time or times prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent, such properly completed and executed documentation prescribed by applicable law as will permit such payments to be made without withholding or at a reduced rate of withholding. In addition, any Lender, if requested by the Borrower or the Administrative Agent, shall deliver such other documentation prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent as will enable the Borrower or the Administrative Agent to determine whether or not such Lender is subject to backup withholding or information reporting requirements.

Without limiting the generality of the foregoing, any Foreign Lender shall deliver to the Borrower and the Administrative Agent (in such number of copies as shall be requested by the recipient) on or prior to the date on which such Foreign Lender becomes a Lender under this Agreement (and from time to time thereafter (i) if such Foreign Lender shall determine that any applicable form or certification has expired or will then expire or has or will then become obsolete or incorrect or that an event has occurred that requires or will then require a change in the most recent form or certification previously delivered by it to the Borrower and the Administrative Agent and (ii) upon the request of the Borrower or the Administrative Agent, but only if such Foreign Lender is legally entitled to do so), whichever of the following is applicable:

(i) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E claiming eligibility for benefits of an income Tax treaty to which the United States of America is a party,

(ii) duly completed copies of Internal Revenue Service Form W-8ECI,

(iii) in the case of a Foreign Lender claiming the benefits of the exemption for portfolio interest under Section 881(c) of the Internal Revenue Code, (x) a certificate (a *"United States Tax Compliance Certificate"*) to the effect that such Foreign Lender is not (A) a "bank" within the meaning of Section 881(c)(3)(A) of the Internal Revenue Code, (B) a "10 percent shareholder" of the Borrower within the meaning of Section 881(c)(3)(B) of the Internal Revenue Code, (C) a "controlled foreign corporation" described in Section 881(c)(3)(C) of the Internal Revenue Code or (D) engaged in the conduct of a trade or business within the United States to which the interest payment is effectively connected and (y) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E,

(iv) to the extent a Foreign Lender is not the beneficial owner (for example, where the Foreign Lender is a partnership or participating Lender granting a typical participation), a complete and executed IRS Form W-8IMY, accompanied by a Form W-8ECI, Form W-8BEN, Form W-8BEN-E, a United States Tax Compliance Certificate, IRS Form W-9 and/or other certification documents from each beneficial owner, as applicable; *provided* that, if the Foreign Lender is a partnership (and not a participating Lender) and one or more partners of such Foreign Lender are claiming the portfolio interest exemption, such Foreign Lender shall provide a United States Tax Compliance Certificate, on behalf of such beneficial owner(s) in lieu of requiring each beneficial owner to provide its own certificate, or

(v) any other form prescribed by applicable law as a basis for claiming exemption from or a reduction in U.S. federal withholding Tax duly completed together with such supplementary documentation as may be prescribed by applicable law to permit the Borrower to determine the withholding or deduction required to be made.

If a payment made to a Lender under any Loan Document would be subject to U.S. federal withholding Tax imposed by FATCA if such Lender were to fail to comply with the applicable reporting requirements of FATCA (including those contained in Section 1471(b) or 1472(b) of the Internal Revenue Code, as applicable), such Lender shall deliver to the Borrower and the Administrative Agent at the time or times prescribed by law and at such time or times reasonably requested by the Borrower or the Administrative Agent such documentation prescribed by applicable law (including as prescribed by Section 1471(b)(3)(C) of the Internal Revenue Code) and such additional documentation reasonably requested by the Borrower or the Administrative Agent as may be necessary for the Borrower and the Administrative Agent to comply with their obligations under FATCA and to determine that such Lender has complied with such Lender's obligations under FATCA or to determine the amount to deduct and withhold from such payment. Solely for purposes of this clause, "FATCA" shall include any amendments made to FATCA after the date of this Agreement.

Without limiting the foregoing, upon request of the Administrative Agent or the Borrower, each Lender that is a "United States person" within the meaning of Section 7701(a)(30) of the Internal Revenue Code that lends to the Borrower (each, a

"U.S. Lender") shall deliver to the Administrative Agent and the Borrower two duly signed, properly completed copies of IRS Form W-9 on or prior to the Effective Date (or on or prior to the date it becomes a party to this Agreement), certifying that such U.S. Lender is entitled to an exemption from United States backup withholding, or any successor form.

(f) Treatment of Certain Refunds . If the Administrative Agent or a Lender determines, in its sole discretion exercised in good faith, that it has received a refund of any Taxes or Other Taxes as to which it has been indemnified by the Borrower or with respect to which the Borrower has paid additional amounts pursuant to this Section 3.10 , it shall pay to the Borrower an amount equal to such refund (but only to the extent of indemnity payments made, or additional amounts paid, by the Borrower under this Section 3.10 with respect to the Taxes or Other Taxes giving rise to such refund), net of all reasonable and documented out-of-pocket expenses of the Administrative Agent, such Lender, and without interest (other than any interest paid by the relevant Governmental Authority with respect to such refund), *provided* that the Borrower, upon the request of the Administrative Agent or such Lender, agrees to repay the amount paid over to the Borrower (plus any penalties, interest or other charges imposed by the relevant Governmental Authority) to the Administrative Agent or such Lender in the event the Administrative Agent or such Lender is required to repay such refund to such Governmental Authority. This paragraph shall not be construed to require the Administrative Agent or any Lender to make available its Tax returns (or any other information relating to its taxes that it deems confidential) to the Borrower or any other Person.

(g) Designation of a Different Lending Office . If any Lender requests compensation under Section 3.6 , or requires the Borrower to pay any additional amount to any Lender or any Governmental Authority for the account of any Lender pursuant to this Section 3.10 , then such Lender shall use reasonable efforts to designate a different lending office for funding or booking its Loans hereunder or to assign its rights and obligations hereunder to another of its offices, branches or affiliates, if, in the judgment of such Lender, such designation or assignment (i) would eliminate or reduce amounts payable pursuant to Section 3.6 or this Section 3.10 , as the case may be, in the future and (ii) would not subject such Lender to any unreimbursed cost or expense and would not otherwise be disadvantageous to such Lender. The Borrower hereby agrees to pay all reasonable and documented out-of-pocket costs and expenses incurred by any Lender in connection with any such designation or assignment.

3.11 *Facility Fees*

The Borrower agrees to pay to the Administrative Agent for the pro rata account of each Lender a fee (the *"Facility Fee"*) during the period commencing on the Effective Date and ending on the Expiration Date, payable quarterly in arrears on the last day of March, June, September and December of the year, commencing on the last day of the calendar quarter during which the Facility Fee shall commence to accrue, and on the Expiration Date, at a rate per annum equal to the Applicable Margin of (a) prior to the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6 , the Commitment Amount of such Lender (whether used or unused), and (b) thereafter, the sum of the outstanding principal balance of all Revolving Credit Loans of such Lender. Notwithstanding anything to the contrary contained in this Section 3.11 , on and after the Commitment Termination Date, the Facility Fee shall be payable upon demand. In addition, upon each reduction of the Aggregate Commitment Amount, the Borrower shall pay the Facility Fee accrued on the amount of such reduction to the date of such reduction. The Facility Fee shall be computed on the basis of a 360-day year for the actual number of days elapsed.

3.12 *[Reserved]*

3.13 *Replacement of Lender*

If (x) the Borrower is obligated to pay to any Lender any amount under Section 3.6 or Section 3.10 , the Borrower shall have the right within 90 days thereafter, or (y) any Lender shall be a Defaulting Lender, the Borrower shall have the right at any time during which such Lender shall remain a Defaulting Lender, in each case in accordance with the requirements of Section 11.7(b) and only if no Default or Event of Default shall exist, to replace such Lender (the *"Replaced Lender"*) with one or more Eligible Assignees (each a *"Replacement Lender"*), reasonably acceptable to the Administrative Agent, *provided* that (i) at the time of any replacement pursuant to this Section 3.13 , the Replacement Lender shall enter into one or more Assignment and Assumptions pursuant to Section 11.7(b) (with the processing and recordation fee referred to in Section 11.7(b) payable pursuant to said Section 11.7(b) to be paid by the Replacement Lender) pursuant to which the Replacement Lender shall acquire the Commitment and the outstanding Loans of the Replaced Lender and, in connection therewith, shall pay the following: (a) to the Replaced Lender, an amount equal to the sum of (A) an amount equal to the principal of, and all accrued interest on, all outstanding Loans of the Replaced Lender, (B) [reserved], and (C) an amount equal to all accrued, but unpaid, fees owing to the Replaced Lender, and (b) to the Administrative Agent an amount equal to all amounts owed by such Replaced Lender to the Administrative Agent under this Agreement, including, without limitation, an amount equal to the principal of, and all accrued interest on, all outstanding Loans of the Replaced Lender, a corresponding amount of which was made available by the Administrative Agent to the Borrower pursuant to Section 3.1 and which has not been repaid to the Administrative Agent by such Replaced Lender or the Borrower, and (ii) all obligations of the Borrower owing to the Replaced Lender (other than those specifically described in clause (i) above in respect of

which the assignment purchase price has been, or is concurrently being, paid) shall be paid in full to such Replaced Lender concurrently with such replacement. Upon the execution of the respective Assignment and Acceptance Agreements and the payment of amounts referred to in clauses (i) and (ii) of this Section 3.13 , the Replacement Lender shall become a Lender hereunder and the Replaced Lender shall cease to constitute a Lender hereunder, except with respect to indemnification provisions under this Agreement that are intended to survive the termination of the Commitments and the repayment of the Loans which may be applicable to any such Replaced Lender prior to the date of its replacement. Solely for the purpose of calculating break funding payments under Section 3.5 , the assignment by any Replaced Lender of any Eurodollar Advance prior to the last day of the Interest Period applicable thereto pursuant to clause (x) or (z) of this Section 3.13 shall be deemed to constitute a prepayment by the Borrower of such Eurodollar Advance.

4. REPRESENTATIONS AND WARRANTIES

In order to induce the Administrative Agent and the Lenders to enter into this Agreement and the Lenders to make the Loans, the Borrower hereby makes the following representations and warranties to the Administrative Agent and the Lenders:

4.1 *Existence and Power*

Each of the Borrower and the Subsidiaries is duly organized, validly existing and in good standing under the laws of the jurisdiction of its incorporation or formation (except, in the case of the Subsidiaries, where the failure to be in such good standing could not reasonably be expected to have a Material Adverse effect), has all requisite corporate power and authority to own its Property and to carry on its business as now conducted, and is qualified to do business as a foreign corporation and is in good standing in each jurisdiction in which it owns or leases real Property or in which the nature of its business requires it to be so qualified (except those jurisdictions where the failure to be so qualified or to be in good standing could not reasonably be expected to have a Material Adverse effect).

4.2 *Authority*

The Borrower has full corporate power and authority to enter into, execute, deliver and perform the terms of the Loan Documents, all of which have been duly authorized by all proper and necessary corporate action and are not in contravention of any applicable law or the terms of its Certificate of Incorporation and By-Laws. No consent or approval of, or other action by, shareholders of the Borrower, any Governmental Authority, or any other Person (which has not already been obtained) is required to authorize in respect of the Borrower, or is required in connection with the execution, delivery, and performance by the Borrower of the Loan Documents or is required as a condition to the enforceability of the Loan Documents against the Borrower.

4.3 *Binding Agreement*

The Loan Documents constitute the valid and legally binding obligations of the Borrower, enforceable in accordance with their respective terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by equitable principles relating to the availability of specific performance as a remedy.

4.4 *Litigation*

As of the Effective Date, there are no actions, suits, arbitration proceedings or claims (whether purportedly on behalf of the Borrower, any Subsidiary or otherwise) pending or, to the knowledge of the Borrower, threatened against the Borrower or any Subsidiary or any of their respective Properties, or maintained by the Borrower or any Subsidiary, at law or in equity, before any Governmental Authority which could reasonably be expected to have a Material Adverse effect. There are no proceedings pending or, to the knowledge of the Borrower, threatened against the Borrower or any Subsidiary (a) which call into question the validity or enforceability of any Loan Document, or otherwise seek to invalidate, any Loan Document, or (b) which might, individually or in the aggregate, materially and adversely affect any of the transactions contemplated by any Loan Document.

4.5 *No Conflicting Agreements*

(a) Neither the Borrower nor any Subsidiary is in default under any agreement to which it is a party or by which it or any of its Property is bound the effect of which could reasonably be expected to have a Material Adverse effect. No notice to, or filing with, any Governmental Authority is required for the due execution, delivery and performance by the Borrower of the Loan Documents.

(b) No provision of any existing material mortgage, material indenture, material contract or material agreement or of any existing statute, rule, regulation, judgment, decree or order binding on the Borrower or any Subsidiary or affecting the Property of the Borrower or any Subsidiary conflicts with, or requires any consent which has not already been obtained under, or would in any way prevent the execution, delivery or performance by the Borrower of the terms of, any Loan Document. The execution, delivery or performance by the Borrower of the terms of each Loan Document will not constitute a default under, or result in the creation or imposition of, or obligation to create, any Lien upon the Property of the Borrower or any Subsidiary pursuant to the terms of any such mortgage, indenture, contract or agreement.

4.6 *Taxes*

The Borrower and each Subsidiary has filed or caused to be filed all tax returns, and has paid, or has made adequate provision for the payment of, all taxes shown to be due and payable on said returns or in any assessments made against them, the failure of which to file or pay could reasonably be expected to have a Material Adverse effect, and no tax Liens (other than Liens permitted under Section 8.2) have been filed against the Borrower or any Subsidiary and no claims are being asserted with respect to such taxes which are required by GAAP to be reflected in the Financial Statements and are not so reflected, except for taxes which have been assessed but which are not yet due and payable. The charges, accruals and reserves on the books of the Borrower and each Subsidiary with respect to all federal, state, local and other taxes are considered by the management of the Borrower to be adequate, and the Borrower knows of no unpaid assessment which (a) could reasonably be expected to have a Material Adverse effect, or (b) is or might be due and payable against it or any Subsidiary or any Property of the Borrower or any Subsidiary, except such thereof as are being contested in good faith and by appropriate proceedings diligently conducted, and for which adequate reserves have been set aside in accordance with GAAP or which have been assessed but are not yet due and payable.

4.7 *Compliance with Applicable Laws; Filings*

Neither the Borrower nor any Subsidiary is in default with respect to any judgment, order, writ, injunction, decree or decision of any Governmental Authority which default could reasonably be expected to have a Material Adverse effect. The Borrower and each Subsidiary is complying with all applicable statutes, rules and regulations of all Governmental Authorities, a violation of which could reasonably be expected to have a Material Adverse effect. The Borrower and each Subsidiary has filed or caused to be filed with all Governmental Authorities all reports, applications, documents, instruments and information required to be filed pursuant to all applicable laws, rules, regulations and requests which, if not so filed, could reasonably be expected to have a Material Adverse effect.

4.8 *Governmental Regulations*

The Borrower is not subject to regulation under the Investment Company Act of 1940, as amended.

4.9 *Federal Reserve Regulations; Use of Proceeds*

The Borrower is not engaged principally, or as one of its important activities, in the business of extending credit for the purpose of purchasing or carrying any Margin Stock. No part of the proceeds of the Loans has been or will be used, directly or indirectly, and whether immediately, incidentally or ultimately, for a purpose which violates the provisions of Regulations T, U or X of the Board of Governors of the Federal Reserve System, as amended. Anything in this Agreement to the contrary notwithstanding, no Lender shall be obligated to extend credit to or on behalf of the Borrower in violation of any limitation or prohibition provided by any applicable law, regulation or statute, including said Regulation U. Following application of the proceeds of each Loan, not more than 25% (or such greater or lesser percentage as is provided in the exclusions from the definition of *"* Indirectly Secured *"* contained in said Regulation U as in effect at the time of the making of such Loan) of the value of the assets of the Borrower and the Subsidiaries on a Consolidated basis that are subject to Section 8.2 will be Margin Stock. In addition, no part of the proceeds of any Loan will be used, whether directly or indirectly, and whether immediately, incidentally or ultimately, to make a loan to any director or executive officer of the Borrower or any Subsidiary.

4.10 *No Misrepresentation*

No representation or warranty contained in any Loan Document and no certificate or written report furnished by the Borrower to the Administrative Agent or any Lender pursuant to any Loan Document contains, as of its date, a misstatement of a material fact, or omits to state, as of its date, a material fact required to be stated in order to make the statements therein contained, when taken as a whole, not materially misleading (*provided* that any representation, warranty, statement or written report that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such date) in the light of the circumstances under which made (after giving effect to all supplements and updates with respect thereto) (it being understood that the Borrower makes no representation or warranty hereunder with respect to any projections or other forward looking information).

4.11 *Plans*

The Borrower, each Subsidiary and each ERISA Affiliate have complied with the material requirements of Section 515 of ERISA with respect to each Pension Plan which is a Multiemployer Plan, except where the failure to so comply could not reasonably be expected to have a Material Adverse effect. The Borrower, each Subsidiary and each ERISA Affiliate has, as of the date hereof, made all contributions or payments to or under each Pension Plan required by law or the terms of such Pension Plan or any contract or agreement, except where the failure to make such contributions or payments could not reasonably be expected to have a Material Adverse effect. No liability to the PBGC has been, or is reasonably expected by the Borrower, any Subsidiary or any ERISA Affiliate to be, incurred by the Borrower, any Subsidiary or any ERISA Affiliate that could reasonably be expected to have a Material Adverse effect. Liability, as referred to in this Section 4.11 , includes any joint and several liability, but excludes any current or, to the extent it represents future liability in the ordinary course, any future liability for premiums under Section 4007 of ERISA.

4.12 *Environmental Matters*

Neither the Borrower nor any Subsidiary (a) has received written notice or otherwise learned of any claim, demand, action, event, condition, report or investigation indicating or concerning any potential or actual liability which individually or in the aggregate could reasonably be expected to have a Material Adverse effect, arising in connection with (i) any non-compliance with or violation of the requirements of any applicable Environmental Law, or (ii) the release or threatened release of any Hazardous Material, (b) to the best knowledge of the Borrower, has any threatened or actual liability in connection with the release or threatened release of any Hazardous Material into the environment which individually or in the aggregate could reasonably be expected to have a Material Adverse effect, (c) has received notice of any federal or state investigation evaluating whether any remedial action is needed to respond to a release or threatened release of any Hazardous Material into the environment for which the Borrower or any Subsidiary is or would be liable, which liability would reasonably be expected to have a Material Adverse effect, or (d) has received notice that the Borrower or any Subsidiary is or may be liable to any Person under the Comprehensive Environmental Response, Compensation and Liability Act, as amended, 42 U.S.C. Section 9601 et seq ., or any analogous state law, which liability would reasonably be expected to have a Material Adverse effect. The Borrower and each Subsidiary is in compliance with the financial responsibility requirements of federal and state Environmental Laws to the extent applicable, including those contained in 40 C.F.R., parts 264 and 265, subpart H, and any analogous state law, except in those cases in which the failure so to comply would not reasonably be expected to have a Material Adverse effect.

4.13 *Financial Statements*

The Borrower has heretofore delivered to the Lenders through the Administrative Agent copies of the audited Consolidated Balance Sheet of the Borrower and its Subsidiaries as of December 31, 2015, and the related Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for the fiscal year then ended. The financial statements referred to immediately above, including all related notes and schedules, are herein referred to collectively as the *"Financial Statements"* . The Financial Statements fairly present, in all material respects, the Consolidated financial condition and results of the operations of the Borrower and the Subsidiaries as of the dates and for the periods indicated therein and, except as noted therein, have been prepared in conformity with GAAP as then in effect. Neither the Borrower nor any of the Subsidiaries has any material obligation or liability of any kind (whether fixed, accrued, contingent, unmatured or otherwise) which, in accordance with GAAP as then in effect, should have been disclosed in the Financial Statements and was not. During the period from January 1, 2016 to and including the Effective Date, there was no Material Adverse change, including as a result of any change in law, in the consolidated financial condition, operations, business or Property of the Borrower and the Subsidiaries taken as a whole.

4.14 *Anti-Corruption Laws and Sanctions*

The Borrower has implemented and maintains in effect policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions, and the Borrower, the Subsidiaries and their respective officers and employees and, to the knowledge of the Borrower, its directors and agents are in compliance with Anti-Corruption Laws and applicable Sanctions in all material respects. None of (a) the Borrower, any Subsidiary or, to the knowledge of the Borrower or such Subsidiary, any of their respective directors, officers or employees, or (b) to the knowledge of the Borrower, any agent of the Borrower or any Subsidiary that will act in any capacity in connection with or benefit from the credit facility established hereby, is a Sanctioned Person. No Loan, use of proceeds or other transaction contemplated by this Agreement will violate Anti-Corruption Laws or applicable Sanctions.

5. *CONDITIONS TO EFFECTIVENESS*

This Agreement shall become effective on and as of the date (the " *Effective Date* ") that the following conditions shall have been satisfied:

5.1 *Agreement*

The Administrative Agent shall have received counterparts of this Agreement executed by the Borrower, the Administrative Agent and each Lender.

5.2 *Notes*

The Administrative Agent shall have received a Note, executed by the Borrower, for each Lender that shall have given at least three Domestic Business Days' prior written notice of its request for a Note.

5.3 *Corporate Action*

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Secretary or an Assistant Secretary of the Borrower (i) attaching a true and complete copy of the resolutions of its Board of Directors and of all documents evidencing all other necessary corporate action (in form and substance reasonably satisfactory to the Administrative Agent) taken by the Borrower to authorize this Agreement, the Loan Documents and the transactions contemplated hereby and thereby, (ii) attaching a true and complete copy of its Certificate of Incorporation and By-Laws, (iii) setting forth the incumbency of the officer or officers of the Borrower who may sign this Agreement and the Loan Documents, and any other certificates, requests, notices or other documents required hereunder or thereunder, and (iv) attaching a certificate of good standing of the Secretary of State of the State of Delaware.

5.4 *Opinion of Counsel to the Borrower*

The Administrative Agent shall have received an opinion of Thomas Moffatt, assistant general counsel of the Borrower, dated the Effective Date, in the form of Exhibit D .

5.5 *[Reserved]*

5.6 *No Default and Representations and Warranties*

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Senior Vice President and Treasurer of the Borrower certifying that there shall exist no Default or Event of Default and that the representations and warranties contained in this Agreement shall be true and correct in all material respects (provided that any representation and warranty that is

qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on the Effective Date), except those which are expressly specified to be made as of an earlier date.

5.7 *Fees*

The Administrative Agent shall have received all fees and other amounts due and payable to it, including the upfront fees payable to the Lenders in respect of this Agreement, on or prior to the Effective Date.

6. CONDITIONS OF LENDING - ALL LOANS

The obligation of each Lender on any Borrowing Date to make each Revolving Credit Loan are subject to the fulfillment of the following conditions precedent:

6.1 *Compliance*

On each Borrowing Date, and after giving effect to the Loans to be made on such Borrowing Date, (a) there shall exist no Default or Event of Default, and (b) the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on such Borrowing Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such Borrowing Date), except those which are expressly specified to be made as of an earlier date.

6.2 *Requests*

The Administrative Agent shall have timely received from the Borrower on or before such Borrowing Date, as applicable, a duly executed Borrowing Request.

7. AFFIRMATIVE COVENANTS

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the Fees and all other sums payable under the Loan Documents, the Borrower will:

7.1 *Legal Existence*

Except as may otherwise be permitted by Section 8.3 and Section 8.4 , maintain, and cause each Subsidiary to maintain, its corporate existence in good standing in the jurisdiction of its incorporation or formation and in each other jurisdiction in which the failure so to do could reasonably be expected to have a Material Adverse effect, except that the corporate existence of Subsidiaries may be terminated if (i) such Subsidiaries operate closing or discontinued operations or (ii) if the Borrower determines in good faith that such termination is in the best interests of the Borrower and is not materially disadvantageous to the Lenders.

7.2 *Taxes*

Pay and discharge when due, and cause each Subsidiary so to do, all taxes, assessments, governmental charges, license fees and levies upon or with respect to the Borrower and such Subsidiary, and upon the income, profits and Property thereof unless, and only to the extent, that either (i)(a) such taxes, assessments, governmental charges, license fees and levies shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Subsidiary, and (b) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor, or (ii) the failure to pay or discharge such taxes, assessments, governmental charges, license fees and levies could not reasonably be expected to have a Material Adverse effect.

7.3 *Insurance*

Keep, and cause each Subsidiary to keep, insurance with responsible insurance companies in such amounts and against such risks as is usually carried by the Borrower or such Subsidiary.

7.4 *Performance of Obligations*

Pay and discharge when due, and cause each Subsidiary so to do, all lawful Indebtedness, obligations and claims for labor, materials and supplies or otherwise which, if unpaid, could reasonably be expected to (a) have a Material Adverse effect, or (b) become a Lien on the Property of the Borrower or any Subsidiary, except those Liens permitted under Section 8.2 , *provided* that neither the Borrower nor such Subsidiary shall be required to pay or discharge or cause to be paid or discharged any such

Indebtedness, obligation or claim so long as (i) the validity thereof shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Subsidiary, and (ii) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor.

7.5 *Condition of Property*

Except for ordinary wear and tear, at all times, maintain, protect and keep in good repair, working order and condition, all material Property necessary for the operation of its business (other than Property which is replaced with similar Property) as then being operated, and cause each Subsidiary so to do.

7.6 *Observance of Legal Requirements*

(a) Observe and comply in all material respects, and cause each Subsidiary so to do, with all laws, ordinances, orders, judgments, rules, regulations, certifications, franchises, permits, licenses, directions and requirements of all Governmental Authorities, which now or at any time hereafter may be applicable to it or to such Subsidiary, a violation of which could reasonably be expected to have a Material Adverse effect; and

(b) Maintain in effect and enforce policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions.

7.7 *Financial Statements and Other Information*

Maintain, and cause each Subsidiary to maintain, a standard system of accounting in accordance with GAAP, and furnish to the Administrative Agent for distribution to the Lenders:

(a) As soon as available and, in any event, within 90 days after the close of each fiscal year, a copy of (x) the Borrower's 10-K in respect of such fiscal year, and (y) (i) the Borrower's Consolidated Balance Sheet as of the end of such fiscal year, and (ii) the related Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows, as of and through the end of such fiscal year, setting forth in each case in comparative form the corresponding figures in respect of the previous fiscal year, all in reasonable detail, and accompanied by a report of the Borrower's auditors, which report shall state that (A) such auditors audited such financial statements, (B) such audit was made in accordance with generally accepted auditing standards in effect at the time and provides a reasonable basis for such opinion, and (C) said financial statements have been prepared in accordance with GAAP;

(b) As soon as available, and in any event within 45 days after the end of each of the first three fiscal quarters of each fiscal year, a copy of (x) the Borrower's 10-Q in respect of such fiscal quarter, and (y) (i) the Borrower's Condensed Consolidated Balance Sheet as of the end of such quarter and (ii) the related Condensed Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for (A) such quarter and (B) the period from the beginning of the then current fiscal year to the end of such quarter, in each case in comparable form with the prior fiscal year, all in reasonable detail and prepared in accordance with GAAP (without footnotes and subject to year-end adjustments);

(c) Simultaneously with the delivery of the financial statements required by clauses (a) and (b) above, a certificate of the chief financial officer or treasurer of the Borrower certifying that no Default or Event of Default shall have occurred or be continuing or, if so, specifying in such certificate all such Defaults and Events of Default, and setting forth computations in reasonable detail demonstrating compliance with Section 8.1 and Section 8.9.

(d) Prompt notice upon the Borrower becoming aware of any change in a Pricing Level;

(e) As soon as practicable after becoming available, copies of all regular or periodic reports (including current reports on Form 8-K) which the Borrower or any Subsidiary may now or hereafter be required to file with or deliver to the U.S. Securities and Exchange Commission, or any other Governmental Authority succeeding to the functions thereof;

(f) Prompt written notice of: (i) any citation, summons, subpoena, order to show cause or other order naming the Borrower or any Subsidiary a party to any proceeding before any Governmental Authority which could reasonably be expected to have a Material Adverse effect, and include with such notice a copy of such citation, summons, subpoena, order to show cause or other order, (ii) any lapse or other termination of any license, permit, franchise or other authorization issued to the Borrower or any Subsidiary by any Governmental Authority, (iii) any refusal by any Governmental Authority to renew or extend any license, permit, franchise or other authorization, and (iv) any dispute between the Borrower or any Subsidiary and any Governmental Authority, which lapse, termination, refusal or dispute, referred to in clause (ii), (iii) or (iv) above, could reasonably be expected to have a Material Adverse effect;

(g) Prompt written notice of the occurrence of (i) each Default, (ii) each Event of Default and (iii) each Material Adverse change;

(h) As soon as practicable following receipt thereof, copies of any audit reports delivered in connection with the statements referred to in Section 7.7(a) ;

(i) From time to time, such other information regarding the financial position or business of the Borrower and the Subsidiaries as the Administrative Agent, at the request of any Lender, may reasonably request; and

(j) Prompt written notice of such other information with documentation required by bank regulatory authorities under applicable "know your customer" and anti-money laundering laws, rules and regulations (including, without limitation, the Patriot Act), as from time to time may be reasonably requested by the Administrative Agent or any Lender.

Information required to be delivered pursuant to (x) this Section 7.7 shall be deemed to have been delivered if such information shall have been posted by the Administrative Agent on a Debtdomain, IntraLinks, Syndtrak or similar electronic system (the *"Platform"*) to which each Lender has been granted access and (y) clauses (a), (b) and (e) of this Section 7.7 shall be deemed delivered to the Administrative Agent and to the Lenders when available on the Borrower's website at http://www.cvshealth.com or the website of the U.S. Securities and Exchange Commission at http://www.sec.gov . Information delivered pursuant to Section 7.7 may also be delivered by electronic communications pursuant to procedures approved by the Administrative Agent.

The Borrower hereby acknowledges that the Administrative Agent and/or the Sole Lead Arranger and Sole Bookrunner named on the cover page hereof will make available to the Lenders materials and/or information provided by or on behalf of the Borrower hereunder (collectively, " *Borrower Materials* ") by posting the Borrower Materials on the Platform.

7.8 *Records*

Upon reasonable notice and during normal business hours and, if no Event of Default has occurred and is continuing, not more than once in each fiscal year, permit representatives of the Administrative Agent and each Lender to visit the offices of the Borrower and each Subsidiary, to examine the books and records (other than tax returns and work papers related to tax returns) thereof and auditors' reports relating thereto, to discuss the affairs of the Borrower and each Subsidiary with the respective officers thereof, and to meet and discuss the affairs of the Borrower and each Subsidiary with the Borrower's auditors.

7.9 *Authorizations*

Maintain and cause each Subsidiary to maintain, in full force and effect, all copyrights, patents, trademarks, trade names, franchises, licenses, permits, applications, reports, and other authorizations and rights, which, if not so maintained, would individually or in the aggregate have a Material Adverse effect.

8. NEGATIVE COVENANTS

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the Fees and all other sums which are payable under the Loan Documents, the Borrower will not:

8.1 *Subsidiary Indebtedness*

Permit the Indebtedness of all Subsidiaries (excluding Indebtedness under capital leases incurred in connection with a sale leaseback transaction) to exceed (on a combined basis) 15% of Net Tangible Assets.

8.2 *Liens*

Create, incur, assume or suffer to exist any Lien against or on any Property now owned or hereafter acquired by the Borrower or any of the Subsidiaries, or permit any of the Subsidiaries so to do, except any one or more of the following types of Liens: (a) Liens in connection with workers' compensation, unemployment insurance or other social security obligations (which phrase shall not be construed to refer to ERISA or the minimum funding obligations under Section 412 of the Internal Revenue Code), (b) Liens to secure the performance of bids, tenders, letters of credit, contracts (other than contracts for the payment of Indebtedness), leases, statutory obligations, surety, customs, appeal, performance and payment bonds and other obligations of like nature, or to qualify to do business, maintain insurance or obtain other benefits, in each such case arising in the ordinary course of business, (c) mechanics', workmen's, carriers', warehousemen's, materialmen's, landlords' or other like Liens arising in the ordinary course of business with respect to obligations which are not due or which are being contested in good faith and by appropriate proceedings diligently conducted, (d) Liens for taxes, assessments, fees or governmental charges the payment of which is not

required by Section 7.2 or Section 7.4 , (e) easements, rights of way, restrictions, leases of Property to others, easements for installations of public utilities, title imperfections and restrictions, zoning ordinances and other similar encumbrances affecting Property which in the aggregate do not materially impair its use for the operation of the business of the Borrower or such Subsidiary, (f) Liens on Property of the Subsidiaries under capital leases and Liens on Property (including on the capital stock or other equity interests) of the Subsidiaries acquired (whether as a result of purchase, capital lease, merger or other acquisition) and either existing on such Property when acquired, or created contemporaneously with or within 12 months of such acquisition to secure the payment or financing of the purchase price of such Property (including the construction, development, substantial repair, alteration or improvement thereof), and any renewals thereof, *provided* that such Liens attach only to the Property so purchased or acquired (including any such construction, development, substantial repair, alteration or improvement thereof) and *provided further* that the Indebtedness secured by such Liens is permitted by Section 8.1 , (g) statutory Liens in favor of lessors arising in connection with Property leased to the Borrower or any of the Subsidiaries, (h) Liens of attachments, judgments or awards against the Borrower or any of the Subsidiaries with respect to which an appeal or proceeding for review shall be pending or a stay of execution or bond shall have been obtained, or which are otherwise being contested in good faith and by appropriate proceedings diligently conducted, and in respect of which adequate reserves shall have been established in accordance with GAAP on the books of the Borrower or such Subsidiary, (i) Liens securing Indebtedness of a Subsidiary to the Borrower or another Subsidiary, (j) Liens (other than Liens permitted by any of the foregoing clauses) arising in the ordinary course of its business which do not secure Indebtedness and do not, in the aggregate, materially detract from the value of the business of the Borrower and its Subsidiaries, taken as a whole, (k) Liens in favor of the United States of America, or any state thereof, to secure partial, progress, advance or other payments pursuant to any contract or provisions of any statute, and (l) additional Liens securing Indebtedness of the Borrower and the Subsidiaries in an aggregate outstanding Consolidated principal amount not exceeding 15% of Net Tangible Assets.

8.3 *Dispositions*

Make any Disposition, or permit any of its Subsidiaries so to do, of all or substantially all of the assets of the Borrower and the Subsidiaries on a Consolidated basis.

8.4 *Merger or Consolidation, Etc.*

Consolidate with, be acquired by, or merge into or with any Person unless (x) immediately after giving effect thereto no Default or Event of Default shall or would exist and (y) either (i) the Borrower or (ii) a corporation organized and existing under the laws of one of the States of the United States of America shall be the survivor of such consolidation or merger, *provided* that if the Borrower is not the survivor, the corporation which is the survivor shall expressly assume, pursuant to an instrument executed and delivered to the Administrative Agent, and in form and substance reasonably satisfactory to the Administrative Agent, all obligations of the Borrower under the Loan Documents and the Administrative Agent shall have received such documents, opinions and certificates as it shall have reasonable requested in connection therewith.

8.5 *Acquisitions*

Make any Acquisition, or permit any of the Subsidiaries so to do, except any one or more of the following: (a) Intercompany Dispositions not prohibited by Section 8.3 and (b) Acquisitions by the Borrower or any of the Subsidiaries, *provided* that immediately before and after giving effect to each such Acquisition no Event of Default shall or would exist.

8.6 *Restricted Payments*

Make any Restricted Payment or permit any of the Subsidiaries so to do, except any one or more of the following Restricted Payments: (a) any direct or indirect Subsidiary may make dividends or other distributions to the Borrower or to any other direct or indirect Subsidiary or otherwise ratably with respect to its stock or other equity interests, and (b) the Borrower may make Restricted Payments, *provided* that, in the case of this clause (b), immediately before and after giving effect thereto, no Event of Default shall or would exist.

8.7 *Limitation on Upstream Dividends by Subsidiaries*

Permit or cause any of the Subsidiaries to enter into or agree, or otherwise be or become subject, to any agreement, contract or other arrangement (other than this Agreement) with any Person (each a *"Restrictive Agreement"*) pursuant to the terms of which (a) such Subsidiary is or would be prohibited from declaring or paying any cash dividends on any class of its stock owned directly or indirectly by the Borrower or any of the other Subsidiaries or from making any other distribution on account of any class of any such stock (herein referred to as *"Upstream Dividends"*), or (b) the declaration or payment of Upstream Dividends by a Subsidiary to the Borrower or another Subsidiary, on an annual or cumulative basis, is or would be otherwise limited or restricted (*"Dividend Restrictions"*). Notwithstanding the foregoing, nothing in this Section 8.7 shall prohibit:

(i) Dividend Restrictions set forth in any Restrictive Agreement in effect on the date hereof and any extensions, refinancings, renewals or replacements thereof; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(ii) Dividend Restrictions existing with respect to any Person acquired by the Borrower or any Subsidiary and existing at the time of such acquisition, which Dividend Restrictions are not applicable to any Person or the property or assets of any Person other than such Person or its property or assets acquired, and any extensions, refinancings, renewals or replacements of any of the foregoing; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(iii) Dividend Restrictions consisting of customary net worth, leverage and other financial covenants, customary covenants regarding the merger of or sale of stock or assets of a Subsidiary, customary restrictions on transactions with affiliates, and customary subordination provisions governing Indebtedness owed to the Borrower or any Subsidiary, in each case contained in, or required by, any agreement governing Indebtedness incurred by a Subsidiary in accordance with Section 8.1 ; or

(iv) Dividend Restrictions contained in any other credit agreement so long as such Dividend Restrictions are no more restrictive than those contained in this Agreement (including Dividend Restrictions contained in the Existing 2013 Credit Agreement, the Existing 2014 Credit Agreement and the Existing 2015 Credit Agreement).

8.8 *Limitation on Negative Pledges*

Enter into any agreement (other than (i) this Agreement, (ii) any other credit agreement that is substantially similar to this Agreement, (iii) purchase money financings or capital leases permitted by this Agreement (in which cases, any prohibition or limitation shall only be effective against the assets financed thereby), (iv) customary restrictions and conditions contained in agreements relating to the Disposition of a Subsidiary, property or assets pending such Disposition, *provided* such restrictions and conditions apply only to such Subsidiary, property or assets, (v) restrictions and conditions contained in documentation relating to a Subsidiary acquired after the Effective Date, *provided* that such restriction or condition (x) existed at the time such Person became a Subsidiary and was not created in contemplation of or in connection with such Person becoming a Subsidiary and (y) applies only to such Subsidiary, and (vi) customary provisions in joint venture agreements, leases, licenses and other contracts restricting or conditioning the assignment or encumbrance thereof, including, without limitation, licenses and sublicenses of patents, trademarks, copyrights and similar intellectually property rights) or permit any Subsidiary so to do, which prohibits or limits the ability of the Borrower or such Subsidiary to create, incur, assume or suffer to exist any Lien upon any of its Property or revenues, whether now owned or hereafter acquired, to secure the obligations of the Borrower hereunder.

8.9 *Ratio of Consolidated Indebtedness to Total Capitalization*

Permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.6 : 1.0.

9. *DEFAULT*

9.1 *Events of Default*

The following shall each constitute an *"Event of Default"* hereunder:

(a) The failure of the Borrower to make any payment of principal on any Loan when due and payable; or

(b) The failure of the Borrower to make any payment of interest on any Loan or of any Fee on any date when due and payable and such default shall continue unremedied for a period of 5 Domestic Business Days after the same shall be due and payable; or

(c) The failure of the Borrower to observe or perform any covenant or agreement contained in Section 2.5 , Section 7.1 or in Section 8 ; or

(d) The failure of the Borrower to observe or perform any other covenant or agreement contained in this Agreement, and such failure shall have continued unremedied for a period of 30 days after the Borrower shall have become aware of such failure; or

(e) [Reserved]; or

(f) Any representation or warranty of the Borrower (or of any of its officers on its behalf) made in any Loan Document, or made in any certificate, report, opinion (other than an opinion of counsel) or other document delivered on or after the date hereof shall in any such case prove to have been incorrect or misleading (whether because of misstatement or omission) in any material respect when made; or

(g) (i) Obligations in an aggregate Consolidated amount in excess of $75,000,000 of the Borrower (other than its obligations hereunder and under the Notes) and the Subsidiaries, whether as principal, guarantor, surety or other obligor, for the payment of any Indebtedness or any net liability under interest rate swap, collar, exchange or cap agreements, (A) shall become or shall be declared to be due and payable prior to the expressed maturity thereof, or (B) shall not be paid when due or within any grace period for the payment thereof, or (ii) any holder of any such obligations shall have the right to declare the Indebtedness evidenced thereby due and payable prior to its stated maturity; or

(h) An involuntary proceeding shall be commenced or an involuntary petition shall be filed seeking (i) liquidation, reorganization or other relief in respect of the Borrower or any Subsidiary or its debts, or of a substantial part of its assets, under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect or (ii) the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Subsidiary or for a substantial part of its assets, and, in any such case, such proceeding or petition shall continue undismissed for 60 days or an order or decree approving or ordering any of the foregoing shall be entered; or

(i) The Borrower or any Subsidiary shall (9) voluntarily commence any proceeding or file any petition seeking liquidation, reorganization or other relief under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect, (9) consent to the institution of, or fail to contest in a timely and appropriate manner, any proceeding or petition described in clause (h) of this Section 9.1 , (9) apply for or consent to the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Subsidiary or for a substantial part of its assets, (9) file an answer admitting the material allegations of a petition filed against it in any such proceeding, (9) make a general assignment for the benefit of creditors or (9) take any action for the purpose of effecting any of the foregoing; or

(j) The Borrower or any Subsidiary shall (i) generally not be paying its debts as such debts become due or (ii) admit in writing its inability to pay its debts as they become due; or

(k) Judgments or decrees in an aggregate Consolidated amount in excess of $75,000,000 against the Borrower and the Subsidiaries shall remain unpaid, unstayed on appeal, undischarged, unbonded or undismissed for a period of 60 days during which execution shall not be effectively stayed, or any action shall be legally taken by a judgment creditor to attach or levy upon any assets of the Borrower or any Subsidiary to enforce any such judgment; or

(l) After the Effective Date a Change of Control shall occur; or

(m) (i) Any Termination Event shall occur (x) with respect to any Pension Plan (other than a Multiemployer Plan) or (y) with respect to any other retirement plan subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, which plan, during the five year period prior to such Termination Event, was the responsibility in whole or in part of the Borrower, any Subsidiary or any ERISA Affiliate, provided that this clause (y) shall only apply if, in connection with such Termination Event, it is reasonably likely that liability in an aggregate Consolidated amount in excess of $100,000,000 will be imposed upon the Borrower; (ii) any failure to satisfy the minimum funding standards (within the meaning of Section 412 of the Code or Section 302 of ERISA), whether or not waived, as of the end of the applicable grace period for contributions to a Pension Plan for the applicable plan year of such Pension Plan (other than with respect to a Multiemployer Plan) in an aggregate Consolidated amount in excess of $75,000,000; (iii) any Person shall engage in a Prohibited Transaction involving any Employee Benefit Plan in respect of which it is reasonably likely that liability in an aggregate Consolidated amount in excess of $75,000,000 will be imposed upon the Borrower; (iv) the Borrower shall fail to pay when due an amount which is payable by it to the PBGC or to a Pension Plan (including a Multiemployer Plan) under Title IV of ERISA; (v) the imposition on the Borrower of any tax under Section 4980(B)(a) of the Internal Revenue Code; or (vi) the assessment of a civil penalty on the Borrower with respect to any Employee Benefit Plan under Section 502(c) of ERISA; in each case, to the extent such event or condition would have a Material Adverse effect. In determining the Consolidated amount for any purpose pursuant to this Section 9.1(m), the liabilities, funding amounts, taxes and penalties referenced in the foregoing clauses of this Section 9.1(m) shall include those of the Subsidiaries and ERISA Affiliates of the Borrower to the extent the Borrower is obligated to pay any such liabilities, funding amounts, taxes and penalties.

9.2 *Remedies*

(a) Upon the occurrence of an Event of Default or at any time thereafter during the continuance of an Event of Default, the Administrative Agent, at the written request of the Required Lenders, shall notify the Borrower that the Commitments

have been terminated and/or that all of the Loans and the Notes and all accrued and unpaid interest on any thereof and all other amounts owing under the Loan Documents have been declared immediately due and payable, *provided* that upon the occurrence of an Event of Default under Section 9.1(h), (i) or (j) with respect to the Borrower, the Commitments shall automatically terminate and all of the Loans and the Notes and all accrued and unpaid interest on any thereof and all other amounts owing under the Loan Documents shall become immediately due and payable without declaration or notice to the Borrower. To the fullest extent not prohibited by law, except for the notice provided for in the preceding sentence, the Borrower expressly waives any presentment, demand, protest, notice of protest or other notice of any kind in connection with the Loan Documents and its obligations thereunder. To the fullest extent not prohibited by law, the Borrower further expressly waives and covenants not to assert any appraisement, valuation, stay, extension, redemption or similar law, now or at any time hereafter in force which might delay, prevent or otherwise impede the performance or enforcement of the Loan Documents.

(b) In the event that the Commitments shall have been terminated or all of the Loans and the Notes shall have been declared due and payable pursuant to the provisions of this Section 9.2 , the Administrative Agent and the Lenders agree, among themselves, that any funds received from or on behalf of the Borrower under any Loan Document by any Lender (except funds received by any Lender as a result of a purchase from such Lender pursuant to the provisions of Section 11.9(b)) shall be remitted to the Administrative Agent, and shall be applied by the Administrative Agent in payment of the Loans and the other obligations of the Borrower under the Loan Documents in the following manner and order: (1) first, to the payment or reimbursement of the Administrative Agent and the Lenders, in that order, for any fees, expenses or amounts due from the Borrower pursuant to the provisions of Section 11.5 , (2) second, to the payment of the Fees, (3) third, to the payment of any other fees, expenses or amounts (other than the principal of and interest on the Loans and the Notes) payable by the Borrower to the Administrative Agent or any of the Lenders under the Loan Documents, (4) fourth, to the payment, pro rata according to the outstanding principal balance of the Loans of each Lender, of interest due on the Loans, (5) fifth, to the payment, pro rata according to the aggregate outstanding principal balance of the Loans of each Lender, of the aggregate outstanding principal balance of the Loans, and (6) sixth, any remaining funds shall be paid to whosoever shall be entitled thereto or as a court of competent jurisdiction shall direct.

(c) In the event that the Loans and the Notes shall have been declared due and payable pursuant to the provisions of this Section 9.2 , the Administrative Agent upon the written request of the Required Lenders, shall proceed to enforce the rights of the holders of the Loans and the Notes by suit in equity, action at law and/or other appropriate proceedings, whether for payment or the specific performance of any covenant or agreement contained in the Loan Documents. In the event that the Administrative Agent shall fail or refuse so to proceed, each Lender shall be entitled to take such action as the Required Lenders shall deem appropriate to enforce its rights under the Loan Documents.

10. AGENT

10.1 *Appointment and Authority*

Each Credit Party hereby irrevocably appoints Barclays to act on its behalf as the Administrative Agent hereunder and under the other Loan Documents and authorizes the Administrative Agent to take such actions on its behalf and to exercise such powers as are delegated to the Administrative Agent by the terms hereof or thereof, together with such actions and powers as are reasonably incidental thereto. The provisions of this Section 10 are solely for the benefit of the Administrative Agent and the Credit Parties and the Borrower shall have no rights as a third party beneficiary of any of such provisions.

10.2 *Rights as a Lender*

The Person serving as the Administrative Agent hereunder shall have the same rights and powers in its capacity as a Lender as any other Lender and may exercise the same as though it were not the Administrative Agent and the term "Lender" or "Lenders" shall, unless otherwise expressly indicated or unless the context otherwise requires, include the Person serving as the Administrative Agent hereunder in its individual capacity. Such Person and its Affiliates may accept deposits from, lend money to, act as the financial advisor or in any other advisory capacity for and generally engage in any kind of business with the Borrower, any of its Subsidiaries or any other Affiliate thereof as if such Person were not the Administrative Agent hereunder and without any duty to account therefor to the Lenders.

10.3 *Exculpatory Provisions*

(a) The Administrative Agent shall not have any duties or obligations except those expressly set forth herein and in the other Loan Documents. Without limiting the generality of the foregoing, the Administrative Agent:

(1) shall not be subject to any fiduciary or other implied duties, regardless of whether a Default has occurred and is continuing;

(2) shall not have any duty to take any discretionary action or exercise any discretionary powers, except discretionary rights and powers expressly contemplated hereby or by the other Loan Documents that the Administrative Agent is required to exercise as directed in writing by the Required Lenders (or such other number or percentage of the Lenders as shall be expressly provided for herein or in the other Loan Documents); provided that the Administrative Agent shall not be required to take any action that, in its opinion or the opinion of its counsel, may expose the Administrative Agent to liability or that is contrary to any Loan Document or applicable law; and

(3) shall not, except as expressly set forth herein and in the other Loan Documents, have any duty to disclose, and shall not be liable for the failure to disclose, any information relating to the Borrower, any of its Subsidiaries or any Affiliate thereof that is communicated to or obtained by the Person serving as the Administrative Agent or any of its Affiliates in any capacity.

(b) The Administrative Agent shall not be liable for any action taken or not taken by it (i) with the consent or at the request of the Required Lenders (or such other number or percentage of the Lenders as shall be necessary, or as the Administrative Agent shall believe in good faith shall be necessary, under the circumstances as provided in Section 11.1 and Section 9) or (ii) in the absence of its own gross negligence or willful misconduct as determined by a court of competent jurisdiction by a final and non-appealable judgment. The Administrative Agent shall be deemed not to have knowledge of any Default unless and until notice describing such Default is given to the Administrative Agent by the Borrower or a Lender.

(c) The Administrative Agent shall not be responsible for or have any duty to ascertain or inquire into (10) any statement, warranty or representation made in or in connection with this Agreement or any other Loan Document, (10) the contents of any certificate, report or other document delivered hereunder or thereunder or in connection herewith or therewith, (10) the performance or observance of any of the covenants, agreements or other terms or conditions set forth herein or therein or the occurrence of any Default, (10) the validity, enforceability, effectiveness or genuineness of this Agreement, any other Loan Document or any other agreement, instrument or document or (10) the satisfaction of any condition set forth in Section 5 or Section 6 or elsewhere herein, other than to confirm receipt of items expressly required to be delivered to the Administrative Agent.

10.4 *Reliance by Administrative Agent*

The Administrative Agent shall be entitled to rely upon, and shall not incur any liability for relying upon, any notice, request, certificate, consent, statement, instrument, document or other writing (including any electronic message, internet or intranet website posting or other distribution) believed by it to be genuine and to have been signed, sent or otherwise authenticated by the proper Person. The Administrative Agent also may rely upon any statement made to it orally or by telephone and believed by it to have been made by the proper Person, and shall not incur any liability for relying thereon. In determining compliance with any condition hereunder to the making of a Loan, that by its terms must be fulfilled to the satisfaction of a Lender, the Administrative Agent may presume that such condition is satisfactory to such Lender unless the Administrative Agent shall have received notice to the contrary from such Lender. The Administrative Agent may consult with legal counsel (who may be counsel for the Borrower), independent public accounting firm and other experts selected by it, and shall not be liable for any action taken or not taken by it in accordance with the advice of any such counsel, accounting firm or experts.

10.5 *Delegation of Duties*

The Administrative Agent may perform any and all of its duties and exercise its rights and powers hereunder or under any other Loan Document by or through any one or more sub-agents appointed by the Administrative Agent. The Administrative Agent and any such sub-agent may perform any and all of its duties and exercise its rights and powers by or through their respective Related Parties. The exculpatory provisions of this Section 10 shall apply to any such sub-agent and to the Related Parties of the Administrative Agent and any such sub-agent, and shall apply to their respective activities in connection with the syndication of the credit facilities provided for herein as well as activities as the Administrative Agent.

10.6 *Resignation of Administrative Agent*

The Administrative Agent may at any time give notice of its resignation to the Credit Parties and the Borrower. Upon receipt of any such notice of resignation, the Required Lenders shall have the right, subject to, so long as no Default or Event of Default has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed), to appoint a successor, which shall be a bank with an office in New York, New York, or an Affiliate of any such bank with an office in New York, New York. If no such successor shall have been so appointed by the Required Lenders and shall have accepted such appointment within 30 days after the retiring Administrative Agent gives notice of its resignation, then the retiring Administrative Agent may on behalf of the Credit Parties, appoint a successor Administrative Agent meeting the qualifications set forth above, subject to, so long as no Default or Event of Default has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed); *provided* that if the Administrative Agent shall notify the Borrower and the Credit Parties that

no qualifying Person has accepted such appointment, then such resignation shall nonetheless become effective in accordance with such notice and (10) the retiring Administrative Agent shall be discharged from its duties and obligations hereunder and under the other Loan Documents and (10) all payments, communications and determinations provided to be made by, to or through the Administrative Agent shall instead be made by or to each Credit Party directly, until such time as the Required Lenders appoint a successor Administrative Agent as provided for above in this paragraph. Upon the acceptance of a successor's appointment as Administrative Agent hereunder, such successor shall succeed to and become vested with all of the rights, powers, privileges and duties of the retiring (or retired) Administrative Agent, and the retiring Administrative Agent shall be discharged from all of its duties and obligations hereunder or under the other Loan Documents (if not already discharged therefrom as provided above in this paragraph). The fees payable by the Borrower to a successor Administrative Agent shall be the same as those payable to its predecessor unless otherwise agreed between the Borrower and such successor. After the retiring Administrative Agent's resignation hereunder and under the other Loan Documents, the provisions of this Section 10 and Section 11.5 shall continue in effect for the benefit of such retiring Administrative Agent, its sub-agents and their respective Related Parties in respect of any actions taken or omitted to be taken by any of them while the retiring Administrative Agent was acting as Administrative Agent.

10.7 *Non-Reliance on Administrative Agent and Other Credit Parties*

Each Credit Party acknowledges that it has, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it has deemed appropriate, made its own credit analysis and decision to enter into this Agreement. Each Credit Party also acknowledges that it will, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it shall from time to time deem appropriate, continue to make its own decisions in taking or not taking action under or based upon this Agreement, any other Loan Document or any related agreement or any document furnished hereunder or thereunder.

10.8 *No Other Duties, etc.*

Anything herein to the contrary notwithstanding, none of the Sole Bookrunner, or the Sole Lead Arranger listed on the cover page hereof shall have any powers, duties or responsibilities under this Agreement or any of the other Loan Documents, except in its capacity, as applicable, as the Administrative Agent or a Lender hereunder.

11. OTHER PROVISIONS

11.1 *Amendments, Waivers, Etc.*

With the written consent of the Required Lenders, the Administrative Agent and the Borrower may, from time to time, enter into written amendments, supplements or modifications of the Loan Documents and, with the written consent of the Required Lenders, the Administrative Agent on behalf of the Lenders may execute and deliver to any such parties a written instrument waiving or consenting to the departure from, on such terms and conditions as the Administrative Agent may specify in such instrument, any of the requirements of the Loan Documents or any Default or Event of Default and its consequences, *provided* that no such amendment, supplement, modification, waiver or consent shall (i) increase the Commitment Amount of any Lender without the consent of such Lender (*provided* that no waiver of a Default or Event of Default shall be deemed to constitute such an increase), (ii) extend the Commitment Period without the consent of each Lender directly affected thereby, (iii) reduce the amount, or extend the time of payment, of the Fees without the consent of each Lender directly affected thereby, (iv) reduce the rate, or extend the time of payment of, interest on any Revolving Credit Loan or any Note (other than the applicability of any post-default increase in such rate of interest) without the consent of each Lender directly affected thereby, (v) reduce the amount, or extend the time of payment of any payment of principal on any Revolving Credit Loan or any Note without the consent of each Lender directly affected thereby, (vi) decrease or forgive the principal amount of any Revolving Credit Loan or any Note without the consent of each Lender directly affected thereby, (vii) consent to any assignment or delegation by the Borrower of any of its rights or obligations under any Loan Document without the consent of each Lender, (viii) change the provisions of this Section 11.1 without the consent of each Lender, (ix) change the definition of Required Lenders without the consent of each Lender, (x) change the several nature of the obligations of the Lenders without the consent of each Lender, or (xi) change the sharing provisions among Lenders without the consent of each Lender directly affected thereby. Notwithstanding the foregoing, no such amendment, supplement, modification, waiver or consent shall amend, modify or waive any provision of Section 10 or otherwise change any of the rights or obligations of the Administrative Agent under any Loan Document without the written consent of the Administrative Agent. Any such amendment, supplement, modification, waiver or consent shall apply equally to each of the Lenders and shall be binding upon the parties to the applicable Loan Document, the Lenders, the Administrative Agent and all future holders of the Loans and the Notes. In the case of any waiver, the Borrower, the Lenders and the Administrative Agent shall be restored to their former position and rights under the Loan Documents, but any Default or Event of Default waived shall not extend to any subsequent or other Default or Event of Default, or impair any right consequent thereon.

11.2 *Notices*

(a) *Notices Generally*. Except in the case of notices and other communications expressly permitted to be given by telephone, all notices and other communications provided for herein shall be in writing and shall be delivered by hand or overnight courier service, mailed by certified or registered mail or sent by facsimile or email, as follows:

If to the Borrower :

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Carol A. DeNale
Treasury Department
Facsimile: (401) 770-5768
Telephone: (401) 770-4407
Email: carol.denale@cvshealth.com

with a copy, in the case of a notice of Default or Event of Default, to:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Tom Moffatt
Vice President, Assistant Secretary and Assistant General Counsel – Corporate Services
Facsimile: (401) 216-3758
Telephone: (401) 770-5409
Email: thomas.moffatt@cvshealth.com

If to the Administrative Agent :

in the case of each Borrowing Request, each notice of Conversion, each notice of continuation and each notice of prepayment under Section 2.7 :

Barclays Bank PLC
Loan Operations
700 Prides Crossing
Newark, Delaware 19713
Attention: Agency Services – CVS Health Corporation – Jason Jones
Facsimile: 917-522-0569
Telephone: 302-286-2319
Email: 12145455230@TLS.LDSPROD.com
and
jason.jones@barclays.com

For any other purpose:

Barclays Bank PLC
745 Seventh Avenue
New York, New York 10019
Attention: Sean Duggan
Facsimile: 212-526-5115
Telephone: 212-320-6116
Email: sean.duggan@barclays.com

If to any Lender : to it at its address (or facsimile number or email address) set forth in its Administrative Questionnaire.

(b) *Electronic Communications* . Notices and other communications to the Credit Parties hereunder may be delivered or furnished by electronic communication (including email and internet or intranet websites) pursuant to procedures approved by the Administrative Agent; *provided* that the foregoing shall not apply to notices to any Credit Party pursuant to

Section 2 and Section 3.3 if such Credit Party has notified the Administrative Agent that it is incapable of receiving notices under such Sections by electronic communication. The Administrative Agent or the Borrower may, in its discretion, agree to accept notices and other communications to it hereunder by electronic communications pursuant to procedures approved by it; *provided* that approval of such procedures may be limited to particular notices or communications.

Unless the Administrative Agent otherwise prescribes, (i) notices and other communications sent to an email address shall be deemed received upon the sender's receipt of an acknowledgement from the intended recipient (such as by the "return receipt requested" or "read requested" function, as available, return email or other written acknowledgement); *provided* that if such notice or other communication is not sent during the normal business hours of the recipient, such notice or communication shall be deemed to have been sent at the opening of business on the next Domestic Business Day for the recipient, and (ii) notices or communications posted to an internet or intranet website shall be deemed received upon the deemed receipt by the intended recipient at its email address as described in the foregoing clause (i) of notification that such notice or communication is available and identifying the website address therefor.

(c) *Change of Address.* Any party hereto may change its address, facsimile number or email address for notices and other communications hereunder by notice to the other parties hereto (or, in the case of any Lender, by notice to the Administrative Agent and the Borrower). All notices and other communications given to any party hereto in accordance with the provisions of this Agreement shall be deemed to have been given on the date of receipt; *provided* that any such notice or communication that is not received on a Domestic Business Day during the normal business hours of the recipient shall be deemed received at the opening of business on the next Domestic Business Day.

11.3 *No Waiver; Cumulative Remedies*

No failure to exercise and no delay in exercising, on the part of the Administrative Agent or any Lender, any right, remedy, power or privilege under any Loan Document shall operate as a waiver thereof, nor shall any single or partial exercise of any right, remedy, power or privilege under any Loan Document preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege. The rights, remedies, powers and privileges under the Loan Documents are cumulative and not exclusive of any rights, remedies, powers and privileges provided by law.

11.4 *Survival of Representations and Warranties*

All representations and warranties made in the Loan Documents and in any document, certificate or statement delivered pursuant thereto or in connection therewith shall survive the execution and delivery of the Loan Documents.

11.5 *Payment of Expenses; Indemnified Liabilities*

The Borrower agrees, as soon as practicable following presentation of a statement or invoice therefor setting forth in reasonable detail the items thereof, and whether any Loan is made, (a) to pay or reimburse the Administrative Agent and its Affiliates for all its reasonable and documented out-of-pocket costs and expenses actually incurred in connection with the development, syndication, preparation and execution of, and any amendment, waiver, consent, supplement or modification to, the Loan Documents, any documents prepared in connection therewith and the consummation of the transactions contemplated thereby, whether such Loan Documents or any such amendment, waiver, consent, supplement or modification to the Loan Documents or any documents prepared in connection therewith are executed and whether the transactions contemplated thereby are consummated, including the reasonable and documented out-of-pocket fees and disbursements of Special Counsel, (b) to pay, indemnify, and hold the Administrative Agent and the Lenders harmless from any and all recording and filing fees and any and all liabilities and penalties with respect to, or resulting from any delay (other than penalties to the extent attributable to the negligence of the Administrative Agent or the Lenders, as the case may be, in failing to pay such fees, liabilities or penalties when due) which may be payable or determined to be payable in connection with the execution and delivery of, or consummation of any of the transactions contemplated by, or any amendment, supplement or modification of, or any waiver or consent under or in respect of, the Loan Documents or any documents prepared in connection therewith, and (c) to pay, reimburse, indemnify and hold each Indemnified Person harmless from and against any and all other liabilities, obligations, claims, losses, damages, penalties, actions, judgments, suits, costs, expenses and disbursements of any kind or nature whatsoever (including the reasonable and documented out-of-pocket fees and disbursements of one counsel representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Party))) actually incurred with respect to the enforcement, performance of, and preservation of rights under, the Loan Documents (all the foregoing, collectively, the *"Indemnified Liabilities"*) and, if and to the extent that the foregoing indemnity may be unenforceable for any reason, the Borrower agrees to

make the maximum payment permitted under applicable law; *provided* that the Borrower shall have no obligation hereunder to pay Indemnified Liabilities to an Indemnified Person to the extent (A) arising from the gross negligence, willful misconduct, fraud or bad faith of such Indemnified Person, (B) from a material breach of the obligations hereunder of such Indemnified Person, or (C) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by an Indemnified Person against any other Indemnified Person (other than the Sole Bookrunner or Sole Lead Arranger named on the cover page hereof or the Administrative Agent, in its capacity as such), in each case under the foregoing clauses (A) through (C), to the extent determined by a court of competent jurisdiction by a final and non-appealable judgment. The agreements in this Section 11.5 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

11.6 *Lending Offices*

Each Lender shall have the right at any time and from time to time to transfer any Loan to a different office of such Lender, subject to Section 3.10 .

11.7 *Successors and Assigns*

(a) *Successors and Assigns Generally* . The provisions of this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns permitted hereby, except that the Borrower may not assign or otherwise transfer any of its rights or obligations hereunder without the prior written consent of the Administrative Agent and each Lender and no Lender may assign or otherwise transfer any of its rights or obligations hereunder except (11) to an assignee in accordance with the provisions of paragraph (b) of this Section 11.7 , (11) by way of participation in accordance with the provisions of paragraph (d) of this Section 11.7 or (11) by way of pledge or assignment of a security interest subject to the restrictions of paragraph (f) of this Section 11.7 (and any other attempted assignment or transfer by any party hereto shall be null and void). Nothing in this Agreement, expressed or implied, shall be construed to confer upon any Person (other than the parties hereto, their respective successors and assigns permitted hereby, the Participants to the extent provided in paragraph (d) of this Section 11.7 and, to the extent expressly contemplated hereby, the Related Parties of each Credit Party) any legal or equitable right, remedy or claim under or by reason of this Agreement.

(b) *Assignments by Lenders* . Any Lender may at any time assign to one or more assignees all or a portion of its rights and obligations under this Agreement (including all or a portion of its Commitment and the Loans at the time owing to it); *provided* that any such assignment shall be subject to the following conditions:

(1) *Minimum Amounts* .

(A) in the case of an assignment of the entire remaining amount of the assigning Lender's Commitment Amount and the Loans at the time owing to it or in the case of an assignment to a Lender, an Affiliate of a Lender or an Approved Fund, no minimum amount need be assigned; and

(B) in any case not described in paragraph (b)(1)(A) of this Section 11.7 , the Commitment Amount (which for this purpose includes the Loans of the assigning Lender outstanding thereunder) or, if the Commitment of the assigning Lender is not then in effect, the principal outstanding balance of the Loans of the assigning Lender subject to each such assignment (determined as of the date the Assignment and Assumption with respect to such assignment is delivered to the Administrative Agent or, if a "Trade Date" is specified in the Assignment and Assumption, as of such "Trade Date") shall not be less than $5,000,000, unless each of the Administrative Agent and, so long as no Event of Default has occurred and is continuing, the Borrower otherwise consents (each such consent not to be unreasonably withheld or delayed).

(2) *Proportionate Amounts* . Each partial assignment shall be made as an assignment of a proportionate part of all the assigning Lender's rights and obligations under this Agreement with respect to the Loans or the Commitment assigned.

(3) *Required Consents* . No consent shall be required for any assignment except to the extent required by paragraph (b)(1)(B) of this Section 11.7 and, in addition:

(A) the consent of the Borrower (such consent not to be unreasonably withheld or delayed) shall be required unless (x) an Event of Default has occurred and is continuing at the time of such assignment or (y) such assignment is to a Lender, an Affiliate of a Lender or an Approved Fund; and

(B) the consent of the Administrative Agent (such consent not to be unreasonably withheld or delayed) shall be required for assignments in respect of an unfunded or revolving facility hereunder if such assignment is to a Person that is not a Lender with a Commitment in respect of such facility, an Affiliate of such Lender or an Approved Fund with respect to

such Lender.

(4) *Assignment and Assumption* . The parties to each assignment shall execute and deliver to the Administrative Agent an Assignment and Assumption, together with a processing and recordation fee of $4,500 ($7,500 in the case of an assignment by a Defaulting Lender) (which fee may be waived or reduced in the sole discretion of the Administrative Agent), and the assignee, if it is not a Lender, shall deliver to the Administrative Agent an Administrative Questionnaire.

(5) *No Assignment to Certain Parties* . No such assignment shall be made to the Borrower, any of its Subsidiaries or any of their respective Affiliates.

(6) *No Assignment to Natural Persons* . No such assignment shall be made to a natural person.

Subject to acceptance and recording thereof by the Administrative Agent pursuant to paragraph (c) of this Section 11.7 , from and after the effective date specified in each Assignment and Assumption, the assignee thereunder shall be a party to this Agreement and, to the extent of the interest assigned by such Assignment and Assumption, have the rights and obligations of a Lender under this Agreement, and the assigning Lender thereunder shall, to the extent of the interest assigned by such Assignment and Assumption, be released from its obligations under this Agreement (and, in the case of an Assignment and Assumption covering all of the assigning Lender's rights and obligations under this Agreement, such Lender shall cease to be a party hereto) but shall continue to be entitled to the benefits of Section 3.6, Section 3.7 , and Section 11.10 with respect to facts and circumstances occurring prior to the effective date of such assignment. Any assignment or transfer by a Lender of rights or obligations under this Agreement that does not comply with this paragraph shall be treated for purposes of this Agreement as a sale by such Lender of a participation in such rights and obligations in accordance with paragraph (d) of this Section 11.7 .

(c) *Register* . The Administrative Agent, acting solely for this purpose as a non-fiduciary agent of the Borrower, shall maintain at one of its offices in New York, New York a copy of each Assignment and Assumption delivered to it and a register for the recordation of the names and addresses of the Lenders, and the Commitments of, and principal amounts (and stated interest) of the Loans owing to, each Lender pursuant to the terms hereof from time to time (the " Register "). The entries in the Register shall be conclusive, and the Borrower, the Administrative Agent and the Lenders may treat each Person whose name is recorded in the Register pursuant to the terms hereof as a Lender hereunder for all purposes of this Agreement, notwithstanding notice to the contrary. The Register shall be available for inspection by the Borrower and any Lender, at any reasonable time and from time to time upon reasonable prior notice.

(d) *Participations* . Any Lender may at any time, without the consent of, or notice to, the Borrower or the Administrative Agent, sell participations to any Person (other than a natural person, the Borrower, any of its Subsidiaries or any of their respective Affiliates) (each, a " *Participant* ") in all or a portion of such Lender's rights and/or obligations under this Agreement (including all or a portion of its Commitment and/or the Loans owing to it); *provided* that (i) such Lender's obligations under this Agreement shall remain unchanged, (ii) such Lender shall remain solely responsible to the other parties hereto for the performance of such obligations and (iii) the Borrower, the Administrative Agent and each Credit Party shall continue to deal solely and directly with such Lender in connection with such Lender's rights and obligations under this Agreement. Any agreement or instrument pursuant to which a Lender sells such a participation shall provide that such Lender shall retain the sole right to enforce this Agreement and to approve any amendment, modification or waiver of any provision of this Agreement; *provided* that such agreement or instrument may provide that such Lender will not, without the consent of the Participant, agree to any amendment, modification or waiver which requires the consent of all Lenders or all affected Lenders that directly affects such Participant. Subject to paragraph (e) of this Section 11.7 , the Borrower agrees that each Participant shall be entitled to the benefits of Section 3.5 , Section 3.6 , Section 3.7 and Section 3.10 to the same extent as if it were a Lender and had acquired its interest by assignment pursuant to paragraph (b) of this Section 11.7 . To the extent permitted by law, each Participant also shall be entitled to the benefits of Section 11.9(a) as though it were a Lender, *provided* that such Participant agrees to be subject to Section 11.9(b) as though it were a Lender. Each Lender that sells a participation with respect to a Commitment or Loan to the Borrower shall, solely for the purposes of complying with the rules regarding registered form in the Internal Revenue Code, act as a non-fiduciary agent of the Borrower, maintaining a register on which it enters the name and address of each Participant and the principal amounts (and related interest amounts) of each Participant's interest in the Commitment and/or Loan (the " *Participant Register* "). The entries in the Participant Register shall be conclusive, absent manifest error, and such Lender shall treat each Person whose name is recorded in the Participant Register as the owner of such participation for all purposes of this Agreement notwithstanding any notice to the contrary. No Lender shall be required to disclose the existence of, or any of the information contained in, any Participant Register maintained by it to the Borrower or any other Person unless requested in writing by the Borrower, and only to the Internal Revenue Service to the extent such disclosure is required in order to comply with the rules requiring registered form pursuant to the Internal Revenue Code.

(e) *Limitations upon Participant Rights* . A Participant shall not be entitled to receive any greater payment under Section 3.6 , Section 3.7 or Section 3.10 than the applicable Lender would have been entitled to receive with respect to the participation sold to such Participant, unless the sale of the participation to such Participant is made with the Borrower's prior written

consent. A Participant shall not be entitled to the benefits of Section 3.10 unless the Borrower is notified of the participation sold to such Participant and such Participant agrees, for the benefit of the Borrower, to comply with Section 3.10(e) as though it were a Lender.

(f) *Certain Pledges* . Any Lender may at any time pledge or assign a security interest in all or any portion of its rights under this Agreement to secure obligations of such Lender, including any pledge or assignment to secure obligations to a Federal Reserve Bank or other central bank having jurisdiction over such Lender; *provided* that no such pledge or assignment shall release such Lender from any of its obligations hereunder or substitute any such pledgee or assignee for such Lender as a party hereto.

11.8 *Counterparts; Electronic Execution of Assignments*

(a) *Counterparts* . Each of the Loan Documents (other than the Notes) may be executed on any number of separate counterparts and all of said counterparts taken together shall be deemed to constitute one and the same agreement. It shall not be necessary in making proof of any Loan Document to produce or account for more than one counterpart signed by the party to be charged. A set of the copies of this Agreement signed by all of the parties hereto shall be lodged with each of the Borrower and the Administrative Agent. Delivery of an executed counterpart of a signature page of any Loan Document by fax or other electronic means (e.g., ".pdf" or ".tif") shall be effective as delivery of a manually executed counterpart of such Loan Document.

(b) *Electronic Execution of Assignments* . The words "execution," "signed," "signature," and words of like import in any Assignment and Assumption shall be deemed to include electronic signatures or the keeping of records in electronic form, each of which shall be of the same legal effect, validity or enforceability as a manually executed signature or the use of a paper-based recordkeeping system, as the case may be, to the extent and as provided for in any applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, the New York State Electronic Signatures and Records Act, or any other similar state laws based on the Uniform Electronic Transactions Act.

11.9 *Set-off and Sharing of Payments*

(a) In addition to any rights and remedies of the Lenders provided by law, upon the occurrence of an Event of Default under Section 9.1(a) or Section 9.1(b) or upon the acceleration of the Loans, each Lender shall have the right, without prior notice to the Borrower, any such notice being expressly waived by the Borrower, to set-off and apply against any indebtedness or other liability, whether matured or unmatured, of the Borrower to such Lender arising under the Loan Documents, any amount owing from such Lender to the Borrower. To the extent permitted by applicable law, the aforesaid right of set-off may be exercised by such Lender against the Borrower or against any trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors, receiver, or execution, judgment or attachment creditor of the Borrower, or against anyone else claiming through or against the Borrower or such trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors, receivers, or execution, judgment or attachment creditor, notwithstanding the fact that such right of set-off shall not have been exercised by such Lender prior to the making, filing or issuance of, service upon such Lender of, or notice to such Lender of, any petition, assignment for the benefit of creditors, appointment or application for the appointment of a receiver, or issuance of execution, subpoena, order or warrant. Each Lender agrees promptly to notify the Borrower and the Administrative Agent after each such set-off and application made by such Lender, *provided* that the failure to give such notice shall not affect the validity of such set-off and application.

(b) If any Lender (each a *"Benefited Lender"*) shall obtain any payment (whether voluntary, involuntary, through the exercise of any right of set-off, or otherwise) on account of its Loans or its Notes in excess of its pro rata share (in accordance with the outstanding principal balance of all Loans) of payments then due and payable on account of the Loans and Notes received by all the Lenders, such Lender shall forthwith purchase, without recourse, for cash, from the other Lenders such participations in their Loans and Notes as shall be necessary to cause such purchasing Lender to share the excess payment with each of them according to their pro rata share (in accordance with the outstanding principal balance of all Loans); *provided* that if all or any portion of such excess payment is thereafter recovered from such purchasing Lender, such purchase from each Lender shall be rescinded and each such Lender shall repay to the purchasing Lender the purchase price to the extent of such recovery, together with an amount equal to such Lender's pro rata share (according to the proportion of (i) the amount of such Lender's required repayment to (ii) the total amount so recovered from the purchasing Lender) of any interest or other amount paid or payable by the purchasing Lender in respect of the total amount so recovered. The Borrower agrees, to the fullest extent permitted by law, that any Lender so purchasing a participation from another Lender pursuant to this Section 11.9 may exercise such rights to payment (including the right of set-off) with respect to such participation as fully as if such Lender were the direct creditor of the Borrower in the amount of such participation.

11.10 *Indemnity*

(a) The Borrower shall indemnify each Credit Party, each of the Sole Bookrunner and Sole Lead Arranger named

on the cover page hereof, and each Related Party thereof (each such Person being called an " *Indemnified Person* ") against, and hold each Indemnified Person harmless from, any and all losses, claims, damages, liabilities and related expenses, including the reasonable and documented out-of-pocket fees and disbursements of one counsel representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Person)), actually incurred by any Indemnified Person arising out of, in connection with, or as a result of (11) the execution or delivery of any Loan Document or any agreement or instrument contemplated thereby, the performance by the parties to the Loan Documents of their respective obligations thereunder or the consummation of the transactions contemplated hereby or any other transactions contemplated thereby, (11) any Loan or the use of the proceeds thereof, (11) any actual or alleged presence or release of Hazardous Materials on or from any property owned or operated by the Borrower or any of the Subsidiaries, or any Environmental Liability related in any way to the Borrower or any of the Subsidiaries or (11) any actual or prospective claim, litigation, investigation or proceeding relating to any of the foregoing, whether based on contract, tort or any other theory and regardless of whether any Indemnified Person is a party thereto. Notwithstanding anything to the contrary contained in this Section 11.10(a) , the foregoing indemnity will not, as to any Indemnified Person, apply to any losses, claims, damages, liabilities and related expenses to the extent arising (A) from the willful misconduct, gross negligence, fraud or bad faith of such Indemnified Person, (B) from a material breach of the obligations hereunder of such Indemnified Person, or (C) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by an Indemnified Party against any other Indemnified Party (other than the Sole Bookrunner or Sole Lead Arranger named on the cover page hereof or the Administrative Agent, in its capacity as such), in each case under clauses (A) through (C), to the extent determined by a final and non-appealable judgment of a court of competent jurisdiction. The Borrower shall not be liable for any settlement of any investigation, litigation or proceeding to which the indemnity in this Section 11.10(a) applies (any of the foregoing, a *"Proceeding"*) effected without the Borrower's prior written consent (which consent shall not be unreasonably withheld or delayed, it being understood and agreed that the withholding or delaying of the Borrower's consent in connection with a settlement which does not include an unconditional release of the Borrower and the Subsidiaries from all liability or claims that are the subject matter of such Proceeding or which includes a statement as to any admission of fault by or on behalf of the Borrower or any Subsidiary shall not be deemed unreasonable), but if settled with the Borrower's prior written consent or if there is a final judgment for the plaintiff in any such Proceeding, the Borrower agrees to indemnify and hold harmless each Indemnified Person from and against any and all losses, claims, damages, liabilities and expenses by reason of such settlement or judgment in accordance with this Section 11.10(a) . The Borrower shall not, without the prior written consent of an Indemnified Person, effect any settlement of any pending or threatened Proceeding against such Indemnified Person in respect of which indemnity could have been sought hereunder by such Indemnified Person unless such settlement (x) includes an unconditional release of such Indemnified Person from all liability or claims that are the subject matter of such Proceeding and (y) does not include any statement as to any admission of fault by or on behalf of such Indemnified Person. Notwithstanding the above, the Borrower shall have no liability under clause (i) of this Section 11.10(a) to indemnify or hold harmless any Indemnified Person for any losses, claims, damages, liabilities and related expenses relating to income or withholding taxes or any tax in lieu of such taxes.

(b) To the extent that the Borrower fails to pay as soon as practicable any amount required to be paid by it to the Administrative Agent under subsection (a) of this Section 11.10 , each Lender severally agrees to pay to the Administrative Agent an amount equal to the product of such unpaid amount *multiplied by* (i) at any time when no Loans are outstanding, its Commitment Percentage, or if no Commitments then exist, its Commitment Percentage on the last day on which Commitments did exist, and (ii) at any time when Loans are outstanding (x) if the Commitments then exist, its Commitment Percentage or (y) if the Commitments have been terminated or otherwise no longer exist, the percentage equal to the fraction, (A) the numerator of which is the sum of such Lender's Credit Exposure and (B) the denominator of which is the sum of the Aggregate Credit Exposure (in each case determined as of the time that the applicable unreimbursed expense or indemnity payment is sought), *provided* that the unreimbursed expense or indemnified loss, claim, damage, liability or related expense, as applicable, was incurred by or asserted against the Administrative Agent in its capacity as such.

(c) The obligations of the Borrower and the Lenders under this Section 11.10 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

(d) To the extent permitted by applicable law, the Borrower shall not assert, and hereby waives, any claim against any Indemnified Person, on any theory of liability, for special, indirect, consequential or punitive damages (as opposed to direct and actual damages) arising out of, in connection with, or as a result of, any Loan Document or any agreement, instrument or other document contemplated thereby, the transactions contemplated hereby or any Loan or the use of the proceeds thereof.

11.11 *Governing Law*

The Loan Documents and the rights and obligations of the parties thereto shall be governed by, and construed and interpreted in accordance with, the laws of the State of New York.

11.12 *Severability*

Every provision of the Loan Documents is intended to be severable, and if any term or provision thereof shall be invalid, illegal or unenforceable for any reason, the validity, legality and enforceability of the remaining provisions thereof shall not be affected or impaired thereby, and any invalidity, illegality or unenforceability in any jurisdiction shall not affect the validity, legality or enforceability of any such term or provision in any other jurisdiction.

11.13 *Integration*

All exhibits to the Loan Documents shall be deemed to be a part thereof. Each Loan Document embodies the entire agreement and understanding between or among the parties thereto with respect to the subject matter thereof and supersedes all prior agreements and understandings between or among the parties thereto with respect to the subject matter thereof.

11.14 *Treatment of Certain Information*

(a) Each Credit Party agrees to maintain the confidentiality of the Information (as defined below), except that Information may be disclosed (11) to its Affiliates and to its and its Affiliates' respective partners, directors, officers, employees, agents, advisors and other representatives (it being understood that the Persons to whom such disclosure is made will be informed of the confidential nature of such Information and instructed to keep such Information confidential), (11) to the extent requested by any regulatory authority purporting to have jurisdiction over it (including any self-regulatory authority, such as the National Association of Insurance Commissioners), (11) to the extent required by applicable laws or regulations or by any subpoena or similar legal process, (11) to any other party hereto, (11) in connection with the exercise of any remedies hereunder or under any other Loan Document or any action or proceeding relating to this Agreement or any other Loan Document or the enforcement of rights hereunder or thereunder, (11) subject to an agreement containing provisions substantially the same as those of this Section 11.14 , to (A) any assignee of or Participant in, or any prospective assignee of or Participant in, any of its rights or obligations under this Agreement or (B) any actual or prospective counterparty (or its advisors) to any swap or derivative transaction relating to the Borrower and its obligations, (11) to Gold Sheets and other similar bank trade publications, such information to consist of deal terms and other information customarily found in such publications, (11) with the consent of the Borrower or (11) to the extent such Information (x) becomes publicly available other than as a result of a breach of this Section 11.14 or (y) becomes available to the Administrative Agent, any Credit Party or any of their respective Affiliates on a non-confidential basis from a source other than the Borrower not known to such Credit Party to be prohibited from disclosing such Information.

(b) For purposes of this Section 11.14 , *"Information"* means all information received from the Borrower or any of its Subsidiaries relating to the Borrower or any of its Subsidiaries or any of their respective businesses, other than any such information that is available to the Administrative Agent or any other Credit Party on a non-confidential basis prior to disclosure by the Borrower or any of its Subsidiaries.

11.15 *Acknowledgments*

The Borrower acknowledges that (a) it has been advised by counsel in the negotiation, execution and delivery of the Loan Documents, (b) by virtue of the Loan Documents, none of the Administrative Agent or any Lender has any fiduciary relationship to the Borrower, and the relationship between the Administrative Agent and the Lenders, on the one hand, and the Borrower, on the other hand, is solely that of debtor and creditor, and (c) by virtue of the Loan Documents, no joint venture exists among the Lenders or among the Borrower and the Lenders.

11.16 *Consent to Jurisdiction*

The Borrower irrevocably submits to the exclusive jurisdiction of any New York State or Federal Court sitting in the City of New York, Borough of Manhattan, over any suit, action or proceeding arising out of or relating to the Loan Documents. The Borrower irrevocably waives, to the fullest extent permitted by law, any objection which it may now or hereafter have to the laying of the venue of any such suit, action or proceeding brought in such a court and any claim that any such suit, action or proceeding brought in such a court has been brought in an inconvenient forum. The Borrower agrees that a final judgment in any such suit, action or proceeding brought in such a court, after all appropriate appeals, shall be conclusive and binding upon it.

11.17 *Service of Process*

The Borrower agrees that process may be served against it in any suit, action or proceeding referred to in Section 11.16 by sending the same by first class mail, return receipt requested or by overnight courier service, with receipt acknowledged, to the address of the Borrower set forth in Section 11.2 . The Borrower agrees that any such service (i) shall be deemed in every respect effective service of process upon it in any such suit, action, or proceeding, and (ii) shall to the fullest extent enforceable by law, be taken and held to be valid personal service upon and personal delivery to it.

11.18 *No Limitation on Service or Suit*

Nothing in the Loan Documents or any modification, waiver, or amendment thereto shall affect the right of the Administrative Agent or any Lender to serve process in any manner permitted by law or limit the right of the Administrative Agent or any Lender to bring proceedings against the Borrower in the courts of any jurisdiction or jurisdictions.

11.19 *WAIVER OF TRIAL BY JURY*

EACH OF THE CREDIT PARTIES AND THE BORROWER KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION ARISING OUT OF, UNDER OR IN CONNECTION WITH THE LOAN DOCUMENTS OR THE TRANSACTIONS CONTEMPLATED THEREBY. FURTHER, THE BORROWER HEREBY CERTIFIES THAT NO REPRESENTATIVE OR AGENT OF ANY OF THE CREDIT PARTIES, OR COUNSEL TO ANY OF THE CREDIT PARTIES, HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT ANY OF THE CREDIT PARTIES WOULD NOT, IN THE EVENT OF SUCH LITIGATION, SEEK TO ENFORCE THIS WAIVER OF RIGHT TO JURY TRIAL PROVISION. THE BORROWER ACKNOWLEDGES THAT THE CREDIT PARTIES HAVE BEEN INDUCED TO ENTER INTO THIS AGREEMENT BY, *INTER ALIA* , THE PROVISIONS OF THIS SECTION 11.19 .

11.20 *Patriot Act Notice*

Each Lender and the Administrative Agent (for itself and not on behalf of any Lender) hereby notifies the Borrower that pursuant to the requirements of the USA PATRIOT Act (Title III of Pub. L. 107-56 (signed into law October 26, 2001), as amended from time to time) (the *"Patriot Act"*), it is required to obtain, verify and record information that identifies the Borrower, which information includes the name and address of the Borrower and other information that will allow such Lender or the Administrative Agent, as applicable, to identify the Borrower in accordance with the Patriot Act.

11.21 *No Fiduciary Duty*

The Borrower agrees that in connection with all aspects of the transactions contemplated hereby and any communications in connection therewith, the Borrower and its Affiliates, on the one hand, and the Credit Parties and the Sole Lead Arranger and Sole Bookrunner named on the cover page hereof, and their respective Affiliates, on the other hand, will have a business relationship that does not create, by implication or otherwise, any fiduciary duty on the part of the Credit Parties and such Sole Lead Arranger and Sole Bookrunner, or their respective Affiliates, and no such duty will be deemed to have arisen in connection with any such transactions or communications.

11.22*Acknowledgement and Consent to Bail-In of EEA Financial Institutions*

Solely to the extent the Administrative Agent or any Lender is an EEA Financial Institution and is a party to this Agreement, and notwithstanding anything to the contrary in any Loan Document or in any other agreement, arrangement or understanding among any such parties, each party hereto acknowledges that any liability of any EEA Financial Institution arising under any Loan Document, to the extent such liability is unsecured, may be subject to the Write-Down and Conversion Powers of an EEA Resolution Authority and agrees and consents to, and acknowledges and agrees to be bound by:

(a) the application of any Write-Down and Conversion Powers by an EEA Resolution Authority to any such liabilities arising hereunder which may be payable to it by the Administrative Agent or any Lender that is an EEA Financial Institution; and

(b) the effects of any Bail-in Action on any such liability, including, if applicable:

(1) a reduction in full or in part or cancellation of any such liability;

(2) a conversion of all, or a portion of, such liability into shares or other instruments of ownership in such EEA Financial Institution, its parent undertaking, or a bridge institution that may be issued to it or otherwise conferred on it, and that such shares or other instruments of ownership will be accepted by it in lieu of any rights with respect to any such liability under this Agreement or any other Loan Document; or

(3) the variation of the terms of such liability in connection with the exercise of the Write-Down and Conversion Powers of any EEA Resolution Authority.

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AS EVIDENCE of the agreement by the parties hereto to the terms and conditions herein contained, each such party has caused this Agreement to be executed on its behalf.

CVS HEALTH CORPORATION

By: /s/ Carol A. DeNale
Name: Carol A. DeNale
Title: Senior Vice President and Treasurer

BARCLAYS BANK PLC,
as Administrative Agent and as a Lender

By: /s/ Ritam Bhalla
Name: Ritam Bhalla
Title: Director

2017 CREDIT AGREEMENT

EXHIBIT A

LIST OF COMMITMENTS

Lender	Commitment Amount
Barclays Bank PLC	$2,500,000,000
TOTAL	**$2,500,000,000**

Exhibit 10.19

CVS HEALTH CORPORATION

DEFERRED COMPENSATION PLAN

Amended and Restated Effective November 1, 2016

CVS HEALTH CORPORATION

Deferred Compensation Plan

ARTICLE I – INTRODUCTION

1.1 Name of Plan.

CVS Health Corporation (the "Company") hereby adopts the CVS Health Deferred Compensation Plan as amended and restated as of November 1, 2016 (the "Plan").

1.2 Purpose of Plan.

The purpose of the Plan is to provide certain eligible employees of the Company or an Affiliate authorized by the Committee to participate in the Plan the opportunity to defer elements of his or her compensation which might not otherwise be deferrable under other plans maintained by the Company or an Affiliate and to make deferrals and receive contributions that would be obtainable under the 401(k) and Employee Stock Ownership Plan of CVS Health Corporation and Affiliated Companies ("Future Fund") in the absence of certain restrictions and limitations in the Internal Revenue Code.

1.3 "Top Hat" Pension Benefit Plan.

The Plan is an "employee pension benefit plan" within the meaning of ERISA. However, the Plan is unfunded and maintained for a select group of management or highly compensated employees and, therefore, it is intended that the Plan will be exempt from Parts 2, 3 and 4 of Title I of ERISA. The Plan is not intended to qualify under Section 401(a) of the Code.

1.4 Funding.

The Plan is unfunded. All benefits will be paid from the general assets of the Company. Participants in the Plan shall have the status of general unsecured creditors of the Company.

1.5 Effective Date.

The Plan was originally effective as of January 1, 1997, and amended and restated in its entirety effective as of December 31, 2008, to comply with the provisions of Section 409A of the Internal Revenue Code and regulations promulgated thereunder and as of December 17, 2014 and October 1, 2015 to reflect certain design and administrative changes desired by the Company.

1.6 Administration.

The Plan shall be administered by the Deferred Compensation Plans Committee, as defined in Article VII.

1.7 Number and Gender.

Wherever appropriate herein, words used in the singular shall be considered to include the plural and words used in the plural shall be considered to include the singular. The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender. The feminine gender, where appearing in the Plan, shall be deemed to include the masculine gender.

1.8 Headings.

The headings of Articles and Sections herein are included solely for convenience, and if there is any conflict between such headings and the text of the Plan, the text shall control.

ARTICLE II – DEFINITIONS

For purposes of the Plan, the following words and phrases shall have the meanings set forth below, unless their context clearly requires a different meaning:

2.1 Account.

The Company Account, Deferral Account, Grandfathered Company Account, and the Grandfathered Deferral Account maintained by the Company on behalf of each Participant pursuant to the Plan.

2.2 Affiliate.

A subsidiary of the Company, as defined in the Company's Universal 409A Definition Document.

2.3 Annual Cash Incentive.

The amount awarded to a Participant in cash for a Plan Year under a regular (annual) incentive plan (other than an exceptional performance award program or a one-time incentive plan or program) maintained by the Company or an Affiliate, and any other amount otherwise included in Annual Cash Incentive for purposes of the Plan under rules as are adopted by the Committee.

Effective January 1, 2015, Operation Production Incentives shall be excluded from the definition of Annual Cash Incentive.

2.4 Annual Cash Incentive Deferral.

The amount of a Participant's Annual Cash Incentive which a Participant elects to have withheld on a pre-tax basis from his or her Annual Cash Incentive and credited to his or her Deferral Account pursuant to the Plan.

2.5 Base Salary.

The base rate of cash compensation paid by the Company or an Affiliate to or for the benefit of a Participant for services rendered or labor

performed while a Participant, including deferrals pursuant to the Plan and any pre-tax contribution to be made on the Participant's behalf to any qualified plan maintained by the Company or an Affiliate pursuant to a cash or deferred arrangement maintained by the Company or an Affiliate (as defined under Section 401(k) of the Code) or under any cafeteria plan (as defined under Section 125 of the Code) or under a qualified transportation fringe (as defined under Section 132(f) of the Code). Base Salary shall exclude any overtime, premium pay, shift differentials, bonuses, commissions or any other form of supplemental cash compensation, except to the extent otherwise deemed "Base Salary" for purposes of the Plan under rules as are adopted by the Committee.

2.6 Base Salary Deferral.

The amount of a Participant's Base Salary which the Participant elects to have withheld on a pre-tax basis from his or her Base Salary and credited to his or her Deferral Account pursuant to the Plan.

2.7 Beneficiary.

The person or persons (which may include trusts) designated in writing (either by hand or electronic submission) by the Participant on the beneficiary designation form prescribed by the Plan Administrator to receive the amounts, if any, payable under the Plan upon the death of the Participant. In the absence of such written designation by the Participant, the Beneficiary shall mean, in the following order, the Participant's spouse, if any; the person named as the Participant's beneficiary under the Company's life insurance program; or the Participant's estate.

2.8 Board.

The Board of Directors of the Company.

2.9 Change in Control.

"Change in Control" as such term is defined in the Universal 409A Definition Document.

2.10 Code.

The Internal Revenue Code of 1986, as amended. References to any provision of the Code or regulation (including a proposed regulation) thereunder shall include any successor provisions or regulations.

2.11 Commissions.

The amount of a Participant's sales commissions or other commissions payable under a sales commissions or other commissions plan maintained by the Company or an Affiliate. (Sales commissions for purposes of the Plan shall mean sales commissions as defined in Treas. Reg. Section 1.409A-2(a)(12)(i) and any subsequent guidance and such sales commissions are considered to be earned in the taxable year of the Participant in which the sale is completed.)

2.12 Commissions Deferral.

The amount of a Participant's Commissions that a Participant elects to have withheld on a pre-tax basis from his or her Commissions and credited to his or her Deferral Account pursuant to the Plan.

2.13 Committee.

The Management Planning and Development Committee of the Board of Directors of the Company or any other directors of the Company designated as the Committee.

2.14 Company Account.

The bookkeeping account (or subaccount(s) thereof) maintained for each Participant to record the amount of Company Contributions that are either (i) credited on his or her behalf under Section 4.4 on or after January 1, 2005 or (ii) were credited on his or her behalf under Section 4.4 prior to January 1, 2005, but became vested on or after January 1, 2005, as adjusted pursuant to Section 5.6.

2.15 Company Contribution.

The amount, as determined by the Company on an annual basis based on the provisions of the Plan, which is credited on the Participant's behalf by the Company to his or her Company Account pursuant to the provisions of Section 4.4(a) of the Plan.

2.16 CVS Caremark Retention Payment.

The amount granted to an Eligible Executive, as defined in and provided for under the provisions of the employment term sheet agreement entered into between the Company or an Affiliate and said Eligible Executive, as a former employee of Caremark Rx, Inc., in connection with the merger involving Caremark, Rx, Inc. and the Company.

2.17 Deferrals.

The amount of deferrals credited to a Participant pursuant to Section 4.1.

2.18 Deferral Account.

The bookkeeping account (or subaccount(s) thereof) maintained for each Participant to record any and all deferrals made under the Plan.

2.19 Deferred Compensation Election.

The written election (either by hand or electronic submission) including any amendments, attachments and appendices thereto as prescribed by the Plan Administrator, regardless of how it may be titled, under which the Participant agrees to defer a portion of his or her Base Salary and/or Annual Cash Incentive or Commissions under the Plan (or any other cash remuneration payable to a Participant that he or she may elect to defer under the provisions of the Plan, including but not limited to awards under the Company's Long Term Incentive Plan (LTIP). This election as to deferral and the related form and timing of distribution is made by the Participant and constitutes the agreement entered into between the Company and a Participant for participation in the Plan. The Participant elects the terms of his or her deferral pursuant to the provisions of this Plan and the administrative procedures established by the Plan Administrator.

2.20 Disability.

"Disability" as defined in the Company's Long-Term Disability Plan.

2.21 Distribution Date.

The date on which a Participant's distribution is scheduled to be paid with respect to his or her Account under the Plan pursuant to his or her Deferred Compensation Election, which date shall take into account any processing period.

2.22 Effective Date.

January 1, 1997.

2.23 Elective Deferrals.

Elective Deferrals as defined in Section 3.02 of Future Fund.

2.24 Eligible Executive.

An Executive who is eligible to participate in the Plan as provided in Section 3.1(a).

2.25 Employee.

Any common-law full-time salaried exempt employee of the Company or an Affiliate who has been authorized by the Committee to participate in the Plan.

2.26 ERISA.

The Employee Retirement Income Security Act of 1974, as amended.

2.27 Executive.

An Employee whose Base Salary (determined on the basis of a maximum forty (40) hour work week) equals or exceeds $150,000 (as adjusted from time to time by the Committee).

2.28 Future Fund.

The 401(k) Plan and the Employee Stock Ownership Plan of CVS Health Corporation and Affiliated Companies.

2.29 Grandfathered Company Account.

The bookkeeping account (or subaccount(s)) maintained for each Participant to record the amount of Company Contributions credited on a Participant's behalf under Section 4.4, which were vested as of December 31, 2004, adjusted as provided in Section 5.6.

2.30 Grandfathered Deferral Account.

The bookkeeping account (or subaccount(s)) maintained for each Participant to record (i) the amount of Base Salary and/or Annual Cash Incentive or Commissions deferred in accordance with Section 4.1, (ii) the amount of LTIP deferrals deferred in accordance with Section 4.4, and/or (iii) the amount of cash retention award deferrals deferred in accordance with Section 4.4, as of December 31, 2004, adjusted pursuant to Section 5.6.

2.31 Lost Matching Contributions.

The amounts credited on a Participant's behalf to his or her Company Account pursuant to the provisions of Section 4.4(a).

2.32 Participant.

Each Eligible Executive participating in the Plan as set forth in Section 3.2.

2.33 Plan Administrator.

The Deferred Compensation Plans Committee appointed pursuant to Section 7.1 to administer the Plan.

2.34 Plan Year.

A calendar year ending on December 31.

2.35 Qualified Future Fund Matching Contribution.

The total of all matching contributions made (or that would have been made) by the Company or an Affiliate with respect to a Plan Year for the benefit of a Participant under and in accordance with the terms of Future Fund.

2.36 Retirement.

Termination of Employment with the Company and all Affiliates on or after (i) age fifty-five (55) and the completion of ten (10) or more Years of Service or, if earlier, (ii) age sixty (60) and the completion of five (5) or more Years of Service.

2.37 Specified Employee.

"Specified Employee" as such term is defined in the Universal 409A Definition Document.

2.38 Specific Future Year.

A calendar year in the future elected by a Participant with respect to the distribution of his or her Account(s) (or subaccount(s) thereof) pursuant to the Plan.

2.39 Termination of Employment.

"Termination of employment" as such term is defined in the Universal 409A Definition Document.

2.40 Universal 409A Definition Document.

The document developed by the Company for the purpose of defining terms relating to benefits or amounts in all plans covered by Section 409A of the Code and sponsored by the Company or any Affiliate.

2.41 Valuation Date.

The date on which an Account is valued under the Plan, as determined by the Committee, by reference to the New York Stock Exchange.

2.42 Year of Service.

Vesting Service as defined in Future Fund.

ARTICLE III – ELIGIBILITY AND PARTICIPATION

3.1 Eligibility.

(a) An Employee who is an Executive on October 1 st of a calendar year (or such other date in the calendar year as designated by the Committee) shall be eligible to participate in the Plan. The Committee may, in its sole discretion, designate other key employees of the Company or an Affiliate who are members of a select group of management or highly compensated employees as eligible to participate in the Plan.

(b) Notwithstanding any Plan provision to the contrary, Employees must also be subject to the income tax laws of the United States in order to be eligible for participation in the Plan.

(c) Subject to the provisions of Sections 3.3 and Section 4.1, an Eligible Executive shall remain eligible to continue participation in the Plan for each Plan Year following his or her initial year of participation in the Plan.

3.2 Commencement of Participation.

An Eligible Executive shall become a Participant effective as of the date that the Eligible Executive's first Deferred Compensation Election becomes effective, provided that the Eligible Executive has provided such information as the Plan Administrator deems necessary to properly administer the Plan.

3.3 Termination of Participation.

(a) Participation shall cease when the benefits that have been credited to a Participant's Deferral Account have been distributed to him or her.

(b) Subject to the provisions of Section 4.3(c), a Participant shall only be eligible to make Deferrals under the Plan for as long as he or she remains an Eligible Executive.

(c) If a former Participant who has incurred a Termination of Employment with the Company and all Affiliates and whose participation in the Plan ceased under Section 3.3(a) is reemployed as an Executive, the former Participant may again become eligible to participate in accordance with the provisions of Section 3.1(a).

ARTICLE IV – DEFERRALS & COMPANY CONTRIBUTIONS

4.1 Deferrals.

(a) Subject to the following provisions of this Article IV, an Eligible Executive may defer for any Plan Year, (i) up to fifty percent (50%) of Base Salary otherwise earned and payable in that Plan Year, and/or (ii) up to one hundred percent (100%) of Annual Cash Incentive otherwise earned in that Plan Year and payable in that Plan Year or in the first calendar quarter of the following Plan Year, and/or (iii) up to one hundred percent (100%) of Commissions otherwise earned in that Plan Year and payable in that Plan Year or in the first calendar quarter of the following Plan Year. The Plan Administrator may, as it deems appropriate, establish maximum or minimum limits on the amounts which may be deferred for a Plan Year and/or the times of such Deferred Compensation Elections. An Eligible Executive shall be given advance notice of any such limits. Notwithstanding anything in the Plan to the contrary, a previously submitted Participant's Deferred Compensation Election (with respect to Base Salary, Annual Cash Incentive and/or Commissions) shall be disregarded following the Participant's Termination of Employment.

(b) Deferrals under the Plan shall be calculated with respect to the gross cash compensation payable to the Participant prior to any deductions (e.g., 401(k) deferrals) or withholdings. However, the Deferrals shall be reduced by the Plan Administrator as necessary if it is later determined, after Deferrals are made under the Plan and after additional deduction of all required income and employment taxes, 401(k) and other employee benefit deductions, and other deductions required by law, that all such total deferrals will exceed one hundred percent (100%) of the cash compensation of the Participant available under Section 4.1(a). Changes to payroll withholdings that affect the amount of compensation being deferred to the Plan shall be allowed only to the extent permissible under Section 409A of the Code.

4.2 Filing Requirements of Deferred Compensation Elections.

Subject to the following provisions of this Section, during an annual enrollment period established by the Plan Administrator in any Plan Year, an Eligible Executive described in Section 3.1 may elect, subject to Section 4.1 above, to defer a portion of his or her Base Salary that is otherwise earned and payable in the next Plan Year and/or all or a portion of his or her Annual Cash Incentive or Commissions otherwise earned in the next Plan Year and payable in that Plan Year or in the first calendar quarter of the subsequent Plan Year by submitting a Deferred Compensation Election during such annual enrollment period. If an Executive becomes an Eligible Executive after October 1 (or such later date as prescribed by the Plan Administrator) in any calendar year, he or she may not make a Deferred Compensation Election for Base Salary, Annual Cash Incentive or Commissions earned in the next Plan Year.

A Participant shall submit a Deferred Compensation Election in the manner specified by the Plan Administrator and a Deferred Compensation Election that is not timely filed shall be considered void and have no effect. If a Participant does not file a Deferred Compensation Election applicable to his or her Base Salary, Annual Cash Incentive or Commissions earned in a Plan Year on or before the close of the applicable annual enrollment period (or such later date prescribed by the Plan Administrator), the Participant shall be deemed to have elected not to make a Deferred Compensation Election for such Plan Year. The Plan Administrator shall establish procedures that govern deferral elections under the Plan, including the ability to make separate elections for Base Salary, Annual Cash Incentive or Commissions, and any other cash remuneration payable to the Participant that the Committee or Plan Administrator permits a Participant to defer under the Plan.

Subject to the provisions of this Article, an Eligible Executive must file a new Deferred Compensation Election for each Plan Year that the Eligible Executive is eligible to participate in the Plan if the Eligible Executive intends to make a deferral under the Plan for such Plan Year.

4.3 Modification or Revocation of Election by Participant.

(a) A Participant's Deferred Compensation Election for a Plan Year shall become irrevocable as of the close of business on the date established by the Plan Administrator, but not later than the last day of the calendar year preceding the Plan Year in which such Base Salary, Annual Cash Incentive or Commissions applicable to that election is earned, and shall become effective as of the first day of the Plan Year in which such Base Salary and/or Annual Cash Incentive or Commissions is earned.

Notwithstanding the foregoing, the Plan Administrator may cancel a Participant's Deferred Compensation Elections for the balance of a Plan Year if the Participant submits evidence of an unforeseeable emergency (as defined in the Universal 409A Definition Document) to the Plan Administrator. Any Base Salary, Annual Cash Incentive, Commissions or other cash remuneration which would have been deferred pursuant to that cancelled Deferred Compensation Election shall be paid to the Eligible Executive as if he or she had not made that election.

A Participant may revoke or change a Deferred Compensation Election any time prior to the date such election becomes irrevocable. Any such change or revocation shall be made in a form and manner determined by the Plan Administrator. Under no circumstances may a Participant's Deferred Compensation Election be made, modified or revoked retroactively.

(b) If a Participant's Deferred Compensation Election applicable to his or her Base Salary and/or Annual Cash Incentive or Commissions is cancelled for a Plan Year, he or she will not be permitted to elect to make Deferrals again until the next Plan Year.

(c) If a Participant ceases to be an Executive after the date a Deferred Compensation Election becomes effective but continues to be employed by the Company or an Affiliate, he or she shall continue to be a Participant and his or her Deferred Compensation Election currently in effect shall remain in force, but such Participant shall not be eligible to make any further Deferred Compensation Elections until such time as he or she shall once again become an Eligible Executive.

(d) Notwithstanding anything in the Plan to the contrary, if an Eligible Executive:

i. receives a withdrawal of deferred cash contributions on account of hardship from any plan which is maintained by the Company or an Affiliate and which meets the requirements of Section 401(k) of the Code (or any successor thereto); and

ii. is precluded from making contributions to such 401(k) plan for at least six (6) months after receipt of the hardship withdrawal,

the Eligible Executive's Deferred Compensation Election with respect to Base Salary, Annual Cash Incentive or Commissions in effect at that time shall be cancelled. Any Base Salary, Annual Cash Incentive or Commissions payment which would have been deferred pursuant to that Deferred Compensation Election but for the application of this Section 4.3(d) shall be paid to the Eligible Executive as if he or she had not made that election.

4.4 Company Contributions and Other Deferrals.

(a) *Company Contributions - Restoration of Lost Matching Contribution* . The amount of Lost Matching Contributions credited under the Plan on a Participant's behalf each calendar year shall be equal to (i) minus (ii) where:

i. is the total Qualified Future Fund Matching Contribution that would have been allocated on the Participant's behalf under Future Fund, without giving effect to any

reductions or limitations required by Sections 401(a)(17), 401(k), 402(g) and/or 415 of the Code, for the Plan Year based on the aggregate of the Participant's Elective Deferrals to Future Fund, his or her deferrals to any other qualified defined contribution plan maintained by the Company or an Affiliate, and his or her Deferral under Section 4.1 for the Plan Year, disregarding, in all cases, any deferrals made with respect to Base Salary, Annual Cash Incentives and Commissions otherwise payable prior to the first payroll period commencing in the month following date the Participant's completion of one (1) Year of Service; and

ii. If the Participant is eligible to contribute to Future Fund (whether pre-tax or after-tax) during the Plan Year, the actual matching contributions made on the Participant's behalf to Future Fund or any other qualified defined contribution plan maintained by the Company or any Affiliate for that Plan Year.

In addition, if the Participant is not eligible to contribute to Future Fund during the Plan Year but is eligible to contribute to another qualified defined contribution plan (whether pre-tax or after-tax) maintained by the Company or an Affiliate during that Plan Year, the amount under this clause (ii) shall equal, unless otherwise provided by the Committee, the maximum amount of matching contributions the Participant would have received under the provisions of Future Fund for that Plan Year had he or she been eligible to contribute to Future Fund during that Plan Year, based on his or her Base Salary and/or Annual Cash Incentive or Commissions otherwise earned and payable in that Plan Year, and his or her contributions to such other qualified defined contribution plan for that Plan Year had been made to Future Fund.

Notwithstanding the foregoing, for purposes of determining the Lost Matching Contributions to be credited under this Section 4.4(a), Years of Service with respect to a Participant employed by Red Oak Sourcing, LLC, the limited liability corporation formed pursuant to the Framework Agreement between CVS Pharmacy, Inc. and Cardinal Health 110 Inc., dated December 10, 2013 ("Cardinal"), who immediately prior to becoming employed by Red Oak Sourcing, LLC was employed by Cardinal, shall include the period of such Participant's employment rendered with Cardinal.

Lost Matching Contributions shall be credited under this Section 4.4(a) with respect to a Participant who made a Bonus Deferral Contribution election under the Omnicare, Inc. Deferred Compensation Plan with respect to the 2016 Plan Year but such Lost Matching Contributions shall be subject to the Participant's distribution election and the distribution provisions of the Omnicare, Inc. Deferred Compensation Plan in effect on the date of such Participant's election.

Notwithstanding anything in the Plan to the contrary, a Participant shall not be eligible to receive a Lost Matching Contribution following the Participant's Termination of Employment.

(b) *LTIP Deferrals* .

At the sole discretion of the Committee, all or a portion of a Participant's cash award under the LTIP may be deferred under the Plan. Such election shall be made in accordance with the procedures established by the Plan Administrator. The deferral election applicable to an LTIP cash award shall be made prior to the close of the calendar year preceding the first day of the performance period applicable to that award. Notwithstanding the foregoing, such election shall become irrevocable as of the close of business of the last day of the calendar year preceding the first day of the performance period applicable to that award. However, if such award meets the definition of performance-based compensation (as defined under Treas. Reg. Section 1.409A-1(e) and any subsequent guidance), the Plan Administrator may permit such election to be made in accordance with the provisions under Treas. Reg.

Section 1.409A-2(a)(8) and subsequent guidance. Notwithstanding anything in the Plan to the contrary, a previously submitted deferral election of a Participant's cash award under the LTIP shall be disregarded following the Participant's Termination of Employment.

(c) *Cash Retention Award Deferrals.*

At the sole discretion of the Committee and subject to the procedures established by the Plan Administrator, an Eligible Executive may elect to defer all or a portion of a cash retention award that may be otherwise paid under a cash retention program maintained by the Company or an Affiliate. The deferral election applicable to such cash retention award shall be made in accordance with the provisions of Treasury Regulations Section 1.409A-2(a)(5). Notwithstanding anything in the Plan to the contrary, a previously submitted deferral election of a Participant's cash retention award shall be disregarded following the Participant's Termination of Employment.

4.5 Deferral and Contribution Timing.

Base Salary Deferrals will be credited to the Account of each Participant as of the date of the pay check from which the deferral was withheld. A Participant whose employment terminates during a payroll period will cease deferral withholding effective as of the first day of the following payroll period.

Annual Cash Incentive Deferrals and Commission Deferrals will be credited to the Account of each Participant as of the day on which such Annual Cash Incentive or Commissions, whichever is applicable, otherwise would have been paid to the Participant in cash.

Company Contributions for the Restoration of Lost Matching Contribution pursuant to Section 4.4(a) above will generally be credited to the Participant's Company Account as of the day on which said Lost Matching Contribution would otherwise have been credited to the Participant's account under Future Fund (generally following one Year of Participation Service).

LTIP deferrals shall be credited to the Account of the Participant at the time designated by the Plan Administrator.

Cash retention awards Deferrals will be credited to the Account of the Participant as of the day on which such cash retention award otherwise would have been paid to the Participant in cash.

ARTICLE V – ACCOUNTS

5.1 Establishment of Bookkeeping Accounts.

Separate bookkeeping accounts shall be maintained for each Participant. Said accounts (or subaccount(s) thereof) shall be credited with the deferrals and contributions made by or on behalf of the Participant pursuant to the Plan and credited (or charged, as the case may be) with the hypothetical investment results determined pursuant to this Article of the Plan.

5.2 Subaccounts.

Within each Participant's bookkeeping account, separate subaccount(s) shall be maintained to the extent necessary for the administration of the Plan. Generally, subaccount(s) will be set up for each year, for each Deferred Compensation Election the Participant makes, and for the Company Contribution credited each year on behalf of a Participant.

5.3 Hypothetical Nature of Accounts.

The accounts established under this Article shall be hypothetical in nature and shall be maintained for bookkeeping purposes only so that hypothetical gains or losses on the deferrals or contributions made to the Plan can be credited (or charged, as the case may be).

Neither the Plan nor any of the accounts, or subaccount(s), established hereunder shall hold any actual funds or assets. The right of any person to receive one or more payments under the Plan shall be an unsecured claim against the general assets of the Company. Any liability of the Company to any Participant, former Participant, or Beneficiary with respect to a right to payment shall be based solely upon contractual obligations created by the Plan. The Company, an Affiliate, the Board, the Committee, or any other person shall not be deemed to be a trustee of any amounts to be paid under the Plan. Nothing contained in the Plan, and no action taken pursuant to its provisions, shall create or be construed to create a trust of any kind, or a fiduciary relationship, between the Company, an Affiliate, the Board, the Committee, the Plan Administrator, or any other person and a Participant or any other person.

5.4 Vesting.

Deferral Account . A Participant shall be one hundred percent (100%) vested in his or her Deferral Account and Grandfathered Deferral Account at all times. A Participant shall be one hundred percent (100%) vested in the LTIP deferrals credited on his or her behalf pursuant to Section 4.4(b) and any cash retention award deferrals credited on his or her behalf pursuant to Section 4.4(c).

Company Account . A Participant shall be one hundred percent (100%) vested in his or her Company Account and Grandfathered Company Account at all times.

5.5 Deferral Crediting Options.

Deferral Crediting Options are similar to investment choices in a qualified defined contribution plan, except that they are hypothetical in nature and no funds are actually held in the Plan. Deferral Crediting Options determine the hypothetical gain or loss to be reflected in the Participant Accounts and shall be elected by Participants in the manner determined by the Plan Administrator.

The Deferral Crediting Options offered to Participants are determined by the Plan Administrator at its sole discretion. The Plan Administrator specifically retains the right to change the Deferral Crediting Options at any time, in its sole discretion.

In the event the Plan Administrator designates more than one Deferral Crediting Option, each Participant shall electronically submit a Deferral Crediting Option election during each annual

enrollment period, which shall be used to measure the hypothetical investment performance of his or her Accounts, within such time period and on such form as the Plan Administrator may prescribe. The designation of a Deferral Crediting Option shall not require the Company to invest or earmark their general assets in any manner. If a Participant fails to make a Deferral Crediting Option, his or her Accounts shall be deemed invested in a Deferral Crediting Option as determined by the Plan Administrator.

A Participant may change his or her election of a Deferral Crediting Option used to measure the hypothetical investment performance of his or her Account balance within such time periods and in such manner prescribed by the Plan Administrator. The election shall be effective as soon as administratively practicable after the date on which the election is submitted in the manner specified by the Plan Administrator.

Any amounts added to or subtracted from a Participant's Account on any given Valuation Date will be converted to hypothetical unit equivalents ("HypotheticalUnits") with a value per Hypothetical Unit ("Unit Price") based on the daily closing price on said date ("Unit Price") for any given Deferral Crediting Option.

5.6 Hypothetical Gains or Losses.

Any hypothetical dividends, capital gains and any other income or unit activity will be reflected in the Deferral Crediting Options. The timing of these will be the same as for the funds on which each Deferral Crediting Option is based.

The gain or loss on Participant Accounts will be calculated each Valuation Date. The Unit Price shall determine each Deferral Crediting Option's hypothetical value, based on the number of units within the Account for any given Deferral Crediting Option. Account balances on a given day will be based on the previous day's New York Stock Exchange closing price.

ARTICLE VI – DISTRIBUTION OF ACCOUNT

6.1 Distribution Elections – Timing of Payment.

(a) Subject to the limitations set forth in this Article VI, each time a Participant makes a Deferred Compensation Election with respect to a Plan Year beginning on or after January 1, 2016, the Participant shall designate on that applicable Deferred Compensation Election, separately for Participant deferrals and Company Contributions, as adjusted pursuant to Article V, that the distribution of such deferrals shall be made or commence, as the case may be, pursuant to Section 6.6, as of (i) the Participant's Retirement; or (ii) a Specific Future Year not later than the Plan Year in which the Participant attains age seventy-one (71).

A Participant may choose different options with respect to each Deferred Compensation Election. A Participant may not change the election made pursuant to the provisions of this Section 6.1, except as otherwise provided in Section 6.7 below.

i. *Retirement* . The distribution of the portion of a Participant's Deferral or Company Account (or subaccount(s)) that is deferred to Retirement under this Section shall commence on the first business day in the January next following his or her Retirement, pursuant to the provisions of Section 6.6, provided, however, that with respect to a Participant who is a Specified Employee as of the date of his or her Retirement, payment of any portion of his or her Deferral or Company Account (or any subaccount(s) thereof) that is subject to Section 409A of the Code will be delayed until the first business day of the seventh (7 th) month following the date such Retirement occurs.

ii. S *pecific Future Year* . In the event a Participant elects to have the distribution of such deferrals made or commence as of a Specific Future Year, subject to rules established by the Plan Administrator, the deferral period must be at least five (5) Plan Years. The distribution of the portion of a Participant's Deferral or Company Account (or subaccount(s)) that is deferred to a Specific Future Year shall commence on the first business day of January in that specific year pursuant to the provisions of Section 6.6.

(b) Company Contributions shall be distributed pursuant to the Participant's distribution election. In the event a Participant has not made a distribution election for the Company Contributions for that Plan Year, such distribution shall mirror his or her distribution election made with respect to his or her Base Salary Deferral or Annual Cash Incentive or Commissions Deferral for that Plan Year, if any, in such order; otherwise, such distribution shall be made at the Participant's Retirement.

6.2 Disability Distributions.

Notwithstanding the foregoing, if a Participant has a Termination of Employment because he or she has become Disabled, as determined by the Plan Administrator, such Participant will receive the balance of his or her Deferral Account and Company Account paid out in five (5) annual substantially equal installments with the first payment to be made within seventy-five (75) days from the date of the Participant's Termination of Employment. Subsequent annual payments will be paid as of the first business day in January of each subsequent year of the installment period.

6.3 Distributions in the Event of Death.

Notwithstanding the foregoing, in the event of a Participant's death, the Participant's Beneficiary will receive the remaining balance of the Participant's Deferral Account and Company Account paid in two (2) annual installments with the first payment to be made within seventy-five (75) days of the

Participant's date of death. The second annual payment will be paid as of the first business day in January of the subsequent calendar year.

6.4 Distributions Upon Termination of Employment Other Than Retirement, Death or Disability.

Notwithstanding the foregoing, in the event a Participant incurs a Termination of Employment from the Company and all Affiliates for any reason other than Retirement, death or Disability, said Participant will receive his or her entire Deferral Account and Company Account balance in a single lump sum payment. Such payment shall be made within seventy-five (75) days of the date the Participant's Termination of Employment occurs; provided, however, that with respect to a Participant who is a Specified Employee as of the date of his or her Termination of Employment for reasons other than death, payment of any portion of his or her Deferral or Company Account (or any subaccount(s) thereof) pursuant to the provisions of this Section 6.4 will be delayed until the first business day of the seventh (7 th) month following the date such Termination of Employment occurs.

6.5 Change in Control.

Notwithstanding the foregoing provisions of this Article VI, upon the occurrence of a Change in Control, a Participant who has a valid change in control election(s) in effect shall automatically receive the balance of his or her Deferral Account and Company Account related to that election, in cash, in a single lump sum payment. Such lump sum payment shall be paid within forty-five (45) business days after the Change in Control occurs. If such Participant dies after such Change in Control event occurs, but before receiving such payment, it shall be made to his or her Beneficiary.

6.6 Form of Payment.

(a) *Installments* . Subject to the limitations set forth in Article VI, distributions will be made in annual (or quarterly, if the election was made prior to October 1, 2008) installments, as elected by the Participant, for up to, and including, ten (10) years (fifteen (15) years for an election made prior to October 1, 2008). The initial installment of an annual or quarterly payment stream will begin as of the first business day of the January (a) next following the Participant's date of Retirement or (b) of the Specific Future Year, as the case may be, in accordance with the provisions of set forth in Section 6.1. Subsequent annual or quarterly payments will be as of the first business day of each subsequent calendar year or quarter of the installment period.

Each installment will be equal to a fraction of the Account balance (or subaccount(s) thereof) as of the date the installment is paid, with the numerator of the fraction being "1" and the denominator being the number of payments remaining in the payment schedule.

Notwithstanding the foregoing provisions of this paragraph (a), if a Participant dies before receiving payment of the entire balance of his or her Deferral and Company Accounts under the provisions of this Section, the remaining value of such Accounts shall be payable to his or her Beneficiary in accordance with the provisions of Section 6.9.

(b) *Lump sum* . A Participant may elect distribution in the form of a single lump sum payment. Except for Specified Employees, distribution shall be made as of the first business day of the January (a) next following the Participant's date of Retirement or (b) of the Specific Future Year, as the case may be, in accordance with the provisions of set forth in Section 6.1.

(c) Distributions to a Participant made pursuant to Section 6.1 will occur pursuant to the Participant's payment elections at the time he or she submits the applicable Deferred Compensation Election. A Participant may choose different forms of payment with respect to each Deferred Compensation Election. Company Contributions, adjusted pursuant to

Article V, shall be distributed pursuant to the Participant's form of payment election made with respect to his or her Company Contributions for that year. If the Participant has not made an election with respect to his or her Company Contributions, the portion of his or her Company Account attributable to such Company contributions will be distributed in accordance with his or her form of payment election with respect to his or her Base Salary Deferral, Annual Cash Incentive or Commissions Deferrals for that year, if any, in that order; otherwise payment will be made in a lump sum payment. In the absence of an election of the form of payment by a Participant on a Deferred Compensation Election, the portion of the Participant's Account deferred pursuant to that Deferred Compensation Election, adjusted pursuant to the provisions of Article V, shall be paid in a single lump sum.

(d) A Participant shall not change his or her form of payment election, except as otherwise provided in Section 6.7 below.

6.7 Change of Distribution Election.

(a) In accordance with such procedures as the Plan Administrator may prescribe, a Participant may elect to change his or her Specific Future Year election under Section 6.1(a)(ii) with respect to a portion of his or her Deferral Account (or an Interim Distribution date election applicable to a portion of his or her Deferral Account or Company Account made pursuant to the provisions of the Plan as in effect prior to December 31, 2008) to a later Specific Future Year (or, if applicable, a later Interim Distribution date) by duly completing, executing and filing with the Plan Administrator a new Specific Future Year election (or Interim Distribution date election) applicable to such Deferrals, subject to the following limitations:

i. such election must be made at least twelve (12) months prior to the Specific Future Year (or Interim Distribution date) then in effect with respect to that portion of his or her Deferral or Company Account (or subaccount(s) thereof), and such election will not become effective until at least twelve (12) months after the date on which the election is made; and

ii. the new Specific Future Year (or Interim Distribution date) shall be a calendar year that is not less than five (5) years from the Specific Future Year (or Interim Distribution date) then in effect.

Notwithstanding the foregoing, a Participant may elect to delay his or her distribution from an elected Specific Future Year to the later of Retirement or a new Specific Future Year that is at least five (5) years from the Specific Future Year then in effect, provided the election is made in accordance with the foregoing provisions of this Section 6.7(a). A Participant may elect to delay his or her distribution from an elected Specific Future Year (or Interim Distribution date) pursuant to this Section 6.7(a) more than once, provided that all such elections comply with the provisions of this Section 6.7(a).

(b) In accordance with such procedures as the Plan Administrator may prescribe, a Participant may elect to delay the payment of a portion of his or her Deferral or Company Account (or any subaccount(s) thereof) scheduled to be paid at his or her Retirement to his or her Retirement plus five (5) calendar years by duly completing, executing and filing with the Plan Administrator a new Retirement election applicable to such deferrals; provided, however such election must be made at least twelve (12) months prior to Retirement and shall not become effective until at least twelve (12) months after the date on which the election is made.

(c) In accordance with such procedures as the Plan Administrator may prescribe, a Participant may elect to change the form of payment election under Section 6.6 applicable to his or her

distribution under Section 6.1(a)(i) or (ii) by duly completing, executing and filing with the Plan Administrator a new form of payment election applicable to such deferrals, subject to the following limitations:

i. such election must be made at least twelve (12) months prior to the Specific Future Year then in effect with respect to that portion of his or her Deferral or Company Account (or subaccount(s) thereof), and such election will not become effective until at least twelve (12) months after the date on which the election is made; and

ii. the distribution of that portion of his or her Deferral or Company Account (or subaccount(s) thereof) shall be deferred for five (5) years from the date such amount would otherwise have been paid absent this election.

(d) It is the Company's intent that the provisions of Sections 6.7(a), (b) and (c) comply with the subsequent election provisions in Section 409A(a)(4)(C) of the Code, related regulations and other applicable guidance, and this Section 6.7 shall be interpreted accordingly. The Plan Administrator may impose additional restrictions or conditions on a Participant's ability to make an election pursuant to this Section 6.7. For avoidance of doubt, a Participant may not elect to alter the distribution of any portion of his or her Deferral or Company Accounts (or any subaccount(s) thereof) from Retirement to a Specific Future Year or, except as provided in paragraph (a) above, from a Specific Future Year to Retirement.

6.8 Account Valuation upon a Distribution.

With respect to a distribution made pursuant to this Article, the Valuation Date of a Participant's Account shall be the day immediately preceding the Distribution Date.

6.9 Designation of Beneficiary.

Each Participant shall have the right to designate a Beneficiary to receive payment of his or her Account in the event of death. Any such designation may be changed at any time by executing and submitting (either by hand or electronic submission) a new designation on a form prescribed by the Plan Administrator.

6.10 Unclaimed Account.

If the Plan Administrator is unable to locate a Participant or Beneficiary to whom an Account is payable, such Account may be forfeited to the Company upon the Plan Administrator's determination. Notwithstanding the foregoing, if subsequent to any such forfeiture, the Participant or Beneficiary to whom such Account is payable makes a valid claim, such forfeited Account shall be restored to the Plan and paid by the Company.

6.11 Hardship Withdrawals.

A Participant may apply in writing to the Plan Administrator for, and the Plan Administrator may grant, a hardship withdrawal of all or any part of a Participant's Deferral or Company Account if the Plan Administrator, in its sole discretion, determines that the Participant has incurred an Unforeseeable Emergency, as defined in the Universal 409A Definition Document.

The Plan Administrator shall determine whether an event qualifies as a hardship within this Section, in its sole and absolute discretion. Such request shall be made in a time and manner determined by the Plan Administrator. The payment made from a Participant's Deferral or Company Account (or any subaccount(s) thereof) pursuant to the provisions of this Section 6.11 shall not be in excess of the amount necessary to meet such financial hardship of the Participant, including amounts necessary to pay any federal, state or local income taxes with respect to the payment and shall not be available unless all other financial resources of the Participant have been exhausted. Payment

shall be made in the month following the date the Plan Administrator determines that the Participant has incurred an unforeseeable severe financial hardship and grants the right to a withdrawal pursuant to this Section 6.11.

6.12 Distribution of Grandfathered Deferral Account and the Grandfathered Company Account.

Notwithstanding the foregoing provisions of this Article VI, the distribution from a Participant's Grandfathered Deferral Account and Grandfathered Company Account (or subaccount(s)) shall be made pursuant to the provisions of the Plan as set forth on October 3, 2004, without regard to any amendments after October 3, 2004 which would constitute a material modification for Section 409A of the Code, as modified in Appendix A attached hereto.

ARTICLE VII – ADMINISTRATION

7.1 Plan Administrator.

The Plan shall be administered by the Deferred Compensation Plans Committee, appointed by the Committee as Plan Administrator. The Plan Administrator shall be responsible for the general operation and administration of the Plan and for carrying out the provisions thereof. The Plan Administrator may delegate to others certain aspects of the management and operations of the Plan including the employment of advisors and the delegation of ministerial duties to qualified individuals, provided that such delegation is in writing.

7.2 General Powers of Administration.

The Plan Administrator shall have the exclusive responsibility and complete discretionary authority to control the operation, management and administration of the Plan, with all powers necessary to enable it properly to carry out such responsibilities, including, but not limited to, the power to interpret the Plan and any related documents, to establish procedures for making any elections called for under the Plan, to make factual determinations regarding any and all matters arising hereunder, including, but not limited to, the right to determine eligibility for benefits, the right to construe the terms of the Plan, the right to remedy possible ambiguities, inequities, inconsistencies or omissions, and the right to resolve all interpretive, equitable or other questions arising under the Plan. The decisions of the Plan Administrator or such other party as is authorized under the terms of any grantor trust on all matters shall be final, binding and conclusive on all persons to the extent permitted by law. The Plan Administrator shall have all powers necessary or appropriate to enable it to carry out its administrative duties. Not in limitation, but in application of the foregoing, the Plan Administrator shall have the duty and power to interpret the Plan and determine all questions that may raise hereunder as to the status and rights of Employees, Participants, Beneficiaries, and any other person. The Plan Administrator may exercise the powers hereby granted in its sole and absolute discretion. No member of the Deferred Compensation Plans Committee shall be personally liable for any actions taken by the Plan Administrator unless the member's action involves gross negligence or willful misconduct.

7.3 Costs of Administration.

The costs of administering the Plan shall be borne by the Company unless and until the Participant receives written notice of the imposition of such administrative costs; with such costs to begin with the next Plan Year and none may be assessed retroactively for prior Plan Years.

Such costs shall be charged against the Participant's Account and shall be uniform or proportional for all Participants. Such costs shall not exceed the standard rates for similarly designed nonqualified plans under administration by high quality third party administrators at the time such costs are initially imposed and thereafter.

7.4 Indemnification.

The Company shall indemnify each director, officer or employee of the Company or any Affiliate and each member of the Committee and Deferred Compensation Plans Committee, including any subcommittee or delegates thereof, against any and all claims, losses, damages, expenses, including attorney's fees, incurred by them, and any liability, including any amounts paid in settlement with their approval, arising from their action or failure to act, except when the same is judicially determined to be attributable to their gross negligence or willful misconduct, as a result of the fact that he or she is or was serving the Plan in any capacity at the request of the Company.

7.5 409A Compliance.

With respect to the accounts subject to Section 409A of the Code, the Plan is intended to comply with the requirements of Section 409A of the Code and the provisions hereof shall be interpreted in a manner that satisfies the requirements of Section 409A of the Code and the regulations thereunder, and the Plan shall be operated accordingly. Regardless of, and superseding any other provision of the Plan to the contrary, if any provision of the Plan would otherwise frustrate or conflict with this intent, the provision will be interpreted and deemed amended so as to avoid this conflict.

ARTICLE VIII – CLAIMS PROCEDURE

8.1 Claims.

A person who believes that he or she is being denied a benefit to which he or she is entitled under the Plan (hereinafter referred to as a "Claimant") may file a written request for such benefit with the Plan Administrator, setting forth his or her claim. The request must be addressed to the Senior Vice President, Compensation and Benefits, at the Company's then principal place of business.

8.2 Claim Decision.

Upon receipt of a claim, the Plan Administrator or its delegate shall review and determine the claim within ninety (90) days. If the Plan Administrator determines that additional time is needed to review the claim, the Plan Administrator will provide the Claimant with a notice of the extension before the end of the initial ninety (90)-day period. The notice of extension will provide the date by which the Plan Administrator expects to make a decision.

If the claim is denied in whole or in part, the Plan Administrator shall notify the Claimant in writing of the following:

(a) The reason or reasons for such denial;

(b) The pertinent provisions of the Plan;

(c) Appropriate information as to the steps to be taken if the Claimant wishes to submit the claim for review; and

(d) The time limits for requesting a review under this Section.

8.3 Request for Review/Appeal.

Within sixty (60) days after the receipt by the Claimant of the initial written notice of a denial, the Claimant may request in writing that the initial determination be reviewed. Such request must be addressed to the Senior Vice President, Compensation and Benefits, at the Company's then principal place of business. The Claimant or his or her duly authorized representative may, but need not, submit issues and comments in writing for consideration by the Appeals Committee, a subcommittee of the Deferred Compensation Plans Committee. If the Claimant does not request a review of the initial determination within such sixty (60)-day period, he or she shall be barred and stopped from challenging the Plan Administrator's initial determination.

8.4 Review of Decision.

Within sixty (60) days after the Plan Administrator's receipt of a request for review, the Appeals Committee of the Plan Administrator will review the Plan Administrator's initial determination. After considering all materials presented by the Claimant, the Appeals Committee will render a written decision, setting forth the reasons for the decision and containing references to the pertinent provisions of the Plan. If the Appeals Committee requires an extension of the sixty (60)-day time period, the Appeals Committee will so notify the Claimant and will render the decision as soon as possible, but no later than one hundred twenty (120) days after receipt of the request for review.

8.5 Time Limit for Bringing Legal Action.

Any legal action by the Claimant must be brought within ninety (90) days following the date of the decision on the final review under Section 8.4 above.

ARTICLE IX – MISCELLANEOUS

9.1 Not Contract of Employment.

The adoption and maintenance of the Plan shall not be deemed to be a contract between the Company or an Affiliate and any person and shall not be consideration for the employment of any person. Nothing herein contained shall be deemed to give any person the right to be retained in the employ of the Company or an Affiliate or to restrict the right of the Company or an Affiliate to discharge any person at any time nor shall the Plan be deemed to give the Company or an Affiliate the right to require any person to remain in the employ of the Company or an Affiliate or to restrict any person's right to terminate his or her employment at any time.

9.2 Non-Assignability of Benefits.

No Participant, Beneficiary or distributees of benefits under the Plan shall have any power or right to transfer, assign, anticipate, hypothecate or otherwise encumber any part or all of the amounts payable hereunder, which are expressly declared to be unassignable and nontransferable. Any such attempted assignment or transfer shall be void. No amount payable hereunder shall, prior to actual payment thereof, be subject to seizure by any creditor of any such Participant, Beneficiary or other distributees for the payment of any debt judgment or other obligation, by a proceeding at law or in equity, nor transferable by operation of law in the event of the bankruptcy, insolvency or death of such Participant, Beneficiary or other distributee hereunder.

9.3 Withholding and Deduction and Taxes.

All deferrals and payments provided for hereunder shall be subject to applicable withholding and other deductions as shall be required of the Company under any applicable local, state or federal law. The Company may require that the Participant or Beneficiary making a deferral or receiving payments pay to the Company the amount of any federal, state or local taxes, if any, that the Company or any Affiliate is required to withhold with respect to such deferrals or payments or the Company or any Affiliate may deduct from other wages paid by the Company or any Affiliate the amount of any withholding taxes due with respect to such deferrals or payments. A Participant or Beneficiary shall be solely responsible for any tax consequences related to deferrals or payments made under the Plan. The Company shall have no obligation to make any payment under the Plan until the Company's or any Affiliate's tax withholding obligations have been satisfied by the Participant or Beneficiary.

9.4 Amendment and Termination.

The Committee or its delegate may from time to time, in its discretion, amend, in whole or in part, any or all of the provisions of the Plan; provided, however, that no amendment may be made that would impair the rights of a Participant with respect to amounts already allocated to his or her Account without the Participant's consent. To the extent consistent with the rules relating to plan terminations and liquidations in Treas. Reg. Section 1.409A-3(j)(4)(ix) or otherwise consistent with Section 409A of the Code, the Committee, in its sole discretion, may terminate the Plan and any related Deferred Compensation Election at any time and in that event the Committee may provide that, without the prior written consent of Participants, the Participants' Accounts shall be distributed in a single cash lump sum upon termination of the Plan. Unless so distributed in accordance with the preceding sentence, in the event of a Plan termination, the Plan Administrator shall continue to maintain the Participants' Accounts until distributed pursuant to the terms of the Plan and Participants shall remain one hundred percent (100%) vested in all amounts credited to their Accounts. In the event of a Plan termination, the distribution of a Participant's Grandfathered Deferral Account and Grandfathered Company Account shall be made pursuant to the provisions of the Plan as set forth on October 3, 2004, without regard to any amendments after October 3, 2004 which would constitute a material modification for Section 409A of the Code, as modified in Appendix A attached hereto.

9.5 Compliance with Securities and Other Laws.

Notwithstanding any Plan provision to the contrary, the Committee may at any time impose such restrictions on the Plan and participation therein, including limiting the amount of any deferral or the timing thereof, as the Committee may deem advisable from time to time in order to comply or preserve compliance with any applicable laws, including any applicable state and federal securities laws and exemptions from registration available thereunder.

9.6 No Trust Created.

Nothing contained in the Plan and no action taken pursuant to its provisions by the Company or any person, shall create, nor be construed to create, a trust of any kind or a fiduciary relationship between the Company or an Affiliate and the Participant, Beneficiary, or any other person.

9.7 Unsecured General Creditor Status of Employee.

The payments to the Participant, Beneficiary or any other distributees hereunder shall be made from assets which shall continue, for all purposes, to be a part of the general, unrestricted assets of the Company. No person shall have or acquire any interest in any such assets by virtue of the provisions of the Plan. The Company's obligation hereunder shall be an unfunded and unsecured promise to pay money in the future. To the extent that the Participant, Beneficiary or other distributees acquire a right to receive payments from the Company under the provisions hereof, such right shall be no greater than the right of any unsecured general creditor of the Company. No such person shall have or acquire any legal or equitable right, interest or claim in or to any property or assets of the Company.

In the event that, in its discretion, the Company purchases an insurance policy, or policies, insuring the life of the Employee, or any other property, to allow the Company to recover the cost of providing the benefits, in whole, or in part, hereunder, neither the Participant, Beneficiary or other distributee shall have or acquire any rights whatsoever therein or in the proceeds therefrom. The Company shall be the sole owner and beneficiary of any such policy or policies and, as such, shall possess and, may exercise all incidents of ownership therein. No such policy, policies or other property shall be held in any trust for a Participant, Beneficiary or other distributee or held as collateral security for any obligation of the Company hereunder. An Employee's participation in the underwriting or other steps necessary to acquire such policy or policies may be required by the Company and, if required, shall not be a suggestion of any beneficial interest in such policy or policies to a Participant.

9.8 Limitation.

A Participant and his or her Beneficiary shall assume all risk in connection with any decrease in value of his or her Account, and neither the Company nor the Committee or the Plan Administrator shall be liable or responsible therefor.

9.9 Payment to Minors and Incompetents.

If any Participant, spouse, or Beneficiary entitled to receive any benefits hereunder is a minor or is deemed by the Plan Administrator or is adjudicated to be legally incapable of giving a valid receipt and discharge for such benefits, the benefits will be paid to the person or entity as the Plan Administrator determines has been appointed or established to receive such payment on behalf of such person. Such payment shall, to the extent made, be deemed a complete discharge of any payment obligation under the Plan.

9.10 Acceleration of or Delay in Payments.

The Plan Administrator, in its sole and absolute discretion, may elect to accelerate the time or form of payment of a benefit owed to the Participant hereunder, provided such acceleration is permitted under Treas. Reg. Section 1.409A-3(j)(4) and any subsequent guidance. The Plan Administrator

may also, in its sole and absolute discretion, delay the time for payment of a benefit owed to the Participant hereunder, to the extent permitted under Treas. Reg. Section 1.409A- 2(b)(7) and any subsequent guidance.

9.11 Severability.

If any provision of the Plan shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining provisions hereof; instead, each provision shall be fully severable and the Plan shall be construed and enforced as if said illegal or invalid provision had never been included herein.

9.12 Governing Laws.

All provisions of the Plan shall be construed in accordance with the laws of Rhode Island, except to the extent preempted by federal law.

9.13 Binding Effect.

The terms of the Plan shall be binding on each Participant and his or her heirs and legal representatives and on the Company and its successors and assigns.

APPENDIX A – PROVISIONS APPLICABLE TO A PARTICIPANT'S GRANDFATHERED DEFERRAL ACCOUNT AND GRANDFATHERED COMPANY ACCOUNT

This Appendix A constitutes an integral part of the Plan and is applicable with respect to the Grandfathered Deferral Account and the Grandfathered Company Account of those individuals who were Participants in the Plan on December 31, 2004. The Grandfathered Deferral Account and Grandfathered Company Account are subject to all the terms and conditions of the Plan as set forth on October 3, 2004, without regard to any Plan amendments after October 3, 2004 which would constitute a material modification for Section 409A of the Code, as modified below. Section references in this Appendix A correspond to appropriate Sections of the Plan as set forth on October 3, 2004.

ARTICLE I – DEFINITIONS

Section 2.15 - Company Account means the Participant's Grandfathered Company Account as set forth in Section 2.28.

Section 2.19 - Deferral Account means the Participant's Grandfathered Deferral Account as set forth in Section 2.29 of the foregoing provisions of the Plan.

For purposes of a Participant's Grandfathered Deferral Account and Grandfathered Company Account, the term Change in Control shall have the meaning set forth in the 1997 Incentive Compensation Plan as in effect on October 3, 2004.

ARTICLE IV – DEFERRALS AND COMPANY CONTRIBUTIONS

The provisions of Section 4.03 shall continue to apply to a Participant's Grandfathered Deferral Account, Grandfathered Company Account and amounts transferred from the Melville Deferred Compensation Plan that were vested on or earlier than December 31, 2004.

ARTICLE V – MAINTENANCE OF ACCOUNTS

The provisions of Section V as set forth in the foregoing provisions of the Plan as amended and restated effective as of December 31, 2008 shall be applicable to a Participant's Grandfathered Deferral Account and Grandfathered Company Account on and after January 1, 2009.

ARTICLE VI – PAYMENT OF BENEFIT

For purposes of this Article VI - Payment of Benefit, the term "termination of employment" or any other similar language means with respect to a Participant the complete cessation of providing service to the Company and any Affiliate as an employee.

6.2. Form of Payment

Effective on or after October 1, 2008, a Participant shall not elect installments in excess of ten (10) years or quarterly installments.

6.3. Disability Distributions

A Participant shall be entitled to distribution under this Section if such Participant becomes "Disabled" as such term is defined under Section 6.03 of the Plan.

6.6. Change of Distribution Election

On and after January 1, 2009, a change in a Specific Future Year distribution date or an Interim distribution date shall be effective only if the new Specific Future Year distribution date or an Interim distribution date is not less than five (5) years later then the date in effect prior to the change election.

APPENDIX B – PROVISIONS APPLICABLE TO A PARTICIPANT'S ACCOUNT TRANSFERRED FROM THE LONGS DRUG STORES CORPORATION DEFERRED COMPENSATION PLAN OF 1995

This Appendix B constitutes an integral part of the Plan and is applicable solely with respect to the accounts transferred to the Plan from the Longs Drug Stores Corporation Deferred Compensation Plan of 1995 (the "Longs Plan").

The amounts transferred to the Plan from the Longs Plan consists solely of benefits accrued and vested under the Longs Plan on or before December 31, 2004 (including any permitted adjustments) and are 'grandfathered' for purposes of Section 409A of the Internal Revenue Code (the "Code").

Except as otherwise provided below, the Participant's Grandfathered Transferred Longs Account (as defined below) shall be subject to all the terms and conditions of the Longs Plan as set forth on October 3, 2004, without regard to any amendments after October 3, 2004 which would constitute a material modification for Code Section 409A.

1. The term "Grandfathered Transferred Longs Account" means the bookkeeping account (or subaccount(s) thereof) maintained for each Participant to record the amount transferred to the Plan from the Longs Drug Stores Corporation Deferred Compensation Plan of 1995, as adjusted pursuant to the provisions of Section 5.06 of the Plan.

2. The provisions of Section 5.05 as set forth in the foregoing provisions of the Plan shall be applicable to a Participant's Grandfathered Transferred Longs Account.

3. The provisions of Section 5.06 as set forth in the foregoing provisions of the Plan shall be applicable to a Participant's Grandfathered Transferred Longs Account."

APPENDIX C – PROVISIONS APPLICABLE TO A PARTICIPANT'S ACCOUNT UNDER THE OMNICARE, INC. DEFERRED COMPENSATION PLAN

This Appendix C constitutes an integral part of the Plan and is applicable with respect to a Participant's Account ("Omnicare Account") under the Omnicare, Inc. Deferred Compensation Plan, effective January 1, 2017. The Participants' Omnicare Accounts are subject to all the terms and conditions of the Omnicare Plan as set forth on January 1, 2013. Section references in this Appendix C correspond to appropriate Sections of the Omnicare Plan as set forth on January 1, 2013.

The notional amounts transferred to the Plan from the Omnicare Plan consists solely of benefits accrued and vested under the Omnicare Plan on or before December 31, 2016 and shall be subject to all the terms and conditions of the Omnicare Plan as set forth on January 1, 2013.

Article 2: Participation

Effective December 31, 2016, there shall be no new Participants in the Plan.

Article 3: Contributions & Deferral Elections

3.1 Elections to Defer Compensation.

Effective December 31, 2016 there shall be no new Elections to defer Compensation.

3.2 Company Contributions.

Effective December 31, 2016 there shall be no Discretionary Company Contributions or Company Matching Contributions.

3.3 Investment Elections.

Effective January 1, 2017, a Participant shall be eligible to designate the investment of his or her Omnicare Account solely in accordance with the Deferral Crediting Options of the CVS Health Corporation Deferred Compensation Plan.

Exhibit 10.22

CVSHealth

2016 Management Incentive Plan

I. Objectives and Summary

CVS Health Corporation's Management Incentive Plan (the "MIP") is designed to reward incentive-eligible employees ("Eligible Participants") of CVS Health Corporation and its subsidiaries (together, "the Company") for their role in driving performance and to encourage Eligible Participants' continued employment with the Company. Funding for the payment of incentive awards will be based on actual results measured against pre-established financial goals. The amount of each incentive award paid will be based on the performance of the Company and the performance of the individual Eligible Participant.

The MIP shall be administered by the Management Planning and Development Committee (the "Committee") of the Board of Directors (the "Board") under the provisions herein and of the 2010 Incentive Compensation Plan (the "ICP"), and the Committee may delegate to officers of CVS Health the authority to perform administrative functions of the MIP as the Committee may determine and may appoint officers and others to assist it in administering the MIP.

II. Plan Year

The MIP is a calendar year plan, which runs from January 1 to December 31, 2016 ("Plan Year"). All dates in this document occur during the Plan Year unless otherwise stated.

III. Eligibility

A. Eligibility for Participation

The Chief Executive Officer of CVS Health Corporation ("CEO") will determine those employees who are eligible for participation in the MIP, provided that the Committee shall determine the eligibility of employees who are or may be subject to Section 162(m) of the Internal Revenue Code (collectively, "Section 162(m) Eligible Participants", whom will also be included in the term "Eligible Participants" unless otherwise noted). In general, Eligible Participants include exempt employees who are not covered by any other incentive plans (including the Executive Incentive Plan) and who are employed on or before November 1 of the Plan Year; provided, however, that an employee who becomes a Section 162(m) Eligible Participant after January 1 of the Plan Year shall be eligible for an award under the MIP only to the extent that such award does not violate the requirements of Section 162(m).

The CEO (or, as to Section 162(m) Eligible Participants, the Committee) may, for any reason and in his or her (or its) sole discretion, at any time prior to the end of the Plan Year, determine an employee's eligibility for participation in the MIP. Eligible Participants are subject to the terms and conditions relating to incentive awards set forth in the MIP.

B. Section 162(m) Eligible Participants

Section 162(m) Eligible Participants shall be subject to the limitations required to comply with the provisions of Section 162(m). Subject to the requirements of Section 162(m), the Committee shall retain sole discretion to determine a Section 162(m) Eligible Participant's eligibility for an award, the target award, and the amount of the actual award. In no event shall a Section 162(m) Eligible Participant's award exceed the amount permitted by Section 162(m).

C. Newly-Eligible Employees

The award, if any, to an Eligible Participant who became an Eligible Participant after the beginning of the Plan Year may be prorated based on the date of eligibility.

D. Position Change

An employee who becomes an Eligible Participant on or before November 1 of the Plan Year as a result of a position change may be eligible for a prorated MIP award. If a position change results in an employee becoming an Eligible Participant for part of the Plan Year and other incentives during other parts of the Plan Year, the employee may be eligible to receive a prorated award for the amount of time in each incentive eligible position, subject to the terms of

each applicable incentive plan. A position change from one MIP-eligible position to another MIP-eligible postion during the Plan Year does not result in a prorata award but rather an award funded on the base salary of the Eligible Participant on December 31 of the Plan Year and the individual award opportunity as of that date.

E. Demotions

If a previously Eligible Participant is demoted to a non-incentive eligible position due to his or her violation of CVS Health policy or his or her performance, or if he or she voluntarily transfers to a non-incentive eligible position during the Plan Year, and is in the non-incentive eligible position on the last day of the Plan Year, he or she will not be eligible to earn an incentive award for the Plan Year under the MIP.

F. Terminations

Unless otherwise stated in Section VII of the MIP, if an Eligible Participant's employment terminates prior to the final determination of incentive awards for the Plan Year, he or she will not be eligible to receive an incentive award under the MIP. The final determination of incentive awards generally occurs in February of the year following the Plan Year.

G. Rehires

Employees who are rehired as Eligible Participants on or before November 1 of the Plan Year may be eligible for a prorated incentive award. For purposes of proration, credit will only be given for time worked during the Plan Year in incentive-eligible positions.

IV. Target Measurements and Total Pool

A. Consolidated Company Funding

MIP funding is based on consolidated Company performance, measured by Operating Profit, Pharmacy Benefit Management ("PBM") Client Satisfaction, and Retail Customer Service as defined below. Achievement of the Company's Operating Profit target will determine 80% of the total funding (the "Total Pool"); achievement of PBM Client Satisfaction targets will determine 10% of the Total Pool; and achievement of the Retail Customer Service target, as measured by 'myCustomer Experience' scores, will determine the remaining 10% of the Total Pool.

1. Operating Profit

Operating Profit is determined by reference to EBIT (see Exhibit A) and may be adjusted by the financial adjustments as approved by the Committee prior to the end of the first fiscal quarter of the Plan Year (the "Financial Adjustments").

If Operating Profit is below the minimum threshhold of 96.9% (see Exhibit B), no formulaic funding will be made available for incentive awards, regardless of Retail Customer Service and PBM Client Satisfaction performance, and there shall be no incentive awards paid under the MIP.

2. PBM Client Satisfaction

Achievement of the PBM Client Satisfaction component of incentive funding will be determined by the aggregate actual performance against target (see Exhibit B) of the weighted composite of the following surveys:

- Client Relationship and Loyalty Survey (weight = 50%)
- Mail Service Pharmacy and Customer Care Survey (weight = 25%)
- Specialty Pharmacy Satisfaction Survey (weight = 25%)

PBM Client Satisfaction funding is subject to adjustment based on Operating Profit.

3. Retail Customer Service

The Retail Customer Service component of the incentive funding will be determined using the myCustomer Experience actual performance against the target (see Exhibit B). The myCustomer Experience score is derived based on Rx Score and Front Store score and assigned weightings.

Retail Customer Service funding is subject to adjustment based on Operating Profit.

COMPANY PERFORMANCE - TARGET MEASUREMENTS

Measurement	Percent Weight	Measurement Tool	Achievement Measured Against	Modifier
Operating Profit	80%	Earnings Before Interest and Taxes ("EBIT")	2016 EBIT Goal	CEO & Committee Discretion (1) Financial Adjustments
PBM Client Satisfaction	10%	Client Relationship and Loyalty, Customer Care, Mail Service and Specialty Surveys	2016 PBM Client Satisfaction Target	Operating Profit Funding
Retail Customer Service	10%	myCustomer Service Scorecard	2016 myCustomer Experience Target	Operating Profit Funding

(1) Subject to restrictions applicable to Section 162(m) Eligible Participants

B. Total Pool Funding

After the achievement of at least threshold for Operating Profit has been confirmed, performance of PBM Client Satisfaction and Retail Customer Service compared to target for the Plan Year will be calculated. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The CEO or, in the case of Section 162(m) Eligible Participants, the Committee may adjust the funding of the Total Pool at his or her or its discretion based on (a) input from the PBM and Retail Presidents and Finance regarding their assessment of the overall performance of the Company; and (b) assessment of the achievement of Plan Year performance goals. In no case, however, can the CEO or the Committee increase Total Pool funding due to PBM Client Satisfaction or Retail Customer Service results.

C. Individual Performance

The Total Pool will be available for award to Eligible Participants under the MIP, taking into account the individual contribution of each Eligible Participant. The amount, if any, of the incentive award for an Eligible Participant shall be detemined in the sole discretion of the Company, which shall be final, binding and conclusive as to all parties having an interest therein. The amount, if any, of the incentive award for a Section 162(m) Eligible Participant shall be determined in the sole discretion of the Committee, which shall be final, binding and conclusive as to all parties having an interest therein.

V. Earnings and Payout

A. Timing

Incentive awards will be paid to Eligible Participants as soon as administratively feasible following the date the Total Pool is determined and approved and the amount of incentive payments is determined for each eligible participant, but in any case on or before March 15 of the year immediately following the Plan Year. Incentive payments under the MIP may be subject to garnishments and other state or federal requirements.

B. Calculations

Calculations for full and partial awards will be based on each Eligible Participant's annual base salary and individual target opportunity as of the last day of the Plan Year.

For purposes of proration under the MIP and except as otherwise provided in Section VII, calculations will be based on the number of days that the employee was an Eligible Participant in the MIP during the Plan Year.

C. Award Opportunity

Individual target awards will be determined by position and may vary based on the Eligible Participant's level in the organization.

D. Obligation to Pay Out Percentage of Total Pool

Eligible Participants, as a group, have a right to receive an amount at least equal to the Total Pool, but no individual Eligible Participant shall be entitled to receive an award or any specific amount of the Total Pool. In no event will

the aggregate of the total awards paid from the MIP be less than 92.5% of the Total Pool. To discourage unmerited litigation, any party or class asserting a challenge or claim against the Company under any provision of the MIP, including this Section V, shall bear their own costs relating to such challenge or claim, and if the challenge or claim is unsuccessful, such party or class shall reimburse the Company for all reasonable costs incurred by the Company in responding to such challenge or claim.

VI. Corrections to Incentive Awards

Any requested corrections to incentive award calculations must be submitted through the Human Resources Business Partner to Compensation by April 15 of the year following the Plan Year.

VII. Eligible Participant Status

A. Performance

Subject to the requirements of Section 162(m), the Company has full discretion in determining the amount, if any, of a MIP award to an Eligible Participant, including Eligible Participants whose awards may be based on SGIs, and the Participant's individual performance throughout the Plan Year will be considered by the Company in the final determination of the Eligible Participant's incentive award.

B. Leaves of Absence

An Eligible Participant on a Company-approved leave of absence at any time during the Plan Year who remains employed in an eligible position as of the last day of the Plan Year will earn a prorated incentive award based on the number of days actively worked (including time compensated as vacation, myTime or Paid Time Off ("PTO")) during the Plan Year, provided he or she meets all other eligibility criteria for an incentive award.

C. Reduction in Force, Retirement and Death

1. Reduction in Force

If an Eligible Participant is separated from employment by the Company on or before the last day of the Plan Year due to a reduction in force, he or she may be eligible, at the Company's discretion, to receive a prorated incentive award based on the incentive targets in place immediately before the separation date, provided the Eligible Participant meets all other eligibility criteria for an incentive award.

2. Retirement

If an Eligible Participant is at least age 55 and has a minimum of 10 years of service with CVS Health or a predecessor company/subsidiary **or** is at least age 60 and has a minimum of 5 years of service with CVS Health or a predecessor company/subsidiary **and** the Eligible Participant retires before the end of the Plan Year, he/she may be eligible to receive a prorated incentive award based on the incentive targets in place immediately before the termination date, provided he/she meets all other eligibility criteria for an incentive award. Eligible Participants who do not meet the minimum retirement requirements under this section at the time of retirement and who retire before the end of the Plan Year will not be eligible for an incentive award.

3. Death

In case of the death of an Eligible Participant, a prorated incentive award may be paid to the Eligible Participant's spouse, if living; otherwise, in equal shares to surviving children of the Eligible Participant. If there are no surviving children, the benefit shall be paid to the Eligible Participant's estate. The incentive award will be prorated based on the number of months the Eligible Participant worked during the Plan Year and incentive targets in place immediately before the termination date, and shall be paid as soon as administratively practicable following the death of the Eligible Participant but no later than March 15 of the year following the Plan Year. For this purpose, if the death of an Eligible Participant occurs on or before the 15 th of the month, the month will not be included in the proration calculations, and if the death occurs after the 15 th of the month, the month will be included in the proration calculations.

VIII. Miscellaneous

A. No Promise of Continued Employment

The MIP does not create an express or implied contract of employment between CVS Heath and an Eligible Participant. Both CVS Health and the Eligible Participant retain the right to terminate the employment relationship at will, at any time and for any reason.

B. Rights are Non-Assignable

Neither the Eligible Participant, nor any beneficiary, nor any other person shall have any right to assign, in whole or in part, the right to receive payments under the MIP. Payments are non-assignable and non-transferable, whether voluntarily or involuntarily.

C. Compliance with Applicable Law

An Eligible Participant must comply with all applicable state and federal law and CVS Health policies to be eligible to receive an incentive award under the MIP.

CVS Health will comply with all applicable laws concerning incentive awards; the MIP and its administration are not intended to conflict with any applicable state or federal law.

D. Change in Control

In the event of a change in control of CVS Health, as defined in the ICP, the MIP shall remain in full force and effect. Any amendments, modifications, termination or dissolution of the MIP by the acquiring entity may only occur prospectively and will not affect incentive targets or awards or eligibility in place immediately before the date of the change in control or such later date as it may be modified or dissolved by the acquiring entity.

Provisions regarding the payment of annual incentive awards that are set forth in change in control agreements with Eligible Employees shall supersede those appearing in the MIP.

E. Withholding

All required deductions will be withheld from the incentive awards prior to distribution. This includes all applicable federal, state, or local taxes, as well as any eligible 401(k) deductions and deferred compensation contributions as defined by the applicable plans. Incentive awards that are deferred will be taxed according to applicable federal and state tax law. Each Eligible Participant shall be solely responsible for any tax consequences of his or her award hereunder.

F. MIP Amendment/Modification/Termination

CVS Health retains the right to amend, modify, or terminate the MIP at any time on or before the last day of the Plan Year for any reason, with or without notice to Eligible Participants, provided that no changes shall be made with respect to a Section 162(m) Eligible Participant that would not comply with the requirements of Section 162(m).

G. MIP Interpretation

All inquiries with respect to the MIP and any requests for interpretation of any provision in the MIP must be submitted to the appropriate Human Resources Business Partner in writing. Failure to submit a request for resolution of a dispute or question in writing within 30 days of distribution of the incentive award may result in a waiver of the Eligible Participant's rights to dispute the MIP provision or amount of the incentive award.

Capitalized terms not otherwise defined herein shall have the meaning assigned to such defined term(s) in the ICP. In the event of any conflict between the ICP and the MIP, the terms of the ICP shall govern.

H. Recoupment of Incentive Awards

Each incentive award under the MIP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Eligible Employee to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the MIP.

I. Section 409A of the Internal Revenue Code

The Company intends that the MIP not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Code, as amended, and the regulations and guidance thereunder (collectively, "Section 409A"), and that to the extent any provisions of the Plan do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. Payments hereunder are intended to qualify as short-term deferral payments under Section 409A. In all events, the provisions of CVS Health Corporation's Universal 409A Definition Document are hereby incorporated by reference, and notwithstanding the any other provision of the Plan or any Award to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code (requiring certain delays for "specified employees"), payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh (7 th) month following the date of termination of employment. For purposes of any provision of the Plan

providing for the payment of any amounts or benefits in connection with a termination of employment, references to an Eligible Person's "termination of employment" (and corollary terms) shall be construed to refer to the Eligible Person's "separation from service" with the Company as determined under Section 409A.

CVS Health

2016 Executive Incentive Plan

I. Objectives and Summary

CVS Health Corporation's Executive Incentive Plan (the "Plan") governs annual incentive awards for certain key executive officers of CVS Health Corporation and its subsidiaries (together, "the Company"). The purpose of the Plan is to reward certain key executive officers of the Company for their material contributions to the Company and to motivate them to continue making such contributions in the future. The Plan is intended to provide performance-based compensation within the meaning of Section 162(m) of the Internal Revenue Code of 1986, as amended (the "Code"), and the provisions of the Plan shall be construed and interpreted to effectuate such intent.

The Management Planning and Development Committee (the "Committee") of the Board of Directors (the "Board") shall administer the Plan under the provisions herein and of the 2010 Incentive Compensation Plan (the "ICP") and shall have authority, without limitation, to determine the Participants (as defined in Section III), to determine the terms and conditions of any Award (as defined in Section III) and to interpret the Plan. Subject to the provisions of Section 162(m) of the Code, the Committee may, in its sole discretion, delegate to officers of CVS Health the authority to perform administrative functions of the Plan as the Committee may determine and may appoint officers and others to assist it in administering the Plan.

II. Plan Year

The Plan is a calendar year plan, which runs from January 1 to December 31 ("Plan Year").

III. Eligible Participants

Within 90 days after the start of the applicable Plan Year, the Committee shall designate the key executives of the Company who are eligible to participate in the Plan for the Plan Year (each, a "Participant") and to receive an award under the terms of the Plan (an "Award"). The Participants for the Plan Year shall be set forth in the Exhibit A to the Plan related to the Plan Year ("Exhibit A"). Except as the Committee may otherwise determine, it is intended that the Participants for any Plan Year shall include all employees who are treated as "covered employees" within the meaning of Section 162(m)(3) of the Code for that Plan Year and whose compensation for such Plan Year consequently may be subject to the limit on deductible compensation imposed by Section 162(m) of the Code. The Committee may designate a key executive as a Participant after the first 90 days of the applicable Plan Year, but only if the key executive is a new employee of the Company.

IV. Bonus Pool

A. For each Plan Year, the Company will establish a pool of funds for that Plan Year in an amount equal to 0.5% of the Company's Adjusted Net Income for the Plan year (the "Bonus Pool"). For purposes of the Plan, "Adjusted Net Income" is defined as adjusted income from continuing operations attributable to CVS Health as reported by the Company in its year-end earnings. Within 90 days of the start of the Plan Year, the Committee may make provision for excluding from the calculation of the Bonus Pool the effect of extraordinary events and changes in accounting methods, practices or policies.

B. Within 90 days of the start of each Plan Year, the Committee will designate a percentage of the Bonus Pool to be allocated to each Participant and a percentage to be reserved in the event the Committee wishes to allocate a percentage to a new Participant, if any, after the first 90 days of the applicable Plan Year. The allocations will be set forth in the Exhibit A for the Plan Year. The maximum allocation that may

be made to any Participant for a Plan Year will be 40%, and in no event shall the allocations, in the aggregate, exceed 100% of the Bonus Pool. Regardless of the foregoing, in no event shall any Participant be entitled to receive more than his or her individual cap as set forth in Exhibit A for the Plan Year.

V. Awards

A. Following the completion of each Plan Year, the Committee shall certify in writing the amount of the Bonus Pool and the actual Award amount, if any, payable to each Participant for such Plan Year. Subject to Section V.B, the actual Award amount payable to a Participant shall equal his or her allocable percentage of the Bonus Pool as certified by the Committee.

B. The Committee in its sole and exclusive discretion may reduce (including a reduction to zero) the Award to a Participant otherwise payable under the Plan for the Plan Year at any time prior to the payment of the Award to the Participant. The exercise of such negative discretion with respect to one Participant shall not result in an increase in the amount payable to any other Participant.

VI. Payment of Awards

A. Subject to Section V, a Participant shall receive payment of an Award if he or she remains employed by the Company through the final determination of incentive awards for the Plan Year; provided, however, that no Participant shall be entitled to payment of an Award hereunder until the Committee makes the certification provided for in Section V. The final determination of incentive awards generally occurs in February of the year following the Plan Year.

B. Awards shall be paid in cash or in any other form prescribed by the Committee and shall be paid to Participants as soon as administratively feasible following the date that annual bonuses are determined and approved for Company employees generally, but in any case on or before March 15 of the year immediately following the Plan Year. Awards may be subject to garnishments and other state or federal tax withholding requirements.

C. Calculations for full and partial awards will be based on each Participant's annual base salary and individual target opportunity as of December 31st of the Plan Year. For purposes of proration, the 15 th of the month will be used to determine if the month is included or excluded from the incentive calculation, as follows:

1. If a Participant's employment is terminated on or before the 15 th of the month and the employee is eligible for a prorated award under the Plan, then the full month will be excluded from incentive calculations.

2. If a Participant's employment is terminated after the 15 th of the month and the employee is eligible for a prorated award under the Plan, then the full month will be included in the incentive calculations.

VII. Retirement and Death

A. If a Participant is at least age 55 and has a minimum of 10 years of service with the Company **or** is at least age 60 and has a minimum of 5 years of service with the Company **and** the Participant retires before the end of the Plan Year, he/she may be eligible to receive a prorated Award based on the number of months worked during the Plan Year, provided he/she meets all other eligibility criteria for an Award. Participants who do not meet the minimum retirement requirements under this section at the time of retirement and who retire before the end of the Plan Year will not be eligible for an Award.

B. In the case of the death of a Participant before the end of the Plan Year, a prorated Award may be paid to the Participant's spouse, if living; otherwise, a prorated Award may be paid in equal shares to

surviving children of the Participant. If there are no surviving children, a prorated Award may be paid to the Participant's estate. If an Award is paid, the Award will be prorated based on the number of months the Participant worked during the Plan Year.

VIII. Miscellaneous

A. No Promise of Continued Employment

The Plan does not create an express or implied contract of employment between the Company and a Participant. Both the Company and the Participant retain the right to terminate the employment relationship at will, at any time and for any reason.

B. Rights are Non-Assignable

Neither the Participant, nor any beneficiary, nor any other person shall have any right to assign, in whole or in part, the right to receive payments under the Plan. Payments are non-assignable and non-transferable, whether voluntarily or involuntarily.

C. Compliance with Applicable Law

A Participant must comply with all applicable state and federal law and the policies of the Company to be eligible to receive an Award under the Plan.

The Company will comply with all applicable laws concerning incentive awards; the Plan and its administration are not intended to conflict with any applicable state or federal law.

D. Change in Control

In the event of a change in control of the Company, as defined in the ICP, the Plan shall remain in full force and effect. Any amendments, modifications, termination or dissolution of the Plan by the acquiring entity may only occur prospectively and will not affect incentive earnings or eligibility before the date of the change in control or such date as it may be modified or dissolved by the acquiring entity.

Provisions regarding the payment of annual incentive awards that are set forth in change in control agreements with Participants shall supersede those appearing in the Plan.

E. Withholding

All required deductions will be withheld from the Awards prior to distribution. This includes all applicable federal, state, or local taxes, as well as any eligible 401(k) deductions and deferred compensation contributions as defined by the applicable plans. Awards that are deferred will be taxed according to applicable federal and state tax law. Each Participant shall be solely responsible for any tax consequences of his or her Award hereunder.

F. Amendment/Modification/Termination

The Company retains the right to amend, modify, or terminate the Plan at any time on or before the last day of the Plan Year for any reason, with or without notice to Participants, provided that no changes shall be made that would not comply with the requirements of Section 162(m) of the Code.

G. Interpretation

All inquiries with respect to the Plan and any requests for interpretation of any provision in the Plan must be submitted to the Committee in writing. Failure to submit a request for resolution of a dispute or question in writing within 30 days of distribution of the Award shall result in a waiver of the Participant's rights to dispute the Plan provision or amount of the Award.

Capitalized terms not otherwise defined herein shall have the meaning assigned to such defined term(s) in the ICP. In the event of any conflict between the ICP and the Plan, the terms of the ICP shall govern.

H. Recoupment of Incentive Awards

Each Award under the Plan shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require a Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Plan.

I. Section 409A of the Internal Revenue Code

The Company intends that the MIP not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Code, as amended, and the regulations and guidance thereunder (collectively, "Section 409A"), and that to the extent any provisions of the Plan do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. Payments hereunder are intended to qualify as short-term deferral payments under Section 409A. In all events, the provisions of CVS Health Corporation's Universal 409A Definition Document are hereby incorporated by reference. Notwithstanding any other provision of the Plan or any Award to the contrary, to the extent required to avoid a violation of Section 409A, payment of any amounts to "specified employees" shall be delayed until the first business day of the seventh (7 th) month following the date of termination of employment. References to an Eligible Person's "termination of employment" (and corollary terms) shall be construed to refer to the Eligible Person's "separation from service" with the Company as determined under Section 409A.

Exhibit 10.25

Partnership Equity Program

Partnership Equity Program

Table of Contents

I. Purpose and Status of the PEP. The Partnership Equity Program (the " PEP ") has been adopted by the Management Planning & Development Committee (" Committee ") of the Board of Directors of CVS Health Corporation (the " Company "), as a subplan implemented under the Company's 2010 Incentive Compensation Plan (the " 2010 ICP "). The purpose of the PEP is to promote a partnership between the participating executive and the Company through a mutual commitment based on ownership of a proprietary interest in the Company. This is accomplished through an investment by the participating executive in the Company's common stock and an award by the Company of restricted stock units and stock options. All shares of Stock (as hereinafter defined) issued or delivered in settlement of Participant Purchased RSUs (as hereinafter defined) and Company Matching RSUs (as hereinafter defined) under the PEP or issued upon exercise of Company Matching Options (as hereinafter defined) granted under the PEP shall be shares of Stock reserved and available under the 2010 ICP. All of the terms and conditions of the 2010 ICP are hereby incorporated by reference. Capitalized terms used in the PEP but not defined herein shall have the same meanings as defined in the 2010 ICP Plan. If any provision of the PEP is inconsistent with a provision of the 2010 ICP, the provision of the 2010 ICP shall govern.

II. Eligibility. The Committee shall determine and approve, in its sole discretion, the executives eligible to participate in the PEP.

III. Definitions.

A. "Award" means any Participant Purchased RSUs, Company Matching RSUs, and Company Matching Options granted to a Participant under the PEP.

B. "Beneficiary" has the same meaning as the definition in the 2010 ICP.

C. "Board" means the Company's Board of Directors.

D. "Change in Control" means Change in Control as defined in the 2010 ICP.

E. "Code" means the Internal Revenue Code of 1986, as amended from time to time, including regulations thereunder and successor provisions and regulations thereto.

F. "Company Matching Option" means a right granted to a Participant under Section VIII(B) of the PEP and 6(b) of the 2010 ICP to purchase Stock at a specified price during a specified time period.

G. "Company Matching RSU" refers to a RSU granted by the Company pursuant to which the Participant has a right to receive under Section VIII(A) of the PEP, at the time of settlement specified in the PEP, the value of one share of Stock.

H. "Eligible Participant" means an employee of the Company and of any subsidiary of the Company who is approved by the Committee to have an opportunity to participate in the PEP.

I. "Fair Market Value" or **"FMV"** means the fair market value of the Stock as determined by the Committee or under procedures established by the Committee. Unless otherwise determined by the Committee, the Fair Market Value shall be the closing price of a share of Stock, as quoted on the composite transactions table on the New York Stock Exchange, on the date on which the determination of Fair Market Value is being made.

J. "Grant Date" means the date an Award is granted, as approved by the Committee.

K. "Grant Price" means the Fair Market Value of a share of Stock of the Company on the Grant Date, as approved by the Committee.

L. "Participant" means an Eligible Participant who has been granted an Award that remains outstanding under the PEP.

M "Participant Purchased RSUs" means the number of RSUs credited to a designated account representing a Participant's pre-tax investment in the PEP.

N "Participant Purchased Shares" means number of shares of Stock credited to a designated brokerage account representing a Participant's post-tax investment in the PEP.

O. "Post-Tax Investment Date" means the date on which the Participant purchases Stock in the PEP on a post-tax basis or the Grant Date if designating Stock under Section VII(B)(i). The Post-Tax Investment Date must be no more than 30 days following the Grant Date.

P. "RSU" means a restricted stock unit granted under Sections VII(A) and VIII(A) of the PEP and Section 6(d) of the 2010 ICP, in each case represent a right to receive the value of a share of Stock upon the terms and conditions set forth in the PEP, the 2010 ICP and the applicable Award agreement.

Q. "Stock" means the Company's common stock, $0.01 par value, and such other securities as may be substituted for Stock pursuant to Section 11 (c) of the 2010 ICP.

IV. Administration.

(A) Authority of the Committee . The PEP shall be administered by the Committee. The Committee shall have full and final authority, in each case subject to and consistent with the provisions of the PEP, to select Eligible Participants, grant Awards, determine the type, number and other terms and conditions of, and all other matters relating to, Awards, prescribe Award agreements (which need not be identical for each Participant) and rules and regulations for the administration of the PEP, construe and interpret the PEP and Award agreements and correct defects, supply omissions or reconcile inconsistencies therein, and to make all other decisions and determinations as the Committee may deem necessary or advisable for the administration of the PEP. The Committee, in its sole discretion, may waive the forfeiture provisions applicable to any Participant Purchased RSUs or Company Matching RSUs, provided that those RSUs shall be settled at the same time that they would otherwise have been settled if they had vested in due course under the terms of the PEP and the applicable Award.

(B) Manner of Exercise of Committee Authority . The express grant of any specific power to the Committee, and the taking of any action by the Committee, shall not be construed as limiting any power or authority of the Committee. To the extent permitted by applicable law, the Committee may delegate to officers or managers of the Company or any subsidiary, or committees thereof, the authority, subject to such terms as the Committee shall determine, to perform such functions, including administrative functions, as the Committee may determine. The Committee may appoint agents to assist it in administering the PEP.

(C) Limitation of Liability . The Committee and each member thereof shall be entitled to, in good faith, rely or act upon any report or other information furnished to him or her by any Participant officer, other officer or employee of the Corporation or a subsidiary, the Company's independent auditors, consultants or any other agents assisting in the administration of the PEP. Members of the Committee and any officer or employee of the Company or a subsidiary acting at the direction or on behalf of the Committee shall not be personally liable for any action or determination taken or made in good faith with respect to the PEP, and shall, to the extent permitted by law, be fully indemnified and protected by the Company with respect to any such action or determination.

V. Award. Upon approval by the Committee, an Eligible Participant shall be notified that he or she has been selected to receive an Award, contingent upon the Eligible Participant's decision to invest in the PEP by completion of a PEP participant election form (an " Election Form "). The Award will stipulate the Grant Date and the amount the Eligible Participant may invest in the PEP.

VI. Participation. On or before the Grant Date, the Eligible Participant shall be provided an Election Form to indicate (A) the dollar amount to be invested; and (B) the form of participation (pre- and/or post-tax) by the Eligible Participant. In order to become a Participant in the PEP, the Eligible Participant must return the executed Election Form to the Company within the time period designated on such form.

VII. Form of Participation . At the determination of the Committee, an Eligible Participant may invest in the PEP in one or in a combination of the following:

(A) Participant Purchased RSUs . On a pre-tax basis by electing to use a cash bonus payable to the Participant by the Company to invest in Participant Purchased RSUs, with such investment to occur on the Grant Date (Participant shall pay all applicable FICA taxes on the total dollar value of such pre-tax investment). The Company shall establish and maintain for each Participant an account on its stock administration system for purposes of tracking and administering the Participant Purchased RSUs.

Upon receipt by the Company from the Participant of a commitment to invest an amount in the PEP on a pre-tax basis as set forth on an Election Form, as of the Grant Date the Company will credit to the Participant's account an amount of Participant Purchased RSUs, as follows:

(i) The initial number of Participant Purchased RSUs shall be equal to the Participant's elected investment amount divided by the Fair Market Value of the Stock as of the Grant Date, rounded down to the next whole RSU.

(ii) Each Participant Purchased RSU represents a right to receive, at the time of settlement specified in the PEP, the value of one share of Stock.

(iii) Participant Purchased RSUs are non-transferable.

(B) Participant Purchased Shares. On an after-tax basis by designating Stock as follows:

(i) Designation by the Participant of Stock that the Participant owns as Participant Purchased Shares, with such designation as provided on the completed Election Form. The number of shares of Stock designated by the Participant as Participant Purchased Shares shall have a total Fair Market Value as of the Grant Date at least equal to the amount of the approved investment amount set forth in the Award.

(ii) Purchase of Stock by the Participant to be designated as Participant Purchased Shares, with such purchase and investment in the PEP to occur within thirty (30) days of the Grant Date.

(a) The number of shares of Stock purchased by the Participant shall have a total Fair Market Value as of the purchase date at least equal to the investment amount set forth in the applicable Election Form (or, if applicable, at least equal to the difference between the Fair Market Value of the shares of Stock designated by the Participant under Section VII(B)(i) and the investment amount).

(b) The Participant is responsible for the payment of any brokerage fees associated with the purchase of Stock for this purpose.

Under no circumstance may a Participant designate as Participant Purchased Shares any shares not actually owned by the Participant, including shares that are held in any other deferred compensation program sponsored by the Company or any prior employer of the Participant or any shares of Stock that are held in a qualified defined contribution plan as defined by the Code.

In all cases, the Participant shall maintain an account administered by a brokerage firm to hold the Participant Purchased Shares. The Participant is required to demonstrate, on a semi-annual basis and in the form required by the Company, that he or she has maintained ownership of such designated Participant Purchased Shares throughout the required ownership period.

VIII. Company Matching Investments. The Company shall establish and maintain for each Participant an account on its stock administration system for purposes of tracking and administering the Company Matching RSUs and Company Matching Options. As of the Grant Date, the Company shall make a matching Award to the Participant as described below.

(A) Company Matching RSUs. The Company Matching RSUs are non-transferable, shall be equal in number to the total Participant Purchased RSUs or to the Participant's investment amount divided by the Fair Market Value as of the Grant Date, and shall be credited to the Participant's account as of the Grant Date.

(B) Company Matching Option . The Company Matching Option is non-transferable and shall comprise of an option to purchase a number of shares of Stock equal to ten (10) times the number of Company Matching RSUs and shall be credited to the Participant's account as of the Grant Date.

IX. Restrictions on Disposition of Participant Purchased Shares. Participant Purchased Shares are not subject to restriction on transfer, withdrawal, or other dispositions, except that if the Participant transfers, withdraws, sells or otherwise disposes of Participant Purchased Shares prior to the earlier of the fifth (5^{th}) anniversary of the Grant Date or the date of the settlement of the Company Matching RSUs relating to Participant Purchased Shares, the Participant will immediately forfeit the number of Company Matching RSUs (including additional Company Matching RSUs acquired as a result of dividend reinvestment, as described below) and all or a portion of the Company Matching Options, in each case granted in respect of the Purchased Shares disposed of, determined as follows: such Participant shall forfeit the Company Matching Option to purchase ten (10) shares for each Participant Purchased Share so disposed of, except that only the portion of the Company Matching Option that is not yet exercisable shall be forfeited.

X. Dividends. To the extent that dividends are declared on Stock as of a dividend record date on which Participant Purchased RSUs or Company Matching RSUs remain outstanding and prior to the Settlement Date (as defined below), the Company shall credit as of the dividend payment date, a number of additional Participant Purchased RSUs or Company Matching RSUs to the Participant's account, which shall be determined by multiplying (i) the amount of cash actually paid by the Company as a dividend per share of Stock by (ii) the number of Participant Purchased RSUs and Company Matching RSUs credited to the Participant's account as of the dividend record date and dividing the product by (iii) the FMV per share of Stock on the dividend or dividend equivalent payment date; provided, however, that such additional Participant Purchased RSUs and Company Matching RSUs shall be subject to the same terms and conditions (including vesting) as the underlying award. As necessary to reflect dividend equivalents, a Participant's RSUs account will include fractional Stock units calculated to not less than four decimal places.

XI. Vesting and Settlement of Participant Purchased RSUs and Company Matching RSUs. Except as provided under Section XIII, Company Matching RSUs not previously forfeited shall vest and settle on the fifth anniversary of the Grant Date. Participant Purchased RSUs shall vest immediately on the Grant Date and to the extent not previously forfeited shall settle on the fifth anniversary of the Grant Date.

(A) Pursuant to the rules promulgated by the Committee, the Participant may make a prior election to defer settlement of Participant Purchased RSUs and Company Matching RSUs.

(B) Absent a valid prior election by the Participant to defer settlement of the Stock subject to the Participant Purchased RSUs and Company Matching RSUs, the settlement and delivery of the Stock shall occur as promptly as

practicable, but in any case within fifteen (15) days, following the fifth anniversary of the Grant Date (the " Settlement Date "). On the Settlement Date, the Company shall deliver to the Participant one share of Stock for each Participant Purchased RSU and Company Matching RSU; provided, however, that at the Settlement Date the number of shares of Stock to be delivered by the Company to the Participant shall be reduced by the smallest number of shares of Stock having a FMV at least equal to the dollar amount of Federal, state or local tax withholding required to be withheld by the Company with respect to such Participant Purchased RSUs and Company Matching RSUs on such date. In lieu of having the number of shares of Stock underlying the Participant Purchased RSUs and Company Matching RSU reduced, the Participant may elect to pay the Company for any amounts required to be withheld by the Company in connection with the settlement of the Participant Purchased RSUs and Company Matching RSUs pursuant to the Agreement. Such election may be made electronically at any time prior to the Settlement Date.

If the settlement includes any fractional share of Stock the Company may instead pay cash in lieu of delivery of a fractional share, on such basis as the Committee may determine. Upon settlement, all obligations of the Company in respect of Participant Purchased RSUs and Company Matching RSUs will be terminated, and the shares of Stock so distributed will not be subject to any risk of forfeiture or restriction under the PEP.

The settlement of Participant Purchased RSUs and Company Matching RSUs shall be subject to the settlement timing provisions of Section XIV(C)(ix) of the PEP.

XII. Options to Purchase Common Stock.

(A) Grant of Option. A Participant shall be granted a Company Matching Option in accordance with VIII (B) of the PEP.

(B) Exercise Price . The exercise price per share of Stock under a Company Matching Option shall be the FMV on the Grant Date, unless otherwise determined by the Committee, provided that in no event will the exercise price be less than the FMV of a share of Stock on the Grant Date.

(C) Vesting and Method of Exercise. Unless otherwise determined by the Committee, Company Matching Options will vest as to one-third of the underlying shares of Stock on each of the third, fourth and fifth anniversaries of the Grant Date; provided, however, that the vesting of said Company Matching Option may be accelerated in accordance with the provisions of the PEP Section XIII(D). To the extent vested, a Company Matching Option may be exercised in whole or in part, from time to time, all subject to the limitations on exercise set forth in this Section XII. An exercise shall be accomplished in accordance with Section 6(b) of the 2010 ICP. At the time of exercise, the exercise price of the number of shares as to which the Company Matching Option is being exercised shall be tendered to the Company. The exercise price of such Company Matching Option shall be paid in cash or by check or by surrender to the Company of shares of Stock (valued at their FMV as of the date of exercise) already owned by the Participant, other than shares acquired from the Company by exercise of an option during the preceding six months, or by a combination of cash, check, and surrender of such shares.

(D) Expiration . The Company Matching Option, to the extent it has not been exercised or previously terminated due to forfeiture, shall expire on the tenth (10 th) anniversary of the Grant Date.

XIII. Termination of Employment. Except as provided below in this Section XIII, if, for any reason, a Participant's employment with the Company and any subsidiary of the Company terminates prior to the fifth anniversary of the Grant Date, all Company Matching RSUs not yet vested and all Company Matching Options not yet exercised shall be immediately forfeited as of Participant's employment termination date. For purposes of this section, " Cause " shall have the same meaning as defined in the Company's standard change in control agreement. Participant's transfer of employment from the Company to a subsidiary of the Company, from a subsidiary of the Company to the Company or from one subsidiary of the Company to another subsidiary of the Company shall not be considered a termination of employment.

(A) Involuntary Termination of Participant's Employment without Cause.

(i) In the event that the Company terminates a Participant's employment with the Company and its subsidiaries and the Participant receives severance pay, the Participant's Award shall be treated as follows:

(a) If Participant's employment with the Company and its subsidiaries terminates prior to the second (2 nd) anniversary of the Grant Date as a result of the Participant's voluntary termination of employment or involuntary termination by the Company or any subsidiary for Cause, the Participant Purchased RSUs shall be immediately forfeited as of the termination date. Other than as stated above in this section XIII(A)(i)(a), Participant Purchased RSUs shall not be subject to any transfer or sale restrictions

(b) any Participant Purchased RSUs not settled at the time of Participant's employment termination date shall settle in accordance with the regular schedule set forth in the applicable

Award agreement. All applicable taxes due at time of vesting shall be immediately paid by the Participant;

(c) any Company Matching RSUs not vested at the time of Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall vest as of the Participant's employment termination date and settle in accordance with the regular schedule set forth in the applicable Award agreement. All applicable taxes due at time of vesting shall be immediately paid by the Participant;

(d) any Company Matching Options not vested at the time of Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall be exercisable at any time during the severance period and on or before the ninetieth (90 th) day following the last day of the severance period, as long as no government regulations or rules are violated by such continued vesting or exercise period; provided, however, that no Company Matching Option will be exercisable beyond its original term; and

(e) any Company Matching RSUs and Company Matching Options not scheduled to vest during the specified severance period shall be forfeited as of the Participant's employment termination date.

(ii) The Committee shall have the authority, in its sole discretion, to make any interpretations, determinations, and/or take any administrative actions with respect to whether any post-termination payments to the Participant shall be deemed severance pay, the duration of any severance period, and/or whether a termination was without Cause.

(B) **Retirement of Participant.** " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if the Participant elects to terminate his or her employment voluntarily, the Participant has provided the Company with at least twelve (12) months advance notice of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate the Participant's employment, then such termination is without cause. As of the Participant's retirement date, any Participant Purchased Shares shall not be subject to any transfer or sale restrictions, and any Participant Purchased RSUs shall vest as of the Participant's retirement date and shall settle in accordance with the regular schedule set forth in the applicable Award agreement. The Participant may exercise his or her vested Company Matching Option during the two-year period following the retirement date; any portion of the Company Matching Option which is not vested as of the retirement date shall be forfeited by the Participant as of the retirement date. Any Company Matching RSU or Company Matching Option that is not vested as of the retirement date shall be forfeited by the Participant. In the event the Participant's termination of employment qualifies as a Qualified Retirement and the Participant also enters into a severance agreement with the Company, the terms of Section XIII(A) shall apply with respect to the settlement of Participant Purchased RSUs and the vesting and settlement of Company Matching RSUs and Company Matching Options.

(C) **Disability of Participant.** In the event a Participant ceases to be employed by the Company, or any subsidiary of the Company, by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such plan, as defined by the Social Security Administration), any Participant Purchased Shares shall not be subject to any transfer or sale restrictions. In addition, any Participant Purchased RSUs and any Company Matching RSUs shall vest as of Participant's disability date and shall settle in accordance with the regular schedule set forth in the applicable Award agreement and any Company Matching Option shall vest and be exercisable during the twelve (12) month period following Participant's employment termination date, in each case on a pro rata basis in accordance with the Award in effect for the Participant. Notwithstanding the foregoing, a Participant shall be deemed to have ceased employment due to a qualifying disability under this Section XIII (C) only if at the time of such cessation of employment the Participant is disabled within the meaning of Section 409A of the Code pursuant to the regulations thereunder.

(D) **Death of Participant.** In the event of a Participant's death while employed by the Company or one of its subsidiaries, any Participant Purchased Shares shall not be subject to any transfer or sale restrictions. In addition, all Participant Purchased RSUs and all Company Matching RSUs shall vest and settle on Participant's date of death and Company Matching Options shall become immediately vested in full. The Company Matching Option may be exercised during the twelve (12) month period

following the Participant's date of death, or prior to the Company Matching Option expiration date, whichever occurs first, by the Participant's Beneficiary . At the end of said one-year time period, all rights with respect to any Company Matching Option that is unexercised shall terminate and the unexercised Company Matching Option shall be cancelled.

(E) **Change In Control.** In the event of a Termination Without Cause or a Constructive Termination Without Cause, in each case within the two-year period following a Change in Control, any Participant Purchased Shares shall not be subject to any transfer or sale restrictions. In addition, all of the Participant's outstanding Participant Purchased RSUs and all Company Matching RSUs shall vest and settle as of the Participant's termination date and Company Matching Options that are not then vested will become immediately vested and exercisable for the remainder of the term of the Company Matching Option but not beyond its original Expiration date provided in Section XII(D). All other terms and conditions governing such Company Matching RSUs, Participant Purchased RSUs and Company Matching Options will be subject to the provisions of the Company's 2010 ICP.

(F) **Coordination of Provisions.** Notwithstanding anything to the contrary above, to the extent that the circumstances of the termination of a Participant's employment are within the description of more than one of the subparagraphs above in this Section XIII, each portion of a Participant's Company Matching RSU or Company Matching Option under any Award shall be entitled to the more favorable treatment explicitly applicable to such portion of the Participant's Company Matching RSU or Company Matching Option under the provisions of this Section XIII. For example, if a Participant qualifies as Qualified Retiree at the time of the Participant's termination of employment but the Participant receives severance in connection with the Participant's termination as described in Section XIII (A), the Participant's unvested Matching Company Option shall continue to vest during the applicable severance period and any portion of the Company Matching Option that vests during the severance period shall be exercisable on or before the ninetieth (90 th) day following the last day of the severance period, while any portion of the Participant's Matching Company Option that is vested as of the Participant's termination may be exercised during the two-year period following the Retirement Date. Similarly, by way of example, if a Participant experiences a termination of employment due to disability following a Change in Control, the treatment described in Section XIII (E) shall apply to the Participant's Awards to the extent that such treatment is more favorable to the Participant than the treatment applicable under Section XIII (C).

(G) In any case, the settlement of Participant Purchased RSUs and Company Matching RSUs shall be subject to the settlement timing provisions of Section XIV(C)(ix) of the PEP.

XIV. General Provisions.

(A) Stock Dividends and Stock Splits . If the Company declares and pays a dividend or distribution in the form of Stock payable on Stock, or if there is a stock split of the Stock, and the record date is prior to the Settlement Date of Participant Purchased and/or Company Matching RSUs, the Company shall credit, as of the dividend payment date, distribution, or split, a number of additional Participant Purchased RSUs and Company Matching RSUs, as the case may be, to the Participant's account equal to the number of shares of Stock paid as a dividend or distribution per share of Stock or distributed as a result of the split per share of Stock multiplied by the number of Participant Purchased RSUs and Company Matching RSUs, as the case may be, credited to the Participant's account at the record date.

(B) Treatment of Additional Participant Purchased RSUs and Company Matching RSUs Resulting from Dividends or Splits. Additional Participant Purchased RSUs or Company Matching RSUs will be subject to the same terms, including the risk of forfeiture in the case of Company Matching RSUs, as the Participant Purchased RSUs or Company Matching RSUs in respect of which they were credited. No such additional Company Matching RSUs will be credited to the Participant's account in respect of Company Matching RSUs forfeited on or before the payment date for the dividend, distribution, or split.

(C) Other Terms . The following terms and provisions will be applicable to Participant Purchased Shares or RSUs, Company Matching RSUs and Company Matching Options, as applicable.

(i)**Adjustments** . Participant Purchased Shares or Participant Purchased RSUs, Company Matching RSUs, and Company Matching Options, and the terms and conditions relating thereto, shall be subject to adjustment in accordance with applicable sections of the 2010 ICP.

(ii)**Nontransferability** . Participant Purchased Shares or Participant Purchased RSUs, Company Matching RSUs, Company Matching Options, and all rights relating thereto, shall not be transferable or assignable by a Participant, other than by will or the laws of descent and distribution (or pursuant to a beneficiary designation if and to the extent authorized by the Committee), and shall not be pledged, hypothecated, or otherwise encumbered in any

way or subject to execution, attachment, or similar process, and any such attempt to transfer such rights shall be considered null and void by the Company.

(iii) **Certain Other Terms** . Additional terms applicable to Awards under the PEP are set forth in the 2010 ICP.

(iv) **No Partnership Rights or Rights to Participate** . A Participant's participation in the PEP, investment in Participant Purchased Shares or Participant Purchased RSUs, and grant of an Award under the PEP confers no rights as a partner of a partnership. No Participant has or will have any claim to participate in the PEP, except as selected by the Committee, and the Company will have no obligation to continue the PEP.

(v) **Changes to the PEP** . The Committee may amend, alter, suspend, discontinue or terminate the PEP without the consent of any Participant; provided, however, that, without the consent of an affected Participant, no such action shall materially and adversely affect the rights of such Participant with respect to an outstanding Award.

(vi) **Limitation on Repurchase Obligation** . All repurchases of Stock permitted to occur in the ordinary course pursuant to the terms established under the PEP are intended to qualify for the exemption from Section 16(b) of the Exchange Act pursuant to Rule 16b-3(e) promulgated under the Exchange Act and, accordingly, such repurchases are authorized to occur with respect to all Awards under the PEP unless and until the repurchase rights and obligations relating to an Award are explicitly revoked by the Committee.

(vii) **Agreements and Other Documents** . The Committee shall specify agreements or other documents to evidence rights and obligations under the PEP. A form of agreement that may be used to evidence rights and obligations relating to Participant Purchased Shares and/or Participant Purchased RSUs, Company Matching RSUs and Company Matching Options shall be provided to each Participant.

(viii) **Governing Law** . The validity, construction, and effect of the PEP, any rules and regulations and any award agreements or related documents hereunder shall be determined in accordance with the Delaware General Corporation Law, without giving effect to principles of conflicts of laws and applicable federal law.

(ix) **Section 409A Compliance.** The Participant Purchased RSUs and Company Matching RSUs under the PEP are intended to qualify as nonqualified deferred compensation awards which comply with the provisions of Section 409A and the regulations thereunder. The vesting dates shall be the dates fixed under the terms of the PEP as of the Grant Date, subject to acceleration only upon the following permissible events under Section 409A of the Code as specified under the PEP or as otherwise provided by the Committee in its sole discretion: the Participant's death, the Participant's qualifying disability (under Section XIII (C)) or a Change in Control (within the meaning of the 2010 ICP, which includes a definition of change in control that complies with Section 409A of the Code). Any portion of a Participant Purchased RSU and Company Matching RSU that has become vested in accordance with the terms of the PEP shall be settled as provided under the PEP on a date selected by the Company occurring prior to the 15 th day of the third calendar month following the applicable vesting date. In the event that a Participant experiences a termination of employment and is granted severance and is therefore permitted to continue to vest in one or more installments of a Participant Purchased RSU or Company Matching RSU Award pursuant to Section XIII (A), such installments shall continue to be subject to settlement only after the vesting date originally applicable to such installments and during the settlement period set forth above in this Section XIV (C). In the event that the Committee exercises its sole discretion to waive the forfeiture provisions applicable to any Participant Purchased RSUs or Company Matching RSUs, those RSUs shall be settled at the same time that they would otherwise have been settled if they had vested in due course under the terms of the PEP and the applicable Award. Notwithstanding the foregoing or any other provision of the PEP or any Award to the contrary, to the extent necessary to comply with the requirements of Section 409A of the Code, any settlement amounts to which a Participant may become entitled under the PEP, which are subject to Section 409A of the Code (and not otherwise exempt from its application), that are payable within six months following the date of termination will be withheld until the first business day of the seventh (7 th) month following the date of termination. To the extent any provisions of the PEP or any RSU does not comply with Section 409A of the Code, the Company and any affected Participant will make such changes

with respect to such RSU as are mutually acceptable in order to comply with Section 409A of the Code.

XV. Recoupment Policy. Except as may be specifically provided in the Award agreement, each Award under the PEP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting an Award under the PEP, Participant acknowledges that the Company's Recoupment Policy has been made available for the Participant's reference.

Exhibit 10.27

CVS Health Corporation

Performance-Based Restricted Stock Unit Plan

I. ***Objectives and Summary***

The objective of the CVS Health Corporation (the "Company") Performance-Based Restricted Stock Unit Plan ("PBRS Plan") is to reward eligible participants for their role in achieving the Company's Earnings before Interest and Taxes ("EBIT") target and to encourage continued employment with the Company and its subsidiaries. PBRS Awards are generally delivered as restricted stock units ("RSUs") and are based on actual EBIT results measured against a pre-established target.

II. ***Administration***

The PBRS Plan shall be administered by the Management Planning and Development Committee (the "Committee") of the Board of Directors, or its designee, under the provisions of the 2010 Incentive Compensation Plan, as amended (the "2010 ICP"). The Committee shall have full and final authority, in each case, subject to and consistent with the provisions of the 2010 ICP and the PBRS Plan, to construe and interpret rules and regulations for the administration of the PBRS Plan, correct defects, supply omissions or reconcile inconsistencies therein, and to make all other decisions and determinations as the Committee may deem necessary or advisable for the administration of the PBRS Plan. Capitalized terms not otherwise defined herein shall have the meaning assigned to such terms in the 2010 ICP. In the event of a conflict between the 2010 ICP and the PBRS Plan, the provisions of the 2010 ICP shall control.

III ***PBRS Plan Year***

The "PBRS Plan Year" commences on January 1 and ends on December 31 of each year, unless otherwise approved by the Committee. All dates in this document occur during the PBRS Plan Year unless otherwise stated.

IV. ***Eligibility***

A. Eligible Employees

The Chief Executive Officer (the "CEO") or the CEO's designee determines those employees of the Company and its subsidiaries who are eligible to participate in the PBRS Plan ("Eligible Employees"). In general, Eligible Employees are those employees who are (i) officers of CVS Pharmacy, Inc. who are Vice Presidents or above, and (ii) senior officers of other subsidiaries who have been designated as Eligible Employees by the CEO or his or her designee. Generally, Business Planning Committee ("BPC") members are not eligible to participate, unless otherwise named as an Eligible Employee by the Committee.

B. Newly-Hired Eligible Employees

A newly-hired employee satisfying the requirements set forth on Paragraph IV(A) is an Eligible Employee and may receive a non-prorated PBRS Award for the PBRS Plan Year in which he or she is hired provided he or she is hired on or before November 1 and remains in an Eligible Employee position through December 31 of the PBRS Plan Year.

C. Participants

Unless the Committee is required to make such determinations under applicable law or the 2010 ICP, the CEO or the CEOs designee shall determine which Eligible Employees will receive an award under the PBRS Plan (a "PBRS Award"). All such determinations, whether by the CEO, the CEOs designee, or the Committee, shall be made no later than March 15 of the calendar year following the PBRS Plan Year. Each Eligible Employee who receives a PBRS Award is a "Participant" and the "PBRS Award Date" shall be the last business day of February of the PBRS Plan Year, No Eligible Employee has any right to receive a PBRS Award, regardless of whether such Eligible Employee is employed on the last day of the PBRS Plan Year, and the determination of whether an Eligible Employee will be a Participant shall be made in the sole discretion of the CEO, the CEOs designee or the Committee, as the case may be.

D. Status Changes

(i) Promotions . An employee who is promoted on or before November 1 of the PBRS Plan Year to a position satisfying the requirements set forth on Paragraph IV(A) is an Eligible Employee and may receive a PBRS Award for the year in which the promotion occurs. The salary upon which the Eligible Employee's PBRS Award will be based shall be the base salary as of December 31 of the PBRS Plan Year.

(ii) Demotions . An Eligible Employee who is demoted on or after November 1 of the PBRS Plan Year to a position not satisfying the requirements set forth on Paragraph IV(A) will remain an Eligible Employee and may receive a PBRS Award provided such demotion is not the result of voluntarily transfer to a lower level position, is not related to unsatisfactory performance, and is not as a result of a violation of a Company policy or Code of Ethics.

(iii) Termination of Employment During the PBRS Plan Year

a) **In General.** Except as provided in paragraphs (ii)-(iv) below, if for any reason the employment of an Eligible Employee with the Company and any subsidiary of the Company terminates during a PBRS Plan Year, the Eligible Employee will not receive a PBRS Award for that PBRS Plan Year.

b) **Retirement.** If an Eligible Employee is at least age 55 and has a minimum of 10 years of service with CVS Health or a predecessor company/subsidiary **or** is at least age 60 and has a minimum of 5 years of service with CVS Health or a predecessor company/subsidiary **and** the Eligible Employee retires prior to the last day of the PBRS Plan Year, he or she may receive a PBRS Award. Such PBRS Award may be payable in cash at the same time PBRS Awards are made to other Eligible Employees and may be pro-rated for the number of full months (a partial month will be counted as a full month) during which the Eligible Employee was an active employee based on a full calendar year, provided he or she meets all other eligibility criteria for a PBRS Award.

c) **Death or Disability** . If an Eligible Employee dies or commences a long-term disability (as defined in the Company's LTD plan or by the Social Security Administrator), the Eligible Employee may receive a PBRS Award for the year in which the death or commencement of long-term disability occurs at the same time PBRS Awards are made to other Participants. Such PBRS Award will be pro-rated for the number of full months (a partial month will be counted as a full month) during which the Eligible Employee was an active employee based on a full calendar year and will (unless otherwise determined by the CEO or the Committee) be paid in cash based on the Eligible Employee's base salary in effect at the time of death or commencement of long-term disability. PBRS Awards with respect to deceased Eligible Employees shall be paid to the Eligible Employee's Beneficiary.

d) **Other Terminations** . In the sole discretion of the CEO or the Committee (as the case may be), an Eligible Employee who terminates employment with the Company and its subsidiaries prior to the last day of the PBRS Plan Year or prior to the Plan payout date for any reason other than retirement, death or long-term disability, as

defined above in this section, may receive a PBRS Award. Such PBRS Award may be payable in cash at the same time PBRS Awards are made to other Participants and may be pro-rated for the number of full months (a partial month will be counted as a full month) during which the Eligible Employee was an active employee based on a full calendar year.

V. Plan Performance Measures

A. Unless otherwise approved by the Committee, PBRS funding is based on consolidated Company performance, measured by Operating Profit, Pharmacy Benefit Management ("PBM") Client Satisfaction, and Retail Customer Service as defined below. Achievement of the Company's Operating Profit target will determine 80% of total funding; achievement of PBM Client Satisfaction targets will determine 10% of the total funding; and achievement of the Retail Customer Service target, as measured by 'myCustomer Experience' scores, will determine the remaining 10% of the total funding.

1. Operating Profit

Operating Profit is determined by reference to EBIT (see Exhibit A) and may be adjusted by the financial adjustments as approved by the Committee prior to the end of the first fiscal quarter of the Plan Year.

If Operating Profit is below the minimum threshhold of 96.9% (see Exhibit B), no formulaic funding will be made available for incentive awards, regardless of Retail Customer Service and PBM Client Satisfaction performance, and there shall be no PBRS Awards paid.

2. PBM Client Satisfaction

Achievement of the PBM Client Satisfaction component of incentive funding will be determined by the aggregate actual performance against target (see Exhibit B) of the weighted composite of the following surveys:

- Client Relationship and Loyalty Survey (weight = 50%)
- Mail Service Pharmacy and Customer Care Survey (weight = 25%)
- Specialty Pharmacy Satisfaction Survey (weight = 25%)

PBM Client Satisfaction funding is subject to adjustment based on Operating Profit.

3. Retail Customer Service

The Retail Customer Service component of the incentive funding will be determined using the myCustomer Experience actual performance against the target (see Exhibit B). The myCustomer Experience score is derived based on Rx Score and Front Store score and assigned weightings.

Retail Customer Service funding is subject to adjustment based on Operating Profit.

COMPANY PERFORMANCE - TARGET MEASUREMENTS

Measurement	Percent Weight	Measurement Tool	Achievement Measured Against	Modifier
Operating Profit	80%	Earnings Before Interest and Taxes ("EBIT")	20XX EBIT Goal	CEO & Committee Discretion (1) Financial Adjustments
PBM Client Satisfaction	10%	Client Relationship and Loyalty, Customer Care, Mail Service and Specialty Surveys	20XX PBM Client Satisfaction Target	Operating Profit Funding
Retail Customer Service	10%	myCustomer Service Scorecard	20XX myCustomer Experience Target	Operating Profit Funding

B. Unless otherwise determined by the Committee, in its sole discretion, the maximum PBRS Award that may be payable to any Participant under the PBRS Plan is 50% of base salary.

VI. Plan Payout

A. Target PBRS Award
The target PBRS Award for each Participant is 25% of the base salary in effect as of the last day of the PBRS Plan Year.

B. PBRS Award Determination and Vesting
After the achievement of at least threshold for Operating Profit has been confirmed, performance of PBM Client Satisfaction and Retail Customer Service compared to target for the Plan Year will be calculated. Total funding for PBRS Awards will be fully based (100%) on consolidated Company performance.

The PBRS Award is equal to the Award Payout Percentage multiplied by the Participant's base salary as of the last day of the PBRS Plan Year, generally payable in RSUs. The number of RSUs that the Participant will receive is equal to the PBRS Award divided by the closing price of Company common stock on the PBRS Award Date.

C. Vesting
The RSUs issued in respect of any PBRS Award will vest in accordance with and subject to the terms and conditions of the 2010 ICP and the applicable agreement for each PBRS Award. PBRS Awards unvested as of a Participant's termination of employment shall be governed by the terms and conditions of the applicable agreement for each PBRS Award and the PBRS Plan in effect at the time of grant of each award.

VII. Plan Administration

A. Employment Rights
The PBRS Plan does not create any express or implied contract of employment between the Company and an Eligible Employee. Both the Company and an Eligible Employee (whether or not a Participant) retain the right to terminate the employment relationship at any time and for any reason.

B. Rights are Non-Assignable
Neither a Participant nor any beneficiary nor any other person shall have any right to assign the right to receive payments hereunder, in whole or in part, which payments are non-assignable and non-transferable, whether voluntarily or involuntarily.

C. Change in Control
In the event of a Change in Control, the PBRS Plan shall remain in full force and effect. Any modifications to or dissolution of the PBRS Plan by the acquiring entity may only occur prospectively and will not affect entitlements, awards or eligibility before the date of the Change in Control.

D. Plan Amendment/Modification/Termination
The Company retains the right to amend, modify, or terminate the PBRS Plan for any reason and at any time on or before December 31 of the PBRS Plan Year, with or without notice to Eligible Employees. No representative of the Company or its subsidiaries has the authority to modify the terms of this PBRS Plan without written consent of the Chief Human Resources Officer or his or her designee.

E. Withholding
The Company may provide for the withholding from any benefits payable under the PBRS Plan all federal, state, city or other taxes as shall be required pursuant to any law or governmental regulation or ruling.

F. Section 409A of the Code
The Company intends that the PBRS Plan not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and the regulations and guidance thereunder (collectively, "Section 409A") and that to the extent any provisions of the PBRS Plan do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. In all events, the provisions of CVS Health Corporation's Universal 409A Definitions Document are hereby incorporated by reference and, notwithstanding any other provision of the Plan or any Award to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to

Section 409A shall be delayed until the first business day of the seventh month immediately following the date of termination of employment. For purposes of any provision of the PBRS Plan providing for the payment of any amounts or benefits in connection with a termination of employment, references to an Eligible Employee's "termination of employment" (and corollary terms) shall be construed to refer to the Eligible Employee's "separation from service" with the Company as determined under Section 409A.

G. Request for Plan Interpretation

Any dispute or request for interpretation of any provision in the PBRS Plan must be submitted to the appropriate Human Resources Business Partner by the Eligible Employee or his or her manager in writing.

H. Compliance with Applicable Regulations

In order to be eligible to receive a PBRS Award under the PBRS Plan, a Participant must comply with all applicable state and federal regulations and Company policies.

I. Governing Law

The validity, construction and effect of the PBRS Plan, and any rules and regulations under the Plan shall be determined in accordance with Delaware law, without giving effect to principles of conflicts of laws and applicable federal law.

J. Recoupment

Except as may be specifically provided in the PBRS Award, each PBRS Award under the PBRS Plan shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive under the PBRS Plan.

Exhibit 10.37

CVS HEALTH CORPORATION
BUSINESS PLANNING COMMITTEE
NONQUALIFIED STOCK OPTION AGREEMENT
ANNUAL GRANT

GRANT DATE: APRIL __, ____

1. **GRANT OF OPTION**. Pursuant to the provisions of the 2010 Incentive Compensation Plan, as amended (the " **ICP** ") of CVS Health Corporation (the " **Company"**), on the date set forth above (the " **Grant Date** "), the Company has granted and hereby evidences the Grant to the person named below (the " **Participant** "), subject to the terms and conditions set forth or incorporated in this Nonqualified Stock Option Agreement (" **Agreement** "), the right, and option, to purchase from the Company the aggregate number of shares of Common Stock ($.01 par value) of the Company (" **Shares** ") set forth below, at the purchase price indicated below (the " **Option** "), the Option to be exercised as hereinafter provided. The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. The provisions in this Agreement shall be read in concert with the Amended and Restated Employment Agreement dated as of December 22, 2008, as amended as of December 21, 2012 (the " **Employment Agreement** ") and the ICP. In the event of any ambiguity concerning the coordination of the provisions of this Agreement and the Employment Agreement, the terms of the document which provide Participant with the most favorable treatment with respect to the Option shall govern. The Option is a nonqualified option as defined in the ICP. The Option purchase price per Share as stated below is equal to the Fair Market Value per Share as of the Grant Date.

Participant:	**Larry Merlo**
Employee ID:	**XXXXXX**
Shares:	**XXXXXX**
Option Price:	**$XXX.XX**

2. **TERM OF OPTION .** The term of the Option shall be for a period of seven (7) years from the Grant Date, subject to the earlier termination of the Option, as set forth in the ICP and in this Agreement. No portion of the Option shall be exercisable after the term of the Option.

3. **EXERCISE OF OPTION .** (a) The Option, subject to the provisions of the ICP, shall be exercised by submitting a request to exercise to the Company's stock option administrator, in accordance with the Company's current exercise policies and procedures, specifying the number of Shares to be purchased, which number may not be less than one hundred (100) Shares (unless the number of Shares purchased is the total balance which is then exercisable). An exercise by Participant of all or part of this Option shall effected through the Company's "cashless exercise" procedures. Otherwise, at the time of exercise, Participant shall tender to the Company cash or cash equivalent for the aggregate option price of the Shares Participant has elected to purchase or certificates for Shares of Common Stock of the Company owned by Participant for at least six (6) months with a fair market value at least equal to the aggregate option price of the Shares Participant has elected to purchase, or a combination of the foregoing.

(b) Prior to its expiration or termination and except as otherwise provided herein, the Option will become vested in accordance with the vesting schedule set forth below, each date on which vesting occurs a "Vesting Date", and any vested Option will be exercisable by Participant prior to the expiration of its term so long as Participant has maintained continuous employment with the Company or a subsidiary of the Company from the Grant Date through the exercise date:

(i) 25% of the Option shall vest on the 1st anniversary of the Grant Date;
(ii) 25% of the Option shall vest on the 2nd anniversary of the Grant Date;
(iii) 25% of the Option shall vest on the 3rd anniversary of the Grant Date;
(iv) 25% of the Option shall vest on the 4th anniversary of the Grant Date.

4. **TAXES .** Upon a cashless exercise of the Option the Company shall withhold from the proceeds of the exercise of the Option any required taxes. If the Options is exercised other than through a cashless exercise Company shall have the right to require Participant to pay the amount of any withholding taxes immediately, upon notification from the Company, before the proceeds from the exercise are delivered to Participant. Furthermore, the Company may elect to deduct such taxes from any other amounts then payable to Participant in cash or in Shares or from any other amounts payable any time thereafter to Participant to the extent allowed under applicable law.

5. **TRANSFERABILITY .** The Option may be transferred to and may thereafter be exercised by one or more members of Participant's immediate family, by a trust established by Participant for the benefit of one or more members of Participant's immediate family, or by a partnership of Company of which the only owners are members of Participant's immediate family (the "Transferee(s)"); provided , that no portion of the Option may be transferred until such time as it becomes vested and exercisable pursuant to Section 3(b) hereof, and further provided that no more than fifty percent (50%) of the exercisable Option may be transferred by Participant. An "immediate family member" shall mean Participant's spouse, parents, children, grandchildren and the spouses of such parents, children and grandchildren. Transferee will be subject to all terms and conditions applicable to the Option prior to its transfer. Transferee may not again transfer the Option. In order to transfer the Option, Participant must notify the Company in the form of a "Notice of Transfer of Nonqualified Stock Option" (which form may be obtained from the Company's Legal Department) of such transfer and include the name, address and social security number of Transferee, as well as the relationship of Transferee to Participant. With respect to any transfer of an Option, Participant will be subject to any tax liability due upon exercise of the transferred Option by Transferee.

6. **TERMINATION OF EMPLOYMENT** . Unless otherwise provided for in the ICP, this Agreement or the Employment Agreement as amended from time to time, the Option (whether vested or unvested), to the extent not yet exercised, shall be forfeited immediately upon Participant's termination of employment with the Company or any of its subsidiaries. With respect to terminations addressed in the Employment Agreement, the provisions of the Employment Agreement as amended from time to time shall apply and continue to apply, except as set forth in this Section 6, notwithstanding any termination of the Employment Agreement. Otherwise, the following shall apply:

(a) **Retirement.** In the event of an "Approved Early Retirement" or "Normal Retirement" as such terms are defined below, the Option shall continue to vest and be exercisable in accordance with Section 10(f) of the Employment Agreement as amended from time to time; provided that the Option, to the extent it becomes vested in connection with an Approved Early Retirement or Normal Retirement, shall remain exercisable for the later of (1) the three (3) year period immediately following the Approved Early Retirement or Normal Retirement, or (2) the one (1) year period following the date the Option is fully vested but, in each case, not beyond the original term of the Option. Solely for purposes of the Option, the term "Approved Early Retirement" shall mean the Participant's voluntary termination of employment with the Company at or after attaining age sixty (60) but prior to attaining age sixty-five (65), and the term "Normal Retirement" shall mean Participant's voluntary termination of employment with the Company at or after attaining age sixty-five (65), in each case so long as (i) Participant provides at least twelve (12) months' advance notice to the Committee of his intent to take Approved Early Retirement or Normal Retirement, (ii) Participant fully cooperates with the Company in transitioning his duties during the period between the disclosure to the Committee of his intent to take Approved Early Retirement or Normal Retirement and his retirement date, (iii) Participant continues to be employed by the Company through the Approved Early Retirement or Normal Retirement date, and (iv) in the case of an Approved Early Retirement, the Committee approves such retirement.

(b) **Disability.** Notwithstanding any contrary provisions of any agreement (including the Employment Agreement), in the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the Option shall vest as of the employment termination date on a pro-rata basis as follows: the Option shall vest with respect to a total number of Shares as of the employment termination date (which is the last day that Participant is employed by the Company and any subsidiary of the Company), equal to (i) the number of Shares subject to the Option on the Grant Date *multiplied* by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the employment termination date since the Grant Date and (B) the denominator shall be forty-eight (48), *minus* (ii) the number of Shares with respect to which the Option vested prior to the employment termination date (whether or not the Option was previously exercised). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the employment termination date is eight months and five days, the numerator

in sub-section (A) above shall be nine **.** The Option may be exercised to the extent vested at any time within one (1) year of Participant's employment termination date but not beyond the original term of the Option.

7. REQUIRED ACCEPTANCE OF AWARD. The Option may not be exercised unless and until the Company has received formal acceptance by Participant of the terms and conditions set forth herein as required by the Company. Acceptance may be submitted either electronically, if available, or in writing.

8. NOTICE . Any notice required to be given hereunder to the Company shall be in writing addressed to the Company, attention Senior Vice President, Chief Human Resources Officer, One CVS Drive, Woonsocket, RI 02895, and any notice required to be given hereunder to Participant shall be addressed to Participant at his address as shown on the records of the Company, subject to the right of either party hereafter to designate in writing to the other some other address.

9. RECOUPMENT OF OPTION AWARD . The Option subject to this Agreement under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists *from* time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he may derive from the grant of the Option hereunder. By accepting this Option grant, Participant acknowledges that a copy of the Company's Recoupment Policy has been made available for the Participant's reference.

10. COMMITTEE AUTHORITY . The Committee shall have the authority, in its sole discretion, to make any interpretations, determinations, and/or take any administrative actions with respect to the ICP and this Agreement, including whether any post-termination payments to Participant shall be deemed severance pay, the duration of any severance period, and/or whether a termination was without cause.

11. GOVERNING LAW . This Nonqualified Stock Option Agreement and the Option evidenced hereby shall be governed by the laws of Delaware, without giving effect to principles of conflict of laws.

12. ACKNOWLEDGEMENT. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

BY: _____
Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Accepted By: _____
Larry J. Merlo

_____
Date

Exhibit 10.38

CVSHealth

CVS HEALTH CORPORATION
BUSINESS PLANNING COMMITTEE
RESTRICTED STOCK UNIT AGREEMENT – ANNUAL GRANT
GRANT DATE : APRIL __, ____

1. Pursuant and subject to the provisions of the 2010 Incentive Compensation Plan, as amended (the " **ICP** ") of CVS Health Corporation (the " **Company** "), on the date set forth above (the " **Grant Date** "), the Company has awarded and hereby evidences the Restricted Stock Unit (" **RSU** ") Award to the person named below (the " **Participant** "), subject to the terms and conditions set forth and incorporated in this Restricted Stock Unit agreement (the " **Agreement** "). The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. Except as expressly provided below in Sections 4 and 7, upon termination of employment the treatment of RSUs granted pursuant to this Agreement shall be governed under and subject to the terms of the Amended and Restated Employment Agreement between the Company and the Participant dated December 22, 2008, as amended December 21, 2012 (the " **Employment Agreement** "). On the Grant Date specified above, the Fair Market Value (the "FMV"), which is the Closing Price of the Company's common stock on the Grant Date, of each RSU equals **$XXX.XX.**

Participant:	**Larry J. Merlo**
Employee ID:	**XXXXXX**
RSUs (#):	**XXXXX**

2. Each RSU represents a right to a future payment of one share (" **Share** ") of Common Stock ($0.01 par value) of the Company, subject to required tax withholding.

3. (a) To the extent dividends are paid on Shares while the RSUs remain outstanding and prior to the Settlement Date (as defined below), subject to Section 5(b), Participant shall be entitled to receive a cash payment in an amount equivalent to the cash dividends with respect to the number of Shares covered by the RSUs; provided, however, that no dividends shall be payable with respect to any RSUs forfeited on or prior to the dividend record date.

(b) Participant hereby agrees that the Company may withhold from the dividend equivalent amounts referred to in Paragraph 3(a) above amounts sufficient to satisfy the applicable tax withholding in respect of such dividend equivalent payments.

4. Subject to the terms and conditions of the ICP and this Agreement and subject to Participant's continued employment, Participant shall be entitled to receive (and the Company shall deliver to Participant) the Shares on the Vesting Date(s) set forth herein, or as soon as administratively practicable, but within 30 days thereafter, (or in the Employment Agreement, as the case may be), unless delivery of the Shares has been deferred in accordance with Section 5 below (the date of such delivery of the Shares being hereafter referred to as the " **Settlement Date** "). Each " **Vesting Date** " , except as otherwise provided in Section 7, shall be in accordance with the schedule set forth below:

(a) 50% of the RSUs shall vest on the third anniversary of the Grant Date ("Tranche A");
(b) 50% of the RSUs shall vest on the fifth anniversary of the Grant Date ("Tranche B");

Provided, however, that a fraction of the Shares in Tranche A and Tranche B shall vest earlier on the effective date of the Participant's Approved Early Retirement or Normal Retirement (as such terms are defined in the Employment Agreement) so long as:

(i) Participant provides at least 12 months' advance notice to the Committee of his intent to take Approved Early Retirement or Normal Retirement,
(ii) Participant fully cooperates with the Company in transitioning his duties during the period between the disclosure to the Committee of his intent to take Approved Early Retirement or Normal Retirement and his retirement date,
(iii) Participant continues to be employed by the Company through the Approved Early Retirement or Normal Retirement date, and
(iv) the Committee approves such vesting terms (such approval not to be unreasonably withheld), and, in the case of an Approved Early Retirement, approves such retirement.

If the foregoing conditions are satisfied, the number of RSUs that vest on the Approved Early Retirement or Normal Retirement date shall be calculated as follows: (A) the number of Shares from Tranche A that vest shall be the total number of Shares in Tranche A multiplied by a fraction in which the numerator is the whole number of months worked from the Grant Date through the Approved Early Retirement or Normal Retirement date and the denominator is thirty-six (36); (B) the number of Shares from Tranche B that vest shall be the total number of Shares in Tranche B multiplied by a fraction in which the numerator is the whole number of months worked from the Grant Date through the Approved Early Retirement or Normal Retirement date and the denominator is sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. The Vesting Date shall be the effective date of the Participant's termination of employment as a result of Approved Early Retirement or Normal Retirement. Any Shares represented by RSUs that vest under this Section 4 shall settle in accordance with the original schedule set forth above.

5. (a) In accordance with rules promulgated by the Management Planning and Development Committee of the Board of Directors (the " **Committee** "), Participant, to the extent eligible under the CVS Health Deferred Stock Compensation Plan, may elect to defer delivery of Shares in settlement of RSUs covered by this Agreement. Any such deferred delivery date elected by Participant shall become the Settlement Date for purposes of this RSU Agreement.

(b) Notwithstanding Section 3(a), to the extent dividends are paid on such deferred Shares following the Vesting Date and prior to the Settlement Date, Participant shall be entitled to receive a number of additional deferred Shares equal to: (x) the amount of dividend per Share as declared by the Company's Board of Directors on the Company's common stock multiplied by (y) the number of deferred Shares held by Participant on the record date of such dividend, divided by (z) the FMV of a Share on such dividend payment date.

6. On the Settlement Date the number of Shares to be delivered by the Company to Participant shall be reduced by the smallest number of Shares having a FMV at least equal to the dollar amount of Federal, state and local tax withholding required to be withheld by the Company with respect to such RSUs on such date.

7. (a) Except as provided in Paragraphs 7(b) – (e) below, if, for any reason other than Approved Early Retirement or Normal Retirement, Participant's employment with the Company and any subsidiary of the Company terminates, all RSUs not then vested in accordance with Section 4 above shall be treated in accordance with the Employment Agreement. In the event of a conflict between the Employment Agreement and the provisions in Sections 7(b) – (e) of this Agreement, this Agreement shall control.

(b) In the event Participant's employment with the Company and any subsidiary of the Company, terminates for Cause (as defined in the Employment Agreement) or as a result of voluntary termination (as described in Section 10(d) of the Employment Agreement), all RSUs not then vested shall be immediately forfeited.

(c) (i) In the event Participant's employment with the Company and any subsidiary of the Company terminates prior to the third anniversary of the Grant Date, by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the RSUs shall vest on a pro rata basis as follows: the total number of RSUs vested as of the termination date, which is the last date that the Participant is employed by the Company and any subsidiary of the Company, shall be equal to the number of RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed Participant's termination date and (B) the denominator shall be thirty-six (36). For purposes of

this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is eight months and five days, the numerator in sub-section (A) above shall be nine. The Vesting Date shall be the effective date of the Participant's termination of employment. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(ii) In the event the Participant's employment with the Company and any subsidiary of the Company terminates on or after the third anniversary, but prior to the fifth anniversary, of the Grant Date, by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the remaining unvested RSUs shall vest on a pro rata basis according to the following formula: 50% of the RSUs granted on the Grant Date multiplied by the following fraction: (C) the numerator shall be the whole number of months elapsed as of the termination date since the Grant Date as of Participant's termination date and (D) the denominator shall be sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (C) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is fifty-four months and five days, the numerator in sub-section (C) above shall be fifty-five. The Vesting Date shall be the effective date of the Participant's termination of employment. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(d) Notwithstanding the above, (i) the provisions of Section 10 of the ICP shall apply in the event of a Change in Control (as defined in such Section 10) and (ii) the provisions of Section 7(e)(iv) of the ICP shall apply.

(e) For purposes of this Section 7, transfer of Participant's employment from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, or transfer from a subsidiary of the Company to the Company shall not be treated as termination of employment.

8. An RSU does not represent an equity interest in the Company and carries no voting rights. Participant shall have no rights of a shareholder with respect to the RSUs until the Shares have been delivered to Participant.

9. Neither the execution and delivery hereof nor the granting of the award evidenced hereby shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

10. Any notice required to be given hereunder to the Company shall be in writing addressed to: CVS Health Corporation, Senior Vice President, Chief Human Resources Officer, One CVS Drive, Woonsocket, RI 02895. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

11. All decisions and interpretations made by the Board of Directors or the Committee with regard to any question arising hereunder or under the ICP shall be binding and conclusive on all persons. In the event of any inconsistency between the terms hereof and the provisions of the ICP, the ICP shall govern.

12. By accepting this Award, Participant acknowledges that a copy of the ICP has been made available by the Company for Participant's reference and agrees to be bound by the terms and conditions set forth in this Agreement and the ICP as in effect from time to time.

13. By accepting this Award, Participant further acknowledges that the Federal securities laws and/or Company's policies regarding trading in its securities may limit or restrict Participant's right to trade Shares, including without limitation, sales of Shares acquired in connection with RSUs. Participant agrees to comply with such Federal securities law requirements and Company policies as such laws and policies may be amended from time to time.

14. The Company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and that to the extent any provisions of this Agreement do not comply with Code Section 409A the Company will make such

changes in order to comply with Code Section 409A to the extent it considers reasonable. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and to the extent required to avoid a violation of the applicable rules under all Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A of the Code shall be delayed until the first business day of the seventh month immediately following the employment termination date. For purposes of any provision of this Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to a "termination of employment" (and corollary terms) shall be construed to refer to a "separation from service" (within the meaning of Treas. Reg. Section 1.409A-1(h)). Notwithstanding the foregoing, the Company makes no representations as to the tax treatment or consequences of any payment made hereunder, and Participant, by accepting this Award, acknowledges that Participant shall be solely responsible for same.

15. The Award subject to this RSU Agreement under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he may derive from the Award. By accepting this Award Participant acknowledges that the Company's Recoupment Policy has been made available for the Participant's reference.

16. This Agreement shall be governed by the laws of Delaware, without giving effect to its choice of law provisions.

17. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: _____
Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Accepted By: _____
Larry J. Merlo

_____
Date

Exhibit 10.44

CVS HEALTH CORPORATION
BUSINESS PLANNING COMMITTEE
RESTRICTED STOCK UNIT AGREEMENT – ANNUAL GRANT
GRANT DATE : APRIL 1, 2016

1. Pursuant and subject to the provisions of the 2010 Incentive Compensation Plan, as amended (the " **ICP** ") of CVS Health Corporation (the " **Company** "), on the date set forth above (the " **Grant Date** "), the Company has awarded and hereby evidences the Restricted Stock Unit (" **RSU** ") Award to the person named below (the " **Participant** "), subject to the terms and conditions set forth and incorporated in this Restricted Stock Unit agreement (the " **Agreement** "). The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. On the Grant Date specified above, the Fair Market Value (the "FMV"), which is the Closing Price of the Company's common stock on the Grant Date, of each RSU equals **$104.82.**

Participant:	**Jonathan C. Roberts**
Employee ID:	**XXXXX**
RSUs (#):	**21,465**

2. Each RSU represents a right to a future payment of one share (" **Share** ") of Common Stock ($0.01 par value) of the Company, subject to required tax withholding.

3. (a) To the extent dividends are paid on Shares while the RSUs remain outstanding and prior to the Settlement Date (as defined below), subject to Section 5(b), Participant shall be entitled to receive a cash payment in an amount equivalent to the cash dividends with respect to the number of Shares covered by the RSUs; provided, however, that no dividends shall be payable with respect to any RSUs forfeited on or prior to the dividend record date.

(b) Participant hereby agrees that the Company may withhold from the dividend equivalent amounts referred to in Paragraph 3(a) above amounts sufficient to satisfy the applicable tax withholding in respect of such dividend equivalent payments.

4. Subject to the terms and conditions of the ICP and this Agreement and subject to Participant's continued employment, Participant shall be entitled to receive (and the Company shall deliver to Participant) the Shares on the Vesting Date(s) set forth herein, or as soon as administratively practicable, but within 30 days thereafter, unless delivery of the Shares has been deferred in accordance with Section 5 below (the date of such delivery of the Shares being hereafter referred to as the " **Settlement Date** "). Each " **Vesting Date** ," except as otherwise provided in Section 7, shall be in accordance with the schedule set forth below:

(a) 50% of the RSUs shall vest on the third anniversary of the Grant Date;
(b) 50% of the RSUs shall vest on the fifth anniversary of the Grant Date.

5. (a) In accordance with rules promulgated by the Management Planning and Development Committee of the Board of Directors (the " **Committee** "), Participant, to the extent eligible under the CVS Health Deferred Stock Compensation Plan, may elect to defer delivery of Shares in settlement of RSUs covered by this Agreement. Any such deferred delivery date elected by Participant shall become the Settlement Date for purposes of this RSU Agreement.

(b) Notwithstanding Section 3(a), to the extent dividends are paid on such deferred Shares following the Vesting Date and prior to the Settlement Date, Participant shall be entitled to receive a number of additional deferred Shares equal to: (x) the amount of dividend per Share as declared by the Company's Board of Directors on the Company's common stock multiplied by (y) the number of deferred Shares held by Participant on the record date of such dividend, divided by (z) the FMV of a Share on such dividend payment date.

6. On the Settlement Date the number of Shares to be delivered by the Company to Participant shall be reduced by the smallest number of Shares having a FMV at least equal to the dollar amount of Federal, state and local tax withholding required to be withheld by the Company with respect to such RSUs on such date.

7. (a) Except as provided in Paragraphs 7 (b) – (f) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all RSUs not then vested in accordance with Section 4 above shall be immediately forfeited.

(b) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, RSUs not then vested in accordance with Section 4 will become immediately vested and the Vesting Date shall be the date of death.

(c) (i) In the event Participant's employment with the Company and any subsidiary of the Company terminates prior to the third anniversary of the Grant Date by reason of a " **Qualified Retirement** ", the following shall apply:

(1) RSUs that are unvested as of the Participant's retirement date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company, shall vest as of the Participant's retirement date on a pro rata basis as follows: the total number of RSUs vesting as of the retirement date shall be equal to the number of RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the retirement date since the Grant Date and (B) the denominator shall be thirty-six (36). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the retirement date is eight months and five days, the numerator in sub-section (A) above shall be nine, and any Shares represented by RSUs that so vest shall settle in accordance with the original schedule set forth in Section 4 of this Agreement; and

(2) Provided that Participant has executed and complies in all respects with the " **Restrictive Covenant Agreement** ", upon his Qualified Retirement and his compliance with the Restrictive Covenant Agreement through the expiration of its term, Participant shall vest in any RSUs that are unvested as of his retirement date, as determined after the application of the provisions of subsection (1) above, on the last day of the three-year restrictive period, and the RSUs shall settle on that same day.

(ii) In the event Participant's employment with the Company and any subsidiary of the Company terminates on or after the third anniversary, but prior to the fifth anniversa **ry of the Grant Date** by reason of a " **Qualified Retirement** ", the following shall apply:

(1) RSUs that are unvested as of the Participant's retirement date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company, shall vest as of the Participant's retirement date on a pro rata basis as follows: the total number of RSUs vesting as of the retirement date shall be equal to 50% of the RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the retirement date since the Grant Date and (B) the denominator shall be sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the retirement date is eight months and five days, the numerator in sub-section (A) above shall be nine, and any Shares represented by RSUs that so vest shall settle in accordance with the original schedule set forth in Section 4 of this Agreement; and

(2) Provided that Participant has executed and complies in all respects with the **"Restrictive Covenant Agreement** ", upon his Qualified Retirement and his compliance with the Restrictive Covenant Agreement through the expiration of its term, Participant shall vest in any RSUs that are unvested as of his retirement date, as determined after the application of the provisions of subsection (1) above, on the last day of the three-year restrictive period, and the RSUs shall settle on that same day.

" **Restrictive Covenant Agreement** " shall mean the restrictive covenant agreement in the form required by the Company in connection with the grant hereunder, attached hereto as Exhibit A, that sets forth restrictive covenants, such as non-competition, non-disclosure, and/or non-solicitation obligations, for a three-year period immediately following Participant's employment termination, as well as any later restrictive covenant agreement that may be required by the Company.

" **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his employment voluntarily, Participant has provided the Company with at least twelve (12) months advance written notice of his retirement and retirement date or (ii) if the Company elects to terminate Participant's employment, such termination is without cause; and (iii) in either case, such retirement and retirement date have been approved by the Committee. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 7(c) shall apply.

(d) (i) In the event Participant's employment with the Company and any subsidiary of the Company terminates prior to the third anniversary of the Grant Date by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the RSUs shall vest as of the employment termination date on a pro rata basis as follows: the total number of RSUs vested as of the termination date, which is the last date that the Participant is employed by the Company and any subsidiary of the Company, shall be equal to the number of RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed as of Participant's termination date since the Grant Date and (B) the denominator shall be thirty-six (36). For purposes

of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is eight months and five days, the numerator in sub-section (A) above shall be nine. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(ii) In the event the Participant's employment with the Company and any subsidiary of the Company terminates after the third anniversary, but prior to the fifth anniversary, of the Grant Date, by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the remaining unvested RSUs shall vest as of the employment termination date on a pro rata basis according to the following formula: 50% of the RSUs granted on the Grant Date multiplied by the following fraction: (C) the numerator shall be the whole number of months elapsed as of the termination date since the Grant Date as of Participant's termination date and (D) the denominator shall be sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (C) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is fifty-four months and five days, the numerator in sub-section (C) above shall be fifty-five. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(e) In the event Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay, RSUs not vested at the time of Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall vest as of the Participant's employment termination date and settle in accordance with the original schedule set forth in Section 4 of this RSU Agreement. All RSUs not scheduled to vest during the specified severance period shall be forfeited as of the last day of the Participant's severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period specified in a severance agreement with the Company, Participant shall be treated as if his employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting. In the event Participant's termination of employment qualifies as a Qualified Retirement the terms of Section 7(c) shall apply.

(f) Notwithstanding the above, (i) the provisions of Section 10 of the ICP shall apply in the event of a Change in Control (as defined in such Section 10) and (ii) the provisions of Section 7(e)(iv) of the ICP shall apply.

(g) For purposes of this Section 7, transfer of Participant's employment from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, or transfer from a subsidiary of the Company to the Company shall not be treated as a termination of employment.

(h) Participant will be responsible for any applicable withholding or other taxes that may become due as a result of RSUS that vest as of Participant's employment termination date or thereafter.

8. An RSU does not represent an equity interest in the Company and carries no voting rights. Participant shall have no rights of a shareholder with respect to the RSUs until the Shares have been delivered to Participant.

9. Neither the execution and delivery hereof nor the granting of the award evidenced hereby shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

10. Any notice required to be given hereunder to the Company shall be addressed in writing to: CVS Health Corporation, Senior Vice President, Compensation & Benefits, One CVS Drive, Woonsocket, RI 02895. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

11. All decisions and interpretations made by the Board of Directors or the Committee with regard to any question arising hereunder or under the ICP shall be binding and conclusive on all persons. In the event of any inconsistency between the terms hereof and the provisions of the ICP, the ICP shall govern.

12. The award of RSUs pursuant to this Agreement is expressly subject to and contingent upon the requirement that the Participant shall have fully executed and delivered to the Company the Restrictive Covenant Agreement attached as Exhibit A.

Participant agrees to execute and deliver such agreement by the deadline set forth by the Company, which shall be no less than ten days from the date it is provided to Participant.

Participant agrees that failure to execute and return the Restrictive Covenant Agreement by the deadline set forth by the Company shall result in the immediate and irrevocable forfeiture of the RSU Award hereunder and any right to receive dividend equivalents or Shares with respect thereto. Further, if Participant violates any provision of the Restrictive Covenant Agreement, any unvested RSUs will be immediately and irrevocably forfeited, and no payment of any kind, including dividend equivalents or Shares, shall be payable with respect thereto. This Section shall not constitute the Company's exclusive remedy for Participant's violation of the Restrictive Covenant Agreement, and the Company may seek all available legal or equitable remedies in the event of Participant's violation or threatened of the Restrictive Covenant Agreement, including injunctive relief.

13. By accepting this Award, Participant acknowledges that a copy of the ICP has been made available by the Company for Participant's reference and agrees to be bound by the terms and conditions set forth in this Agreement and the ICP as in effect from time to time, including the requirement that Participant sign and return the Restrictive Covenant Agreement, as required by the Company as set forth in Section 12.

14. By accepting this Award, Participant further acknowledges that the Federal securities laws and/or Company's policies regarding trading in its securities may limit or restrict Participant's right to trade Shares, including without limitation, sales of Shares acquired in connection with RSUs. Participant agrees to comply with such Federal securities law requirements and Company policies as such laws and policies may be amended from time to time.

15. The Company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and that to the extent any provisions of this Agreement do not comply with Code Section 409A the Company will make such changes in order to comply with Code Section 409A to the extent it considers reasonable. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference, and to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the

Code, payment of any amounts subject to Section 409A of the Code shall be delayed until the first business day of the seventh month immediately following the employment termination date. For purposes of any provision of this Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to a "termination of employment" (and corollary terms) shall be construed to refer to a "separation from service" (within the meaning of Treas. Reg. Section 1.409A-1(h)). Notwithstanding the foregoing, the Company makes no representations as to the tax treatment or consequences of any payment made hereunder, and Participant, by accepting this Award, acknowledges that Participant shall be solely responsible for same.

16. The Award subject to this RSU Agreement under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for the Participant's reference.

17. This Agreement shall be governed by the laws of Delaware, without giving effect to its choice of law provisions.

18. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Accepted By: /s/ Jonathan C. Roberts
Participant Signature

May 20, 2016
Date

CVS Pharmacy, Inc.
Restrictive Covenant Agreement

I, Jonathan C. Roberts, enter into this Restrictive Covenant Agreement ("Agreement") with CVS Pharmacy, Inc. ("CVS"), which is effective as of the date I sign the Agreement (the "Effective Date"). In consideration of the mutual promises in this Agreement, the parties agree as follows:

1. Consideration for Agreement . I am entering into this Agreement in consideration of: (a) the Corporation's award of restricted stock units as set forth in the "Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016" (the "2016 RSU Agreement") to which this Agreement is attached, contingent on my execution of this Agreement and compliance with its terms; and (b) in connection with my duties and responsibilities at CVS Health Corporation or one of its subsidiaries or affiliates (collectively, the "Corporation"), the Corporation will provide me with Confidential Information and/or access to the Corporation's customers and clients and the opportunity to develop and maintain relationships and goodwill with them.

2. Non-Competition . During my employment by the Corporation and during the Non-Competition Period following the termination of my employment for any reason, I will not, directly or indirectly, engage in Competition or provide Consulting or Audit Services within the Restricted Area.

a. **Competition** . Engaging in "Competition" means providing services to a Competitor of the Corporation (whether as an employee, independent contractor, consultant, principal, agent, partner, officer, director, investor, or shareholder, except as a shareholder of less than one percent of a publicly traded company) that: (i) are the same or similar in function or purpose to the services I provided to the Corporation during the last two years of my employment by the Corporation, or (ii) will likely result in the disclosure of Confidential Information to a Competitor or the use of Confidential Information on behalf of a Competitor. If a representative of the Corporation, during my employment or the Non-Competition Period, requests that I identify the company or business to which I will be or am providing services, or with which I will be or am employed, and requests that I provide information about the services that I am or will be providing to such entity, I shall provide the Corporation with a written statement detailing the identity of the entity and the nature of the services that I am or will be providing to such entity with sufficient detail to allow the Corporation to independently assess whether I am or will be in violation of this Agreement. Such statement shall be delivered to the Corporation's Chief Human Resources Officer or her authorized delegate via personal delivery or overnight delivery within five calendar days of my receipt of such request.

b. **Com petitor** . A "Competitor" for purposes of this Agreement shall mean any person, corporation or other entity that competes with one or more of the business offerings of the Corporation. As of the Effective Date, the Corporation's business offerings include: (i) pharmacy benefits management ("PBM"), including: (a) the administration of pharmacy benefits for businesses, government agencies and health plans; (b) mail order pharmacy; (c) specialty pharmacy, including but not limited to infusion and related services; (d) Medicare Part D services; (ii) retail, which includes the sale of prescription drugs, over-the-counter medications, beauty products and cosmetics, photo finishing, seasonal merchandise, greeting cards, convenience foods and other product lines that are sold by the Corporation's retail division; (iii) retail health care ("MinuteClinic"); and (iv) the provision of pharmaceutical products and ancillary services, including specialty pharmaceutical products and support services, and the provision of related pharmacy consulting, data management services and medical supplies to long-term care facilities, other healthcare service providers and recipients of services from such facilities ("Long-Term Care"). A person or entity shall not be considered a retail Competitor if such entity derives annual gross revenues from its business in an amount that is less than 5% of the Corporation's gross revenues from its retail business during its most recently completed fiscal year. The Parties acknowledge that both the Corporation's products and services and the entities that compete with the Corporation's products and services evolve and that an entity will be considered a Competitor if it provides products or services competitive with the products and services provided by the Corporation within the last two years of my employment.

Given my role in the Corporation, I agree to this enterprise-wide definition of non-competition that will prevent me from providing services to the Corporation's PBM, retail and MinuteClinic Competitors during the relevant time period.

c. **Consulting or Audit Services** . "Consulting or Audit Services" shall mean any activity that involves providing audit review or other consulting or advisory services with respect to any relationship or prospective relationship between the Corporation and any third party, including but not limited to PBM and Long Term Care clients, suppliers or vendors and that is likely to result in the use or disclosure of Confidential Information.

d. **Non-Competition Period** . The "Non-Competition Period" shall be the period of three (3) years following the termination of my employment with the Corporation for any reason.

e. **Restricted Area** . "Restricted Area" refers to those states within the United States in which the Corporation conducts its business, as well as the District of Columbia and Puerto Rico. To the extent I worked on international projects in Brazil and/or Ireland or other countries where the Corporation may conduct business, the Restricted Area includes those countries and prospective countries.

f. **Acknowledgment.** I acknowledge and agree that the geographic scope and duration of the restrictions set forth in this Section 2

are reasonable and necessary to protect the legitimate business interests of the Corporation, including the Corporation's Confidential Information and good will, in light of the very senior position I hold with the Corporation and the highly sensitive information with which I have been and will be entrusted. I further acknowledge that I have received adequate consideration for any loss of opportunity associated with the provisions herein, which is described in the 2016 RSU Agreement and to which I would not otherwise be entitled but for my execution of this Agreement.

3. Non-Solicitation . During the Non-Solicitation Period, which shall be three (3) years following the termination of my employment with the Corporation for any reason, I will not, unless a duly authorized officer of the Corporation gives me written authorization to do so:

a. interfere with the Corporation's relationship with its Business Partners by soliciting or communicating (regardless of who initiates the communication) with a Business Partner to: (i) induce or encourage the Business Partner to stop doing business or reduce its business with the Corporation, or (ii) buy a product or service that competes with a product or service offered by the Corporation's business. "Business Partner" means: a customer (person or entity), prospective customer (person or entity), supplier, manufacturer, broker, hospital, hospital system, and/or pharmaceutical company with whom the Corporation has a business relationship and with which I had business-related contact or dealings, or about which I received Confidential Information, in the two years prior to the termination of my employment with the Corporation. A Business Partner does not include a customer, supplier, manufacturer, broker, hospital, hospital system, pharmaceutical company that has fully and finally ceased doing any business with the Corporation independent of any conduct or communications by me or breach of this Agreement. Nothing in this Paragraph 3(a) shall prevent me from working as a staff pharmacist or in another retail position wherein I would be providing or selling prescriptions or other products directly to consumers.

b. work on a Corporation account on behalf of a Business Partner or serve as the representative of a Business Partner for the Corporation.

c. interfere with the Corporation's relationship with any employee or contractor of the Corporation by: (i) soliciting or communicating with the employee or contractor to induce or encourage him or her to leave the Corporation's employ or engagement (regardless of who first initiates the communication); (ii) helping another person or entity evaluate such employee or contractor as an employment or contractor candidate; or (iii) otherwise helping any person or entity hire an employee or contractor away from the Corporation.

d. **Acknowledgment.** I acknowledge and agree that the geographic scope and duration of the restrictions set forth in this Section 3 are reasonable and necessary to protect the legitimate business interests of the Corporation, including the Corporation's Confidential Information and good will, in light of the very senior position I hold with the Corporation and the highly sensitive information with which I have been and will be entrusted. I further acknowledge that I have received adequate consideration for any loss of opportunity associated with the provisions herein, which is described in the 2016 RSU Agreement and to which I would not otherwise be entitled but for my execution of this Agreement.

4. Non-Disclosure of Confidential Information .

a. Subject to Section 7 below, I will not at any time, whether during or after the termination of my employment, disclose to any person or entity any of the Corporation's Confidential Information, except as may be appropriately required in the ordinary course of performing my duties as an employee of the Corporation. The Corporation's Confidential Information includes but is not limited to the following non-public information: trade secrets; computer code generated or developed by the Corporation; software or programs and related documentation; strategic compilations and analysis; strategic processes; business or financial methods, practices and plans; non-public costs and prices; operating margins; marketing, merchandising and selling techniques and information; customer lists; details of customer agreements; pricing arrangements with drug manufacturers, including but not limited to any discounts and/or rebates; pharmacy reimbursement rates; expansion strategies; real estate strategies; operating strategies; sources of supply; patient records; and confidential information of third parties which is given to the Corporation pursuant to an obligation or agreement to keep such information confidential (collectively, "Confidential Information"). I shall not use or attempt to use any Confidential Information on behalf of any person or entity other than the Corporation, or in any manner which may injure or cause loss or may be calculated to injure or cause loss, whether directly or indirectly, to the Corporation. For employees residing in Connecticut, these restrictions on use or disclosure of Confidential Information will only apply for three (3) years after the end of my employment where information that does not qualify as a trade secret is concerned; however, the restrictions will continue apply to trade secret information for as long as the information at issue remains qualified as a trade secret.

b. During my employment, I shall not make, use, or permit to be used, any materials of any nature relating to any matter within the scope of the business of the Corporation or concerning any of its dealings or affairs other than for the benefit of the Corporation. I shall not, after the termination of my employment, use or permit to be used any such materials and shall return same in accordance with Section 5 below.

5. Ownership and Return of the Corporation's Property . On or before my final date of employment with the Corporation, I shall return to the Corporation all property of the Corporation in my possession, custody or control, including but not limited to the originals and copies of any information provided to or acquired by me in connection with the performance of my duties for the Corporation, such as files, correspondence, communications, memoranda, e-mails, slides, records, and all other documents, no matter how produced or reproduced, all computer equipment, communication devices (including but not limited to any mobile phone, BlackBerry or other portable digital assistant or device), computer programs and/or files, and all office keys and access cards. I agree that all the items described in this Section are the sole property of the Corporation .

6. Rights to Inventions, Works .

a. **Assignment of Inventions.** All inventions, original works of authorship, developments, concepts, improvements, designs, discoveries, ideas, trademarks or trade secrets, whether patentable or otherwise protectable under similar law, made, conceived or developed by me, whether alone or jointly with others, from the date of my initial employment by the Corporation and continuing until the end of any period during which I am employed by the Corporation, relating or pertaining in any way to my employment with or the business of the Corporation (collectively referred to as "Inventions") shall be promptly disclosed in writing to the Corporation. I hereby assign to the Corporation, or its designee, all of my rights, title and interest to such Inventions. All original works of authorship which are made by me (solely or jointly with others) within the scope of and during the period of my employment with the Corporation and which are protectable by copyright are "works made for hire," as that term is defined in the United States Copyright Act and as such are the sole property of the Corporation. The decision whether to commercialize or market any Invention developed by me solely or jointly with others is within the Corporation's sole discretion and for the Corporation's sole benefit and no royalty will be due to me as a result of the Corporation's efforts to commercialize or market any such Invention.

b. **Inventions Retained and Licensed.** I have attached hereto as Exhibit A, a list describing all inventions, original works of authorship, developments, improvements, and trade secrets which were made by me prior to my employment with the Corporation ("Prior Inventions"), which belong to me and are not assigned to the Corporation hereunder. If no such list is attached, I represent that there are no such Prior Inventions. I will not incorporate, or permit to be incorporated, any Prior Invention owned by me or in which I have an interest into a Corporation product, process or machine without the Corporation's prior written consent. Notwithstanding the foregoing sentence, if, in the course of my employment with the Corporation, I incorporate into a Corporation product, process or machine a Prior Invention owned by me or in which I have an interest, the Corporation is hereby granted and shall have a nonexclusive, royalty-free, irrevocable, perpetual, worldwide license to make, have made, modify, use and sell such Prior Invention as part of or in connection with such product, process or machine.

c. **Patent and Copyright Registrations.** I will assist the Corporation, or its designee, at the Corporation's expense, in every proper way to secure the Corporation's rights in the Inventions and any copyrights, patents, mask work rights or other intellectual property rights relating thereto, including, but not limited to, the disclosure to the Corporation of all pertinent information and data with respect thereto, the execution of all applications, specifications, oaths, assignments and all other instruments which the Corporation shall deem necessary in order to apply for and obtain such rights and in order to assign and convey to the Corporation, its successors, assigns, and nominees the sole and exclusive rights, title and interest in and to such Inventions, and any copyrights, patents, mask work rights or other intellectual property rights relating thereto. My obligation to execute or cause to be executed, when it is in my power to do so, any such instrument or papers shall continue after my employment ends for any reason and/or after the termination of this Agreement. If the Corporation is unable because of my mental or physical incapacity or for any other reason to secure my signature to apply for or to pursue any application for any United States or foreign patents or copyright registrations covering Inventions or original works of authorship assigned to the Corporation as above, then I hereby irrevocably designate and appoint the Corporation and its duly authorized officers and agents as my agent and attorney in fact, to act for and in my behalf and stead to execute and file any such applications and to do all other lawfully permitted acts to further the prosecution and issuance of letters patent or copyright registrations thereon with the same legal force and effect as if executed by me.

d. **Exception to Assignments** . I understand that if I am an employee in Illinois, Kansas, North Carolina, Utah or Minnesota, I should refer to Exhibit B (incorporated herein for all purposes) for important limitations on the scope of the provisions of this Agreement concerning assignment of Inventions. I will advise the Corporation promptly in writing of any inventions that I believe meet the criteria in Exhibit B and that are not otherwise disclosed on Exhibit A.

7. Cooperation .

a. In the event that I receive a subpoena, deposition notice, interview request, or other process or order to testify or produce Confidential Information or any other information or property of the Corporation, I shall promptly: (a) notify the Corporation of the item, document, or information sought by such subpoena, deposition notice, interview request, or other process or order; (b) furnish the Corporation with a copy of said subpoena, deposition notice, interview request, or other process or order; and (c) provide reasonable cooperation with respect to any procedure that the Corporation may initiate to protect Confidential Information or other interests. If the Corporation objects to the subpoena, deposition notice, interview request, process, or order, I shall cooperate to ensure that there shall be no disclosure until the court or other applicable entity has ruled upon the objection, and then only in accordance with the ruling so made. If no such objection is made despite a reasonable opportunity to do so, I shall be entitled to comply with the subpoena, deposition, notice, interview request, or other process or order provided that I have fulfilled the above obligations .

b. I will cooperate fully with the Corporation, its affiliates, and their legal counsel in connection with any action, proceeding, or dispute arising out of matters with which I was directly or indirectly involved while serving as an employee of the Corporation, its predecessors, subsidiaries or affiliates. This cooperation shall include, but shall not be limited to, meeting with, and providing information to, the Corporation and its legal counsel, maintaining the confidentiality of any past or future privileged communications with the Corporation's legal counsel (outside and in-house), and making myself available to testify truthfully by affidavit, in depositions, or in any other forum on behalf of the Corporation. The Corporation agrees to reimburse me for any reasonable and necessary out-of-pocket costs associated with my cooperation.

8. Limitation on Restrictions. Nothing in this Agreement is intended to or shall interfere with my right to file charges or participate in a proceeding with any appropriate federal, state or local government agency, including the Equal Employment Opportunity Commission or the National Labor Relations Board, or to prohibit me from communicating or cooperating with any such agency in its investigation.

9. Eligibility for Severance Pay . If my employment with the Corporation terminates under circumstances in which I am eligible for severance under the Corporation's Severance Plan for Non-Store Employees (the "Severance Plan"), the Corporation will offer me severance in accordance with the Severance Plan and the length of the Non-Competition Period will match the length of the severance period. I acknowledge that the Severance Plan sets forth pre-requisites I must meet in order to receive severance, including but not limited to execution of the Corporation's standard separation agreement and release of claims. In the event that the Corporation fails to comply with its obligations to offer me severance according to the Severance Plan, then Section 2 of this Agreement shall be of no further effect. I agree that if I decline the Corporation's offer of severance, I shall continue to be subject to the restrictions in Section 2.

10. Injunctive Relief . Any breach of this Agreement by me will cause irreparable damage to the Corporation and, in the event of such breach, the Corporation shall have, in addition to any and all remedies of law, the right to an injunction, specific performance or other equitable relief to prevent the violation of my obligations hereunder, and without providing a bond to the extent permitted by the applicable rules of civil procedure.

11. No Right of Continued Employment . This Agreement does not create an obligation on the Corporation or any other person or entity to continue my employment.

12. No Conflicting Agreements . I represent that the performance of my job duties with the Corporation and my compliance with all of the terms of this Agreement does not and will not breach any agreement to keep in confidence proprietary information acquired by me in confidence or in trust prior to my employment by the Corporation.

13. Entire Agreement/No Reliance/No Modifications . This Agreement and any compensation, benefit or equity plan or agreement referred to herein including the CVS Health Corporation Change in Control Agreement ("CIC Agreement"), to the extent those other agreements apply to me, set forth the entire agreement between the parties hereto and fully supersede any and all prior and/or supplemental understandings, whether written or oral, between the parties concerning the subject matter of this Agreement. Notwithstanding the foregoing, if I am a party to the CIC Agreement, then I understand that in the event of a Change in Control, as that term is defined in the CIC, Paragraph 2 of this Agreement shall be null and void. I agree and acknowledge that I have not relied on any representations, promises or agreements of any kind in connection with my decision to accept the terms of this Agreement, except for the representations, promises and agreements herein. Any modification to this Agreement must be made in writing and signed by me and the Corporation's Chief Human Resources Officer or her authorized representative.

14. No Waiver . Any waiver by the Corporation of a breach of any provision of this Agreement, or of any other similar agreement with any other current or former employee of the Corporation, shall not operate or be construed as a waiver of any subsequent breach of such provision or any other provision hereof.

15. Severability . The parties hereby agree that each provision herein shall be treated as a separate and independent clause, and the unenforceability of any one clause shall in no way impair the enforceability of any of the other clauses herein. Moreover, if one or more of the provisions of this Agreement are for any reason held to be excessively broad as to scope, activity, duration, subject or otherwise so as to be unenforceable at law, the parties consent to such provision or provisions being modified or limited by the appropriate judicial body (where allowed by applicable law), so as to be enforceable to the maximum extent compatible with the applicable law.

16. Survival of Employee's Obligations . My obligations under this Agreement shall survive the termination of my employment regardless of the manner of such termination and shall be binding upon my heirs, personal representatives, executors, administrators and legal representatives.

17. Corporation's Right to Assign Agreement . The Corporation has the right to assign this Agreement to its successors and assigns without the need for further agreement or consent by me, and all covenants and agreements hereunder shall inure to the benefit of and be enforceable by said successors or assigns.

18. Non-Assignment . I shall not assign my rights and obligations under this Agreement, in whole or in part, whether by operation of law or otherwise, without the prior written consent of the Corporation, and any such assignment contrary to the terms hereof shall be null and void and of no force or effect.

19. Governing Law; Headings . This Agreement shall be governed by and construed in accordance with the laws of the state of Rhode Island. The headings of the sections contained in this Agreement are for convenience only and shall not be deemed to control or affect the meaning or construction of any provision of this Agreement.

20. Tolling. In the event I violate one of the time-limited restrictions in this Agreement, I agree that the time period for such violated restriction shall be extended by one day for each day I have violated the restriction, up to a maximum extension equal to the length of the original period of the restricted covenant.

IN WITNESS WHEREOF, the undersigned has executed this Agreement as a sealed instrument as of the date set forth below.

/s/ Jonathan C. Roberts

/s/ Lisa G. Bisaccia

Lisa Bisaccia
Chief Human Resources Officer

xxxxxxxxx
Employee ID

CVS Pharmacy, Inc.

Date: May 20, 2016

EXHIBIT A

List of Prior Inventions – See Section 6

EXHIBIT B

Notice Regarding Invention Assignment

1. For an employee residing in **Illinois, Kansas, or North Carolina** , you are hereby advised:

Notice . No provision in this Agreement requires you to assign any of your rights to an invention for which no equipment, supplies, facility, or trade secret information of the Corporation was used and which was developed entirely on your own time, unless (a) the invention relates (i) to the business of the Corporation or (ii) to the Corporation's actual or demonstrably anticipated research or development, or (b) the invention results from any work performed by you for the Corporation. Illinois 765ILCS1060/1-3, "Employees Patent Act"; Kansas Statutes Section 44-130; North Carolina General Statutes Article 10A, Chapter 66, Commerce and Business, Section 66-57.1.

2. For an employee residing in **Utah** , you are hereby advised:

Notice . No provision in this Agreement requires you to assign any of your rights to an invention which was created entirely on your own time, and which is not (a) conceived, developed, reduced to practice, or created by you (i) within the scope of your employment with the Corporation, (ii) on the Corporation's time, or (iii) with the aid, assistance, or use of any of the Corporation's property, equipment, facilities, supplies, resources, or patents, trade secrets, know-how, technology, confidential information, ideas, copy rights, trademarks and service marks and any and all rights, applications and registrations relating to them, (b) the results of any work, services, or duties performed by you for the Corporation, (c) related to the industry or trade of the Corporation, or (d) related to the current or demonstrably anticipated business, research, or development of the Corporation. Utah Code Sections 34-39-1 through 34-39-3, "Employee Inventions Act."

3. For an employee residing in **Minnesota** , you are hereby advised:

Notice. No provision in this Agreement requires you to assign any of your rights to an invention for which no equipment, supplies, facility, or trade secret information of the Corporation was used, and which was developed entirely on your own time, and (a) which does not relate (i) directly to the business of the Corporation, or (ii) to the Corporation's actual or demonstrably anticipated research or development, or (b) which does not result from any work performed by you for the Corporation. Minnesota Statutes 13A Section 181.78.

Exhibit 13

Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis should be read in conjunction with our audited consolidated financial statements and Cautionary Statement Concerning Forward-Looking Statements that are included in this Annual Report.

Overview of Our Business

CVS Health Corporation, together with its subsidiaries (collectively "CVS Health," the "Company," "we," "our" or "us"), is a pharmacy innovation company helping people on their path to better health. At the forefront of a changing health care landscape, the Company has an unmatched suite of capabilities and the expertise needed to drive innovations that will help shape the future of health care.

We are currently the only integrated pharmacy health care company with the ability to impact consumers, payors, and providers with innovative, channel-agnostic solutions. We have a deep understanding of their diverse needs through our unique integrated model, and we are bringing them innovative solutions that help increase access to quality care, deliver better health outcomes, and lower overall health care costs.

Through more than 9,700 retail locations, more than 1,100 walk-in health care clinics, a leading pharmacy benefits manager with nearly 90 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services and a leading stand-alone Medicare Part D prescription drug plan, we enable people, businesses, and communities to manage health in more affordable, effective ways. We are delivering break-through products and services, from advising patients on their medications at our CVS Pharmacy ® locations, to introducing unique programs to help control costs for our clients at CVS Caremark ®, to innovating how care is delivered to our patients with complex conditions through CVS Specialty ™, to improving pharmacy care for the senior community through Omnicare ®, or by expanding access to high-quality, low-cost care at CVS MinuteClinic ®.

We have three reportable segments: Pharmacy Services, Retail/LTC and Corporate.

Overview of Our Pharmacy Services Segment

Our Pharmacy Services business generates revenue from a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, Medicare Part D services, mail order pharmacy, specialty pharmacy and infusion services, retail pharmacy network management services, prescription management systems, clinical services, disease management services and medical spend management.

Our clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans, plans offered on the public and private exchanges, other sponsors of health benefit plans, and individuals throughout the United States. A portion of covered lives primarily within the Managed Medicaid, health plan and employer markets have access to our services through public and private exchanges.

As a pharmacy benefits manager, we manage the dispensing of prescription drugs through our mail order pharmacies, specialty pharmacies, long-term care pharmacies and national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes our CVS Pharmacy ® pharmacies) and 27,000 independent pharmacies, to eligible members in the benefit plans maintained by our clients and utilize our information systems to perform, among other things, safety checks, drug interaction screenings and brand-to-generic substitutions.

Our specialty pharmacies support individuals who require complex and expensive drug therapies. Our specialty pharmacy business includes mail order and retail specialty pharmacies that operate under the CVS Caremark ®, CarePlus CVS Pharmacy ™, Navarro ® Health Services and Advanced Care Scripts ("ACS Pharmacy") names. Substantially all of our mail service specialty pharmacies have been accredited by The Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States. We also offer specialty infusion services and enteral nutrition services through Coram LLC and its subsidiaries (collectively, "Coram"). With Specialty Connect ®, which integrates our specialty pharmacy mail and retail capabilities, we provide members with disease-state specific counseling from our experienced specialty pharmacists and the choice to bring their specialty prescriptions to any CVS Pharmacy location. Whether submitted through our mail order pharmacy or at a CVS Pharmacy, all prescriptions are filled through the Company's specialty mail order pharmacies, so all revenue from this specialty prescription services program is recorded within the Pharmacy

Services Segment. Members then can choose to pick up their medication at their local CVS Pharmacy or have it sent to their home through the mail.

We also provide health management programs, which include integrated disease management for 18 conditions, through our Accordant ® rare disease management offering. The majority of these integrated programs are accredited by the National Committee for Quality Assurance.

In addition, through our SilverScript Insurance Company ("SilverScript") subsidiary, we are a national provider of drug benefits to eligible beneficiaries under the federal government's Medicare Part D program. As of December 31, 2016, we provided Medicare Part D plan benefits to approximately 5.5 million beneficiaries through SilverScript, including our individual and employer group waiver plans.

The Pharmacy Services Segment operates under the CVS Caremark ® Pharmacy Services, Caremark ®, CVS Caremark ™, CarePlus CVS Pharmacy ™, Accordant ®, SilverScript ®, Coram ®, CVS Specialty ™, NovoLogix ®, Navarro ® Health Services and ACS Pharmacy names. As of December 31, 2016, the Pharmacy Services Segment operated 23 retail specialty pharmacy stores, 13 specialty mail order pharmacies, four mail order dispensing pharmacies, and 84 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence, located in 41 states, Puerto Rico and the District of Columbia.

Overview of Our Retail/LTC Segment

Our Retail/LTC Segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products and cosmetics, personal care products, convenience foods, photo finishing, seasonal merchandise and greeting cards. With the acquisition of Omnicare's long-term care ("LTC") operations, the Retail/LTC Segment now also includes the distribution of prescription drugs, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings, as well as commercialization services which are provided under the name RxCrossroads ®. Our Retail/LTC Segment derives the majority of its revenues through the sale of prescription drugs, which are dispensed by our more than 32,000 pharmacists. The role of our retail pharmacists is expanding from primarily dispensing prescriptions to also providing services, including flu vaccinations as well as face-to-face patient counseling with respect to adherence to drug therapies, closing gaps in care, and more cost-effective drug therapies. Our integrated pharmacy services model enables us to enhance access to care while helping to lower overall health care costs and improve health outcomes.

Our Retail/LTC Segment also provides health care services through our MinuteClinic ® health care clinics. MinuteClinics are staffed by nurse practitioners and physician assistants who utilize nationally recognized protocols to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions, and deliver vaccinations. We believe our clinics provide high quality services that are affordable and convenient.

Our proprietary loyalty card program, ExtraCare ®, has about 65 million active cardholders, making it one of the largest and most successful retail loyalty card programs in the country.

As of December 31, 2016, our Retail/LTC Segment included 9,709 retail stores (of which 7,980 were our stores that operated a pharmacy and 1,674 were our pharmacies located within Target stores) located in 49 states, the District of Columbia, Puerto Rico and Brazil operating primarily under the CVS Pharmacy ®, CVS ®, CVS Pharmacy y más ®, Longs Drugs ®, Navarro Discount Pharmacy ® and Drogaria Onofre ™ names, 38 onsite pharmacies primarily operating under the CarePlus CVS Pharmacy ™, CarePlus ® and CVS Pharmacy ® names, and 1,139 retail health care clinics operating under the MinuteClinic ® name (of which 1,132 were located in our retail pharmacy stores or Target stores), and our online retail websites, CVS.com ®, Navarro.com and Onofre.com.br. LTC operations are comprised of 152 spoke pharmacies that primarily handle new prescription orders, of which 32 are also hub pharmacies that use proprietary automation to support spoke pharmacies with refill prescriptions. LTC operates primarily under the Omnicare ® and NeighborCare ® names.

Overview of Our Corporate Segment

The Corporate Segment provides management and administrative services to support the Company. The Corporate Segment consists of certain aspects of our executive management, corporate relations, legal, compliance, human resources, information technology and finance departments.

Results of Operations

Summary of our Consolidated Financial Results

	Year Ended December 31,		
In millions, except per share amounts	**2016**	**2015**	**2014**
Net revenues	$ 177,526	$ 153,290	$ 139,367
Cost of revenues	148,669	126,762	114,000
Gross profit	28,857	26,528	25,367
Operating expenses	18,519	17,074	16,568
Operating profit	10,338	9,454	8,799
Interest expense, net	1,058	838	600
Loss on early extinguishment of debt	643	—	521
Income before income tax provision	8,637	8,616	7,678
Income tax provision	3,317	3,386	3,033
Income from continuing operations	5,320	5,230	4,645
Income (loss) from discontinued operations, net of tax	(1)	9	(1)
Net income	5,319	5,239	4,644
Net income attributable to noncontrolling interest	(2)	(2)	—
Net income attributable to CVS Health	$ 5,317	$ 5,237	$ 4,644
Diluted earnings per share:			
Income from continuing operations attributable to CVS Health	$ 4.91	$ 4.62	$ 3.96
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ 0.01	$ —
Net income attributable to CVS Health	$ 4.90	$ 4.63	$ 3.96

Net revenues increased $24.2 billion in 2016 compared to 2015, and increased $13.9 billion in 2015 compared to 2014. As you review our performance in this area, we believe you should consider the following important information:

- During 2016, net revenues in our Pharmacy Services Segment increased 19.5% and net revenues in our Retail/LTC Segment increased 12.6% compared to the prior year. The Retail/LTC Segment benefited from the 2015 acquisitions of Omnicare and the pharmacies and clinics of Target.

- During 2015, net revenues in our Pharmacy Services Segment increased by 13.5% and net revenues in our Retail/LTC Segment increased 6.2% compared to the prior year.

- In 2016 and 2015, the Pharmacy Services Segment continued to grow from net new business and specialty. The increase in our generic dispensing rates in both of our operating segments continued to have a negative effect on net revenue in 2016 as compared to 2015, as well as in 2015 as compared to 2014.

Please see the Segment Analysis later in this document for additional information about our net revenues.

Gross profit increased $2.3 billion, or 8.8% in 2016, to $28.9 billion , as compared to $26.5 billion in 2015. Gross profit increased $1.2 billion, or 4.6% in 2015, to $26.5 billion, as compared to $25.4 billion in 2014. Gross profit as a percentage of net revenues declined to 16.3%, as compared to 17.3% in 2015 and 18.2% in 2014.

- During 2016, gross profit in our Pharmacy Services Segment and Retail/LTC Segment increased by 12.9% and 7.9% , respectively, compared to the prior year. For the year ended December 31, 2016 , gross profit as a percentage of net revenues in our Pharmacy Services Segment and Retail/LTC Segment was 4.9% and 29.3% , respectively.

- During 2015, gross profit in our Pharmacy Services Segment and Retail/LTC Segment increased by 9.6% and 3.4%, respectively, compared to the prior year. For the year ended December 31, 2015, gross profit as a percentage of net revenues in our Pharmacy Services Segment and Retail/LTC Segment was 5.2% and 30.5%, respectively.

- The increased weighting toward the Pharmacy Services Segment, which has a lower gross profit than the Retail/LTC Segment, resulted in a decline in consolidated gross profit as a percent of net revenues in 2016 as compared to 2015. In addition, gross profit for 2016 and 2015 has been negatively impacted by price compression in the Pharmacy Services Segment and reimbursement pressure in the Retail/LTC Segment.

- Our gross profit continued to benefit from the increased utilization of generic drugs, which normally yield a higher gross profit rate than equivalent brand name drugs, in both the Pharmacy Services and Retail/LTC segments for 2016 and 2015, partially offsetting the negative impacts described above.

Please see the Segment Analysis later in this document for additional information about our gross profit.

Operating expenses increased $1.4 billion, or 8.5%, in the year ended December 31, 2016 , as compared to the prior year. Operating expenses as a percent of net revenues declined to 10.4% in the year ended December 31, 2016 compared to 11.1% in the prior year. The increase in operating expense dollars in the year ended December 31, 2016 was primarily due to the acquisition of the Target pharmacy and clinic businesses in December 2015, the Omnicare acquisition in August 2015 and incremental store operating costs associated with a higher store count, partially offset by lower legal settlement costs in the year ended December 31, 2016. The improvement in operating expenses as a percentage of net revenues in 2016 is primarily due to expense leverage from net revenue growth.

Operating expenses increased $506 million, or 3.0%, in the year ended December 31, 2015 as compared to the prior year. Operating expenses as a percent of net revenues declined to 11.1% in the year ended December 31, 2015 compared to 11.9% in the prior year. The increase in operating expense dollars in the year ended December 31, 2015 was primarily due to incremental store operating costs associated with a higher store count, the Omnicare acquisition in August 2015, the acquisition of the Target pharmacy and clinic businesses in December 2015 and a $90 million legal charge in 2015 related to a disputed 1999 legal settlement. The improvement in operating expenses as a percentage of net revenues in 2015 is primarily due to expense leverage from net revenue growth.

Please see the Segment Analysis later in this document for additional information about operating expenses.

Interest expense, net for the years ended December 31 consisted of the following:

In millions	2016	2015	2014
Interest expense	$ 1,078	$ 859	$ 615
Interest income	(20)	(21)	(15)
Interest expense, net	$ 1,058	$ 838	$ 600

Net interest expense increased $220 million during the year ended December 31, 2016, primarily due to the $15 billion debt issuance in July 2015, the proceeds of which were used to fund the acquisitions of Omnicare and the pharmacies and clinics of Target, and the debt assumed from the Omnicare acquisition. See Note 5 “Borrowings and Credit Agreements” to the consolidated financial statements for additional information. During 2015, net interest expense increased by $238 million, to $838 million compared to 2014, primarily due to the amortization of bridge facility fees of $52 million for the unsecured bridge facility that was entered into on May 2015 and was amortized to interest expense over the period the facility was outstanding, the $15 billion debt issuance in July 2015, and the debt assumed in the Omnicare acquisition.

Loss on early extinguishment of debt - During the year ended December 31, 2016, the Company purchased approximately $4.2 billion aggregate principal amount of certain of its senior notes pursuant to its tender offer for such senior notes and option to redeem the outstanding senior notes (see Note 5 “Borrowings and Credit Agreements” to the consolidated financial statements). The Company paid a premium of $583 million in excess of the debt principal, wrote off $54 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on the early extinguishment of debt of $643 million.

During the year ended December 31, 2014, the Company completed a $2.0 billion tender offer and repurchase of certain Senior Notes. The Company paid a premium of $490 million in excess of the debt principal in connection with the repurchase of the Senior Notes, wrote off $26 million of unamortized deferred financing costs and incurred $5 million in fees, for a total loss on early extinguishment of debt of $521 million. See Note 5, “Borrowings and Credit Agreements” to the consolidated financial statements for additional information.

Income tax provision - Our effective income tax rate was 38.4%, 39.3% and 39.5% in 2016, 2015 and 2014, respectively. The effective income tax rate was lower in 2016 compared to 2015 primarily due to the resolution of income tax matters in open tax years through 2012, as well as other permanent items. The effective income tax rate was lower in 2015 compared to 2014 primarily due to certain permanent items in 2014.

Income (loss) from discontinued operations - In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things, which filed for bankruptcy in 2008. The Company's loss from discontinued operations includes lease-related costs required to satisfy its Linens 'n Things lease guarantees. We incurred a loss from discontinued operations, net of tax, of $1 million in both 2016 and 2014. The Company's income from discontinued operations in 2015 of $9 million, net of tax, was related to the release of certain store lease guarantees due to the settlement of a dispute with a landlord.

See Note 1 "Significant Accounting Policies - Discontinued Operations" to the consolidated financial statements for additional information about discontinued operations and Note 11 "Commitments and Contingencies" for additional information about our lease guarantees.

Segment Analysis

We evaluate the performance of our Pharmacy Services and Retail/LTC segments based on net revenues, gross profit and operating profit before the effect of nonrecurring charges and gains and certain intersegment activities. The Company evaluates the performance of its Corporate Segment based on operating expenses before the effect of nonrecurring charges and gains, and certain intersegment activities. The following is a reconciliation of the Company's business segments to the consolidated financial statements:

In millions	Pharmacy Services Segment [1][2]	Retail/LTC Segment [2]	Corporate Segment	Intersegment Eliminations [2]	Consolidated Totals
2016:					
Net revenues	$ 119,963	$ 81,100	$ —	$ (23,537)	$ 177,526
Gross profit [3]	5,901	23,738	—	(782)	28,857
Operating profit (loss) [4][5][6]	4,672	7,281	(894)	(721)	10,338
2015:					
Net revenues	$ 100,363	$ 72,007	$ —	$ (19,080)	$ 153,290
Gross profit	5,227	21,992	—	(691)	26,528
Operating profit (loss) [5][6]	3,989	7,130	(1,037)	(628)	9,454
2014:					
Net revenues	$ 88,440	$ 67,798	$ —	$ (16,871)	$ 139,367
Gross profit	4,771	21,277	—	(681)	25,367
Operating profit (loss)	3,514	6,762	(796)	(681)	8,799

(1) Net revenues of the Pharmacy Services Segment include approximately $10.5 billion , $8.9 billion and $8.1 billion of Retail/LTC Co-Payments for 2016, 2015 and 2014, respectively. See Note 1 "Significant Accounting Policies - Revenue Recognition" to the consolidated financial statements for additional information about Retail/LTC Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services Segment and the Retail/LTC Segment. These occur in the following ways: when members of Pharmacy Services Segment clients ("members") fill prescriptions at our retail pharmacies to purchase covered products, when members enrolled in programs such as Maintenance Choice ® elect to pick up maintenance prescriptions at one of our retail pharmacies instead of receiving them through the mail, or when members have prescriptions filled at our long-term care pharmacies. When these occur, both the Pharmacy Services and Retail/LTC segments record the revenues, gross profit and operating profit on a standalone basis.

(3) The Retail/LTC Segment gross profit for the year ended December 31, 2016 includes $46 million of acquisition-related integration costs. The integration costs are related to the acquisitions of Omnicare and the pharmacies and clinics of Target.

(4) The Pharmacy Services Segment operating profit for the year ended December 31, 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

(5) The Retail/LTC Segment operating profit for the 2016 and 2015 include $281 million and $64 million , respectively, of acquisition-related integration costs. The integration costs are related to the acquisitions of Omnicare and the pharmacies and clinics of Target. Operating profit for the year ended December 31, 2016 also includes a $34 million asset impairment charge in connection with planned store closures in 2017 related to our enterprise streamlining initiative.

(6) The Corporate Segment operating loss for the year ended December 31, 2016 includes integration costs of $10 million related to the acquisitions of Omnicare and the pharmacies and clinics of Target. For the year ended December 31, 2015, the Corporate Segment operating loss includes $156 million of acquisition-related transaction and integration costs related to the acquisitions of Omnicare and the pharmacies and clinics of Target and a $90 million charge related to a legacy lawsuit challenging the 1999 legal settlement by MedPartners of various securities class actions and a related derivative claim.

Pharmacy Services Segment

The following table summarizes our Pharmacy Services Segment's performance for the respective periods:

	Year Ended December 31,		
In millions	**2016**	**2015**	**2014**
Net revenues	$ 119,963	$ 100,363	$ 88,440
Gross profit	$ 5,901	$ 5,227	$ 4,771
Gross profit % of net revenues	4.9%	5.2%	5.4%
Operating expenses [3]	$ 1,229	$ 1,238	$ 1,257
Operating expenses % of net revenues	1.0%	1.2%	1.4%
Operating profit	$ 4,672	$ 3,989	$ 3,514
Operating profit % of net revenues	3.9%	4.0%	4.0%
Net revenues:			
Mail choice [1]	$ 42,783	$ 37,828	$ 31,081
Pharmacy network [2]	$ 76,848	$ 62,240	$ 57,122
Other	$ 332	$ 295	$ 237
Pharmacy claims processed:			
Total	1,230.0	1,011.9	932.0
Mail choice [1]	89.5	85.7	82.4
Pharmacy network [2]	1,140.5	926.2	849.6
Generic dispensing rate:			
Total	85.4%	83.7%	82.2%
Mail choice [1]	78.2%	76.4%	74.6%
Pharmacy network [2]	85.9%	84.4%	83.0%
Mail choice penetration rate	18.0%	20.6%	21.4%

(1) Mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect ® claims filled at retail, as well as prescriptions filled at our retail pharmacies under the Maintenance Choice ® program.
(2) Pharmacy network net revenues, claims processed and generic dispensing rates do not include Maintenance Choice, which are included within the mail choice category. Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including our retail pharmacies and long-term care pharmacies, but excluding Maintenance Choice activity.
(3) The Pharmacy Services Segment operating expenses for the year ended December 31, 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

Net revenues in our Pharmacy Services Segment increased $19.6 billion, or 19.5% , to $120.0 billion for the year ended December 31, 2016, as compared to the prior year. The increase is primarily due to increased pharmacy network claims, growth in specialty pharmacy, including the growth in Medicare Part D, addition of ACS Pharmacy through the acquisition of Omnicare, and inflation, partially offset by increased generic dispensing and price compression.

Net revenues increased $11.9 billion, or 13.5%, to $100.4 billion for the year ended December 31, 2015, as compared to the prior year. The increase is primarily due to growth in specialty pharmacy, driven by new clients, increased volume from new products and the addition of ACS Pharmacy through the acquisition of Omnicare, as well as inflation and increased pharmacy network claims. Conversely, the increase in our generic dispensing rate had a negative impact on our revenue in 2015, as it did in 2014.

As you review our Pharmacy Services Segment's revenue performance, we believe you should also consider the following important information about the business:

- Our mail choice claims processed increased 4.4% to 89.5 million claims in the year ended December 31, 2016, compared to 85.7 million claims in the prior year. The increase in mail choice claims was driven by growth in specialty pharmacy claims, increase in net new business, and continuing adoption of our Maintenance Choice offerings. During 2015, our mail choice claims processed increased 4.0% to 85.7 million claims. The increase in mail choice claims was driven by net new business, specialty and continuing adoption of our Maintenance Choice offerings.

- During 2016 and 2015, our average revenue per mail choice claim increased by 8.3% and 17.0%, compared to 2015 and 2014, respectively. The increase in both years was primarily due to growth in specialty pharmacy and inflation.

- Our pharmacy network claims processed increased 23.1% to 1,140.5 million claims in the year ended December 31, 2016, compared to 926.2 million claims in the prior year. This increase was primarily due to volume from net new business. During 2015, our pharmacy network claims processed increased 9.0% to 926.2 million compared to 849.6 million pharmacy network claims processed in 2014. This increase was primarily due to net new business.

- During 2016 and 2015, our average revenue per pharmacy network claim processed remained flat.

- Our mail choice generic dispensing rate was 78.2% , 76.4% and 74.6% in the years ended December 31, 2016, 2015 and 2014, respectively. Our pharmacy network generic dispensing rate increased to 85.9% in the year ended December 31, 2016, compared to 84.4% in the prior year. During 2015, our pharmacy network generic dispensing rate increased to 84.4% compared to our pharmacy network generic dispensing rate of 83.0% in 2014. These continued increases in mail choice and pharmacy network generic dispensing rates were primarily due to the impact of new generic drug introductions, and our continuous efforts to encourage plan members to use generic drugs when they are available. We believe our generic dispensing rates will continue to increase in future periods, albeit at a slower pace. This increase will be affected by, among other things, the number of new brand and generic drug introductions and our success at encouraging plan members to utilize generic drugs when they are available and clinically appropriate.

Gross profit in our Pharmacy Services Segment includes net revenues less cost of revenues. Cost of revenues includes (i) the cost of pharmaceuticals dispensed, either directly through our mail service and specialty retail pharmacies or indirectly through our pharmacy network, (ii) shipping and handling costs and (iii) the operating costs of our mail service dispensing pharmacies, customer service operations and related information technology support.

Gross profit increased $674 million, or 12.9% , to $5.9 billion in the year ended December 31, 2016, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 4.9% for the year ended December 31, 2016, compared to 5.2% in the prior year. The increase in gross profit dollars in the year ended December 31, 2016 was primarily due to growth in specialty pharmacy, growth in Medicare Part D lives, higher generic dispensing and favorable purchasing economics, partially offset by price compression. The decrease in gross profit as a percentage of net revenues was primarily due to changes in the mix of our business and continued price compression, partially offset by favorable generic dispensing and purchasing economics.

Gross profit increased $456 million, or 9.6% to $5.2 billion in the year ended December 31, 2015, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 5.2% for the year ended December 31, 2015, compared to 5.4% in the prior year. The increase in gross profit dollars in the year ended December 31, 2015 was primarily due to volume increases and higher generic dispensing, as well as favorable purchasing and rebate economics, partially offset by price compression. The decrease in gross profit as a percentage of net revenues was primarily due to price compression, partially offset by favorable generic dispensing, as well as favorable purchasing and rebate economics.

As you review our Pharmacy Services Segment's performance in this area, we believe you should consider the following important information about the business:

- Our efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts we received from manufacturers, wholesalers and retail pharmacies continue to have an impact on our gross profit dollars and gross profit as a percentage of net revenues. In particular, competitive pressures in the PBM industry have caused us and other PBMs to continue to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, market dynamics and regulatory changes have limited our ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and we expect these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

- Our gross profit as a percentage of revenues benefited from the increase in our total generic dispensing rate, which increased to 85.4% and 83.7% in 2016 and 2015, respectively, compared to our generic dispensing rate of 82.2% in 2014. These increases were primarily due to new generic drug introductions and our continual efforts to encourage plan members to use clinically appropriate generic drugs when they are available. We expect these trends to continue, albeit at a slower pace. The increased use by patients of generic drugs has also resulted in third party payors augmenting their efforts to reduce reimbursement payments for prescriptions. This trend, which we expect to continue, reduces the benefit we realize from brand to generic product conversions.

Operating expenses in our Pharmacy Services Segment, which include selling, general and administrative expenses, depreciation and amortization related to selling, general and administrative activities and administrative payroll, employee benefits and occupancy costs, decreased to 1.0% of net revenues in 2016, compared to 1.2% in 2015 and 1.4% in 2014.

As you review our Pharmacy Services Segment's performance in this area, we believe you should consider the following important information about the business:

- Operating expenses decreased $9 million or 0.7% in the year ended December 31, 2016, compared to the prior year. The decrease in operating expense dollars is primarily due to an $88 million reversal of an accrual in connection with a legal settlement, partially offset by an increase in costs associated with the growth of our business.

- Operating expenses decreased $19 million or 1.5%, to $1.2 billion, in the year ended December 31, 2015, compared to the prior year. The decrease in operating expense dollars is primarily due to lower integration costs from the Coram acquisition which occurred in January 2014, partially offset by the addition of ACS Pharmacy from the Omnicare acquisition in August 2015. Operating expenses as a percentage of net revenues improved slightly from 1.4% in 2014 to 1.2% in 2015.

Retail/LTC Segment

The following table summarizes our Retail/LTC Segment's performance for the respective periods:

	Year Ended December 31,		
In millions	**2016**	**2015**	**2014**
Net revenues	$ 81,100	$ 72,007	$ 67,798
Gross profit [1]	$ 23,738	$ 21,992	$ 21,277
Gross profit % of net revenues	29.3 %	30.5 %	31.4 %
Operating expenses [2]	$ 16,457	$ 14,862	$ 14,515
Operating expenses % of net revenues	20.3 %	20.6 %	21.4 %
Operating profit	$ 7,281	$ 7,130	$ 6,762
Operating profit % of net revenues	9.0 %	9.9 %	10.0 %
Prescriptions filled (90 Day = 3 prescriptions) [3]	1,223.5	1,031.6	935.9
Net revenue increase (decrease):			
Total	12.6 %	6.2 %	3.3 %
Pharmacy	15.9 %	9.5 %	5.1 %
Front Store	0.3 %	(2.5)%	(2.5)%
Total prescription volume (90 Day = 3 prescriptions) [3]	18.6 %	10.2 %	5.2 %
Same store sales increase (decrease) [4]:			
Total	1.9 %	1.7 %	2.1 %
Pharmacy	3.2 %	4.5 %	4.8 %
Front Store [5]	(1.5)%	(5.0)%	(4.0)%
Prescription volume (90 Day = 3 prescriptions) [3]	3.6 %	4.8 %	4.1 %
Generic dispensing rates	85.7 %	84.5 %	83.1 %
Pharmacy % of net revenues	75.0 %	72.9 %	70.7 %

(1) Gross profit for the year ended December 31, 2016 includes $46 million of acquisition-related integration costs related to the acquisitions of Omnicare and the pharmacies and clinics of Target.
(2) Operating expenses for the years ended December 31, 2016 and 2015 include $235 million and $64 million , respectively, of acquisition-related integration costs related to the acquisitions of Omnicare and the pharmacies and clinics of Target. Operating expenses for the year ended December 31, 2016 also includes a $34 million asset impairment charge in connection with planned store closures in 2017 related to our enterprise streamlining initiative.
(3) Includes the adjustment to convert 90-day, non-specialty prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.
(4) Same store sales and prescriptions exclude revenues from MinuteClinic, and revenue and prescriptions from stores in Brazil, from LTC operations and from commercialization services.
(5) Front store same store sales would have been approximately 520 basis points higher for the year ended December 31, 2015 if tobacco and the estimated associated basket sales were excluded from the year ended December 31, 2014.

Net revenues increased approximately $9.1 billion, or 12.6% , to $81.1 billion for the year ended December 31, 2016, as compared to the prior year. This increase was primarily driven by the acquisitions of the pharmacies and clinics of Target and new stores, which accounted for approximately 640 basis points of our total net revenue percentage increase during the year, the acquisition of Omnicare's LTC operations and a same store sales increase of 1.9% . Net revenues increased approximately $4.2 billion, or 6.2%, to $72.0 billion for the year ended December 31, 2015, as compared to the prior year. This increase was primarily driven by the acquisition of LTC, a same store sales increase of 1.7%, and net revenues from new and acquired stores, which accounted for approximately 160 basis points of our total net revenue percentage increase during the year.

As you review our Retail/LTC Segment's performance in this area, we believe you should consider the following important information about the business:

- Front store same store sales declined 1.5% in the year ended December 31, 2016, as compared to the prior year. The decrease is primarily driven by softer customer traffic and efforts to rationalize promotional strategies, partially offset by an increase in basket size.

- Pharmacy same store sales rose 3.2% in the year ended December 31, 2016, as compared to the prior year. Pharmacy same store sales were positively impacted by same store script growth of 3.6% , as well as approximately 20 basis points due to an additional day in 2016 related to leap year for the year ended December 31, 2016. Due to marketplace changes in the latter half of 2016, we expect script growth to be negatively impacted for the next several quarters by restricted network relationships that exclude CVS Pharmacy.

- Pharmacy revenues continue to be negatively impacted by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. Pharmacy same store sales were negatively impacted by approximately 360 and 390 basis points for the years ended December 31, 2016 and 2015, respectively, due to recent generic introductions. The generic dispensing rate grew to 85.7% for the year ended December 31, 2016, compared to 84.5% in the prior year. In addition, our pharmacy revenue growth has also been negatively affected by the mix of drugs sold, continued reimbursement pressure and the lack of significant new brand name drug introductions.

- As of December 31, 2016 , we operated 9,709 retail stores, including the 1,674 locations in Target stores, compared to 9,655 retail stores as of December 31, 2015 and 7,822 retail stores as of December 31, 2014. Total net revenues from new and acquired stores contributed approximately 6.4%, 1.6% and 1.1% to our total net revenue percentage increase in 2016, 2015, and 2014, respectively. The majority of the increase in 2016 was primarily due to the addition of the pharmacies of Target in December 2015.

- Pharmacy revenue continued to benefit from the increased utilization by Medicare Part D beneficiaries, our ability to attract and retain managed care customers, the increased use of pharmaceuticals by an aging population and as the first line of defense for individual health care.

Gross profit in our Retail/LTC Segment includes net revenues less the cost of merchandise sold during the reporting period and the related purchasing costs, warehousing costs, delivery costs and actual and estimated inventory losses.

Gross profit increased $1.7 billion, or 7.9% , to approximately $23.7 billion in the year ended December 31, 2016, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 29.3% in year ended December 31, 2016, from 30.5% in 2015. Gross profit increased $715 million, or 3.4%, to approximately $22.0 billion in the year ended December 31, 2015, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 30.5% in year ended December 31, 2015, from 31.4% in 2014.

The increase in gross profit dollars in the year ended December 31, 2016, was primarily driven by the addition of the pharmacies and clinics of Target and LTC, as well as same store sales, partially offset by continued reimbursement pressure. The decrease in gross profit as a percentage of net revenues was primarily driven by a decline in pharmacy margins due to continued reimbursement pressure and the mix effect of lower margins from the acquisitions of the pharmacies and clinics of Target and LTC, partially offset by increased front store margins. Front store margins increased due to changes in the mix of products sold and efforts to rationalize promotional strategies. The increase in gross profit dollars in the year ended December 31, 2015, was primarily driven by the addition of LTC, same store sales and new store sales, increased generic dispensing, as well as favorable purchasing economics, partially offset by continued reimbursement pressure.

As you review our Retail/LTC Segment's performance in this area, we believe you should consider the following important information about the business:

- Front store revenues as a percentage of total net revenues for the years ended December 31, 2016, 2015 and 2014 were 23.6%, 26.5% and 28.8%, respectively. On average, our gross profit on front store revenues is generally higher than our gross profit on pharmacy revenues. Pharmacy revenues as a percentage of total net revenues increased approximately 210, 220 and 120 basis points in the years ended December 31, 2016, 2015 and 2014, respectively. This was due to pharmacy revenues growing faster than front store revenues, largely driven by the acquisitions of the pharmacies and clinics of Target and LTC. The mix effect from a higher proportion of pharmacy sales had a negative effect on our overall gross profit as a percentage of net revenues for the years ended December 31, 2016, 2015 and 2014, respectively. This negative effect was partially offset by an increase in generic drugs dispensed, an improved front store gross margin rate, which includes efforts to rationalize promotional strategies.

- During 2016 and 2015, our front store gross profit as a percentage of net revenues increased compared to the prior year. In both years, the increase reflects a change in the mix of products sold, including store brand products, as a result of our efforts to rationalize promotional strategies. The increase in 2015 was also partially due to the removal of tobacco products from our stores in late 2014.

- Our pharmacy gross profit rates have been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of our business within the pharmacy portion of the Retail/LTC Segment. In the event the reimbursement pressure accelerates, we may not be able to sustain our current rate of revenue growth and gross profit dollars could be adversely impacted. The increased use of generic drugs has positively impacted our gross profit but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which we expect to continue, reduces the benefit we realize from brand to generic product conversions.

Operating expenses in our Retail/LTC Segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.

Operating expenses increased $1.6 billion, or 10.7% to $16 billion , or 20.3% as a percentage of net revenues, in the year ended December 31, 2016, as compared to $14.9 billion, or 20.6% as a percentage of net revenues, in the prior year. Operating expenses increased $347 million, or 2.4%, to $14.9 billion, or 20.6% as a percentage of net revenues, in the year ended December 31, 2015, as compared to $14.5 billion, or 21.4% as a percentage of net revenues, in the prior year. Operating expenses as a percentage of net revenues for the year ended December 31, 2016 improved primarily due to expense leverage from net revenue growth. The increase in operating expense dollars for the year ended December 31, 2016, was primarily due to the addition of the pharmacies and clinics within Target stores and LTC, including acquisition-related integration costs of $235 million , and incremental store operating costs associated with operating more stores. Operating expenses for the year ended December 31, 2016, includes a gain from a legal settlement with certain credit card companies of $32 million and an asset impairment charge of $34 million in connection with planned store closures in 2017 related to our enterprise streamlining initiative. Additionally, in April 2016, the Retail/LTC Segment made a charitable contribution of $32 million to the CVS Foundation to fund future charitable giving. The CVS Foundation is a non-profit entity that focuses on health, education and community involvement programs. The charitable contribution was recorded as an operating expense in the year ended December 31, 2016. Operating expenses as a percentage of net revenues for the year ended December 31, 2015 improved primarily due to higher legal costs in the prior year and leverage gained from the addition of LTC net revenues. The increase in operating expense dollars for the year ended December 31, 2015, was primarily due to the addition of LTC, including acquisition-related integration costs of $64 million, and incremental store operating costs associated with operating more stores.

Corporate Segment

Operating expenses decreased $143 million , or 13.8%, to $894 million in the year ended December 31, 2016, as compared to the prior year. Operating expenses increased $241 million, or 30.3%, to $1.0 billion in the year ended December 31, 2015. Operating expenses within the Corporate Segment include executive management, corporate relations, legal, compliance, human resources, information technology and finance related costs. The decrease in operating expenses for the year ended December 31, 2016 was primarily due to acquisition-related transaction and integration costs associated with the acquisition of Omnicare that occurred in August 2015, and the acquisition of the pharmacies and clinics of Target that occurred in December 2015. Acquisition-related integration costs for the year ended December 31, 2016 were $10 million . The increase in operating expenses in the year ended December 31, 2015 was primarily due to acquisition-related transaction and integration costs of $156 million associated with the acquisitions of Omnicare and pharmacies and clinics of Target, as well as a $90 million charge related to a legacy lawsuit challenging the 1999 settlement by MedPartners of various securities class actions and a related derivative claim.

Liquidity and Capital Resources

We maintain a level of liquidity sufficient to allow us to meet our cash needs in the short-term. Over the long-term, we manage our cash and capital structure to maximize shareholder return, maintain our financial position and maintain flexibility for future strategic initiatives. We continuously assess our working capital needs, debt and leverage levels, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. We believe our operating cash flows, commercial paper program, credit facilities, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives.

The change in cash and cash equivalents is as follows:

	Year Ended December 31,		
In millions	**2016**	**2015**	**2014**
Net cash provided by operating activities	$ 10,069	$ 8,412	$ 8,137
Net cash used in investing activities	(2,470)	(13,420)	(4,045)
Net cash provided by (used in) financing activities	(6,689)	5,006	(5,694)
Effect of exchange rate changes on cash and cash equivalents	2	(20)	(6)
Net increase (decrease) in cash and cash equivalents	$ 912	$ (22)	$ (1,608)

Net cash provided by operating activities increased by $1.7 billion in 2016 and $275 million in 2015. The increase in 2016 was primarily due to the timing of payments for our Medicare Part D operations. The increase in 2015 was primarily due to increased net income partially offset by various changes in working capital.

Net cash used in investing activities decreased by $11.0 billion in 2016 and increased by $9.4 billion in 2015. The decrease in 2016 and increase in 2015 were primarily due to the $9.6 billion paid for the acquisition of Omnicare and the $1.9 billion paid for the acquisition of the pharmacies and clinics of Target in 2015, compared to the $2.1 billion paid for the Coram acquisition in 2014.

In 2016, gross capital expenditures totaled approximately $2.2 billion , a decrease of approximately $143 million compared to the prior year. During 2016, approximately 31% of our total capital expenditures were for new store construction, 20% were for store, fulfillment and support facilities expansion and improvements and 49% were for technology and other corporate initiatives. Gross capital expenditures totaled approximately $2.4 billion and $2.1 billion during 2015 and 2014, respectively. During 2015, approximately 36% of our total capital expenditures were for new store construction, 21% were for store, fulfillment and support facilities expansion and improvements and 43% were for technology and other corporate initiatives.

Proceeds from sale-leaseback transactions totaled $230 million in 2016. This compares to $411 million in 2015 and $515 million in 2014. Under the sale-leaseback transactions, the properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The specific timing and amount of future sale-leaseback transactions will vary depending on future market conditions and other factors.

Below is a summary of our store development activity for the respective years:

	2016 [2]	2015 [2]	2014 [2]
Total stores (beginning of year)	9,665	7,866	7,702
New and acquired stores [1]	132	1,833	187
Closed stores [1]	(47)	(34)	(23)
Total stores (end of year)	9,750	9,665	7,866
Relocated stores	50	58	60

(1) Relocated stores are not included in new or closed store totals.
(2) Includes retail drugstores, certain onsite pharmacy stores, specialty pharmacy stores and pharmacies within Target stores.

Net cash used in financing activities was $6.7 billion in 2016 versus net cash provided by financing activities of $5.0 billion in 2015. The difference of $11.7 billion is primarily due to lower long-term borrowings and higher net repayments of short and long-term debt in 2016. Net cash provided by financing activities was $5.0 billion in 2015 versus net cash used in financing

activities of $5.7 billion in 2014. The difference of $10.7 billion was primarily due to higher net borrowings in 2015, including the $14.8 billion in net proceeds received from the July 2015 debt issuance, partially offset by an increase in share repurchases in 2015 of $1.0 billion.

Share repurchase programs — The following share repurchase programs were authorized by the Company's Board of Directors:

In billions

Authorization Date	Authorized	Remaining
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 15.0
December 15, 2014 ("2014 Repurchase Program")	$ 10.0	$ 3.2
December 17, 2013 ("2013 Repurchase Program")	$ 6.0	$ —

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2016 and 2014 Repurchase Programs may be modified or terminated by the Board of Directors at any time.

Pursuant to the authorization under the 2014 Repurchase Program, effective August 29, 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion . Upon payment of the $3.6 billion purchase price on January 6, 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares at a price of $80.34 per share, which were placed into treasury stock in January 2017. At the conclusion of the ASRs, the Company may receive additional shares equal to the remaining 20% of the $3.6 billion notional amount. The ultimate number of shares the Company may receive will fluctuate based on changes in the daily volume-weighted average price of the Company's stock over a period beginning on January 6, 2017 and ending on or before July 6, 2017. If the mean daily volume-weighted average price of the Company's common stock, less a discount (the "forward price"), during the ASRs falls below $80.34 per share, the Company will receive a higher number of shares from Barclays. If the forward price rises above $80.34 per share, the Company will either receive fewer shares from Barclays or, potentially have an obligation to Barclays which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASRs, the maximum number of shares that could be received or delivered is 90.1 million .

Pursuant to the authorization under the 2014 Repurchase Program, effective December 11, 2015, the Company entered into a $725 million fixed dollar ASR with Barclays. Upon payment of the $725 million purchase price on December 14, 2015, the Company received a number of shares of its common stock equal to 80% of the $725 million notional amount of the ASR or approximately 6.2 million shares. The initial 6.2 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in December 2015. The ASR was accounted for as an initial treasury stock transaction of $580 million and a forward contract of $145 million . The forward contract was classified as an equity instrument and was recorded within capital surplus on the consolidated balance sheet. On January 28, 2016, the Company received 1.4 million shares of common stock, representing the remaining 20% of the $725 million notional amount of the ASR, thereby concluding the ASR. The remaining 1.4 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in January 2016 and the forward contract was reclassified from capital surplus to treasury stock.

Pursuant to the authorization under the 2013 Repurchase Programs, effective January 2, 2015, the Company entered into a $2.0 billion fixed dollar ASR agreement with J.P. Morgan Chase Bank ("JP Morgan"). Upon payment of the $2.0 billion purchase price on January 5, 2015, the Company received a number of shares of its common stock equal to 80% of the $2.0 billion notional amount of the ASR agreement or approximately 16.8 million shares, which were placed into treasury stock in January 2015. On May 1, 2015, the Company received approximately 3.1 million shares of common stock, representing the remaining 20% of the $2.0 billion notional amount of the ASR, thereby concluding the ASR. The remaining 3.1 million shares of common stock delivered to the Company by JP Morgan were placed into treasury stock in May 2015. The ASR was accounted for as an initial treasury stock transaction of $1.6 billion and a forward contract of $0.4 billion . The forward contract was classified as an equity instrument and was initially recorded within capital surplus on the consolidated balance sheet and was reclassified to treasury stock upon the settlement of the ASR in May 2015.

In the ASR transactions described above, the initial repurchase of the shares and delivery of the remainder of the shares to conclude the ASR, resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

During the year ended December 31, 2016, the Company repurchased an aggregate of 47.5 million shares of common stock for approximately $4.5 billion under the 2014 Repurchase Program. As of December 31, 2016, there remained an aggregate of approximately $18.2 billion available for future repurchases under the 2016 and 2014 Repurchase Programs, $3.6 billion of which was used for the ASR effective January 6, 2017 described previously. As of December 31, 2015, the 2013 Repurchase Program was complete.

Short-term borrowings - The Company had approximately $1.9 billion of commercial paper outstanding at a weighted average interest rate of 1.22% as of December 31, 2016. In connection with its commercial paper program, the Company maintains a $1.0 billion , five -year unsecured back-up credit facility, which expires on May 23, 2018, a $1.25 billion , five -year unsecured back-up credit facility, which expires on July 24, 2019, and a $1.25 billion , five -year unsecured back-up credit facility, which expires on July 1, 2020. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03% , regardless of usage. As of December 31, 2016, there were no borrowings outstanding under the back-up credit facilities.

On January 3, 2017, the Company entered into a $2.5 billion revolving credit facility. The credit facility allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03% , regardless of usage. The maximum available under the credit facility decreases by $750 million on both March 31, 2017 and June 30, 2017 and by $500 million on September 30, 2017. The credit facility expires on December 31, 2017.

On May 20, 2015, in connection with the acquisition of Omnicare, the Company entered into a $13 billion unsecured bridge loan facility. The Company paid approximately $52 million in fees in connection with the facility. The fees were capitalized and amortized as interest expense over the period the bridge facility was outstanding. The bridge loan facility expired on July 20, 2015 upon the Company's issuance of unsecured senior notes with an aggregate principal of $15 billion as discussed below. The bridge loan facility fees became fully amortized in July 2015.

Long-term borrowings - On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the "2016 Notes") for total proceeds of approximately $3.5 billion , net of discounts and underwriting fees. The 2016 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

On May 16, 2016, the Company announced tender offers for (1) any and all of its 5.75% Senior Notes due 2017, its 6.60% Senior Notes due 2019 and its 4.75% Senior Notes due 2020 (collectively, the "Any and All Notes") and (2) up to $1.5 billion aggregate principal amount of its 6.25% Senior Notes due 2027, its 6.125% Senior Notes due 2039, its 5.75% Senior Notes due 2041, the 5.00% Senior Notes due 2024 issued by its wholly-owned subsidiary, Omnicare, Inc. ("Omnicare"), the 4.75% Senior Notes due 2022 issued by Omnicare, its 4.875% Senior Notes due 2035 and its 3.875% Senior Notes due 2025 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion . The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. The Company paid a premium of $486 million in excess of the debt principal in connection with the purchase of the Notes, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on the early extinguishment of debt of $542 million which was recorded in income from continuing operations in the consolidated statement of income for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. The Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of debt of $101 million during the year ended December 31, 2016.

The Company recorded a total loss on the early extinguishment of debt of $643 million which was recorded in the income from continuing operations in the consolidated statement of income for the year ended December 31, 2016.

On July 20, 2015, the Company issued an aggregate of $2.25 billion of 1.9% unsecured senior notes due 2018 (“2018 Notes”), an aggregate of $2.75 billion of 2.8% unsecured senior notes due 2020 (“2020 Notes”), an aggregate of $1.5 billion of 3.5% unsecured senior notes due 2022 (“2022 Notes”), an aggregate of $3 billion of 3.875% unsecured senior notes due 2025 (“2025 Notes”), an aggregate of $2 billion of 4.875% unsecured senior notes due 2035 (“2035 Notes”), and an aggregate of $3.5 billion of 5.125% unsecured senior notes due 2045 (“2045 Notes” and, together with the 2018 Notes, 2020 Notes, 2022 Notes, 2025 Notes and 2035 Notes, the “Notes”) for total proceeds of approximately $14.8 billion , net of discounts and underwriting fees. The Notes pay interest semi-annually and contain redemption terms which allow or require the Company to redeem the Notes at a defined redemption price plus accrued and unpaid interest at the redemption date. The net proceeds of the Notes were used to fund the Omnicare acquisition and the acquisition of the pharmacies and clinics of Target. The remaining proceeds were used for general corporate purposes.

Upon the closing of the Omnicare acquisition in August 2015, the Company assumed the long-term debt of Omnicare that had a fair value of approximately $3.1 billion , $2.0 billion of which was previously convertible into Omnicare shares that holders were able to redeem subsequent to the acquisition. During the period from August 18, 2015 to December 31, 2015, all but $5 million of the $2.0 billion of previously convertible debt was redeemed and repaid and approximately $0.4 billion in Omnicare term debt assumed was repaid for total repayments of Omnicare debt of approximately $2.4 billion in 2015.

The remaining principal of the Omnicare debt assumed was comprised of senior unsecured notes with an aggregate principal amount of $700 million ($400 million of 4.75% senior notes due 2022 and $300 million of 5% senior notes due 2024). In September 2015, the Company commenced exchange offers for the 4.75% senior notes due 2022 and the 5% senior notes due 2024 to exchange all validly tendered and accepted notes issued by Omnicare for notes to be issued by the Company. This offer expired on October 20, 2015 and the aggregate principal amounts of $388 million of the 4.75% senior notes due 2022 and $296 million of the 5% senior notes due 2024 were validly tendered and exchanged for notes issued by the Company. The Company recorded this exchange transaction as a modification of the original debt instruments. Consequently, no gain or loss on extinguishment was recognized in the Company's consolidated income statement as a result of this exchange transaction and the issuance costs of the new debt were expensed as incurred.

On August 7, 2014, the Company issued $850 million of 2.25% unsecured senior notes due August 12, 2019 and $650 million of 3.375% unsecured senior notes due August 12, 2024 (collectively, the “2014 Notes”) for total proceeds of approximately $1.5 billion , net of discounts and underwriting fees. The 2014 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company’s option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2014 Notes were used for general corporate purposes and to repay certain corporate debt.

On August 7, 2014, the Company announced tender offers for any and all of the 6.25% Senior Notes due 2027, and up to a maximum amount of the 6.125% Senior Notes due 2039, the 5.75% Senior Notes due 2041 and the 5.75% Senior Notes due 2017, for up to an aggregate principal amount of $1.5 billion . On August 21, 2014, the Company increased the aggregate principal amount of the tender offers to $2.0 billion and completed the repurchase for the maximum amount on September 4, 2014. The Company paid a premium of $490 million in excess of the debt principal in connection with the tender offers, wrote off $26 million of unamortized deferred financing costs and incurred $5 million in fees, for a total loss on the early extinguishment of debt of $521 million . The loss was recorded in income from continuing operations in the consolidated statement of income for the year ended December 31, 2014.

During the year ended December 31, 2014, the Company repurchased the remaining $41 million of outstanding Enhanced Capital Advantage Preferred Securities (“ECAPS”) at par. The fees and write-off of deferred issuance costs associated with the early extinguishment of the ECAPS were immaterial.

Our credit facilities and unsecured senior notes (see Note 5 “Borrowings and Credit Agreements” to the consolidated financial statements) contain customary restrictive financial and operating covenants.

These covenants do not include a requirement for the acceleration of our debt maturities in the event of a downgrade in our credit rating. We do not believe the restrictions contained in these covenants materially affect our financial or operating flexibility. As of December 31, 2016, the Company is in compliance with all debt covenants.

As of December 31, 2016 and 2015, we had no outstanding derivative financial instruments.

Debt Ratings - As of December 31, 2016, our long-term debt was rated “Baa1” by Moody’s with a stable outlook and “BBB+” by Standard & Poor’s with a stable outlook, and our commercial paper program was rated “P-2” by Moody’s and “A-2” by Standard & Poor’s. In assessing our credit strength, we believe that both Moody’s and Standard & Poor’s considered, among

other things, our capital structure and financial policies as well as our consolidated balance sheet, our historical acquisition activity and other financial information. Although we currently believe our long-term debt ratings will remain investment grade, we cannot guarantee the future actions of Moody's and/or Standard & Poor's. Our debt ratings have a direct impact on our future borrowing costs, access to capital markets and new store operating lease costs.

Quarterly Cash Dividend Increase - In December 2016, our Board of Directors authorized an 18% increase in our quarterly common stock cash dividend to $0.50 per share effective in 2017. This increase equates to an annual dividend rate of $2.00 per share. In December 2015, our Board of Directors authorized a 21% increase in our quarterly common stock cash dividend to $0.425 per share. This increase equated to an annual dividend rate of $1.70 per share. In December 2014, our Board of Directors authorized a 27% increase in our quarterly common stock cash dividend to $0.35 per share. This increase equated to an annual dividend rate of $1.40 per share.

Off-Balance Sheet Arrangements

In connection with executing operating leases, we provide a guarantee of the lease payments. We also finance a portion of our new store development through sale-leaseback transactions, which involve selling stores to unrelated parties and then leasing the stores back under leases that generally qualify and are accounted for as operating leases. We do not have any retained or contingent interests in the stores, and we do not provide any guarantees, other than a guarantee of the lease payments, in connection with the transactions. In accordance with generally accepted accounting principles, our operating leases are not reflected on our consolidated balance sheets.

Between 1991 and 1997, we sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, Marshalls, Kay-Bee Toys, This End Up and Footstar. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations.

As of December 31, 2016, we guaranteed approximately 87 such store leases (excluding the lease guarantees related to Linens 'n Things), with the maximum remaining lease term extending through 2047 . Management believes the ultimate disposition of any of the remaining lease guarantees will not have a material adverse effect on the Company's consolidated financial condition or future cash flows. Please see "Income (loss) from discontinued operations" previously in this document for further information regarding our guarantee of certain Linens 'n Things' store lease obligations.

Below is a summary of our significant contractual obligations as of December 31, 2016:

	Payments Due by Period				
In millions	**Total**	**2017**	**2018 to 2019**	**2020 to 2021**	**Thereafter**
Operating leases	$ 27,346	$ 2,458	$ 4,570	$ 3,950	$ 16,368
Lease obligations from discontinued operations	19	7	7	5	—
Capital lease obligations	1,314	74	143	141	956
Contractual lease obligations with Target [(1)]	1,737	—	—	—	1,737
Long-term debt	25,204	21	4,350	5,050	15,783
Interest payments on long-term debt [(2)]	11,385	916	1,724	1,480	7,265
Other long-term liabilities reflected in our consolidated balance sheet	806	76	377	112	241
	$ 67,811	$ 3,552	$ 11,171	$ 10,738	$ 42,350

(1) The Company leases pharmacy and clinic space from Target. See Note 6 "Leases" to the consolidated financial statements for additional information regarding the lease arrangements with Target. Amounts related to the operating and capital leases with Target are reflected within the operating leases and capital lease obligations above. Amounts due in excess of the remaining estimated economic lives of the buildings are reflected herein assuming equivalent stores continue to operate through the term of the arrangements.

(2) Interest payments on long-term debt are calculated on outstanding balances and interest rates in effect on December 31, 2016.

Critical Accounting Policies

We prepare our consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. We base our estimates and judgments on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, we review our accounting policies and how they are applied and disclosed in our consolidated financial statements. While we believe the historical experience, current trends and other factors considered, support the preparation of our consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from our estimates, and such differences could be material.

Our significant accounting policies are discussed in Note 1"Significant Accounting Policies" to our consolidated financial statements. We believe the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. We have discussed the development and selection of our critical accounting policies with the Audit Committee of our Board of Directors and the Audit Committee has reviewed our disclosures relating to them.

Revenue Recognition

Pharmacy Services Segment

Our Pharmacy Services Segment sells prescription drugs directly through our mail service dispensing pharmacies and indirectly through our retail pharmacy network. We recognize revenues in our Pharmacy Services Segment from prescription drugs sold by our mail service dispensing pharmacies and under retail pharmacy network contracts where we are the principal using the gross method at the contract prices negotiated with our clients. Net revenue from our Pharmacy Services Segment includes: (i) the portion of the price the client pays directly to us, net of any volume-related or other discounts paid back to the client, (ii) the price paid to us ("Mail Co-Payments") or a third party pharmacy in our retail pharmacy network ("Retail Co-Payments") by individuals included in our clients' benefit plans, and (iii) administrative fees for retail pharmacy network contracts where we are not the principal. Sales taxes are not included in revenue.

We recognize revenue in the Pharmacy Services Segment when: (i) persuasive evidence of an arrangement exists, (ii) delivery has occurred or services have been rendered, (iii) the seller's price to the buyer is fixed or determinable, and (iv) collectability is reasonably assured. The following revenue recognition policies have been established for the Pharmacy Services Segment.

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription is delivered. At the time of delivery, the Pharmacy Services Segment has performed substantially all of its obligations under its client contracts and does not experience a significant level of returns or reshipments.

- Revenues generated from prescription drugs sold by third party pharmacies in the Pharmacy Services Segment's retail pharmacy network and associated administrative fees are recognized at the Pharmacy Services Segment's point-of-sale, which is when the claim is adjudicated by the Pharmacy Services Segment's online claims processing system.

We determine whether we are the principal or agent for our retail pharmacy network transactions on a contract by contract basis. In the majority of our contracts, we have determined we are the principal due to us: (i) being the primary obligor in the arrangement, (ii) having latitude in establishing the price, changing the product or performing part of the service, (iii) having discretion in supplier selection, (iv) having involvement in the determination of product or service specifications, and (v) having credit risk. Our obligations under our client contracts for which revenues are reported using the gross method are separate and distinct from our obligations to the third party pharmacies included in our retail pharmacy network contracts. Pursuant to these contracts, we are contractually required to pay the third party pharmacies in our retail pharmacy network for products sold, regardless of whether we are paid by our clients. Our responsibilities under these client contracts typically include validating eligibility and coverage levels, communicating the prescription price and the co-payments due to the third party retail pharmacy, identifying possible adverse drug interactions for the pharmacist to address with the physician prior to dispensing, suggesting clinically appropriate generic alternatives where appropriate and approving the prescription for dispensing. Although we do not have credit risk with respect to Retail Co-Payments or inventory risk related to retail network claims, we believe that all of the other indicators of gross revenue reporting are present. For contracts under which we act as an agent, we record revenues using the net method.

We deduct from our revenues the manufacturers' rebates that are earned by our clients based on their members' utilization of brand-name formulary drugs. We estimate these rebates at period-end based on actual and estimated claims data and our estimates of the manufacturers' rebates earned by our clients. We base our estimates on the best available data at period-end and

recent history for the various factors that can affect the amount of rebates due to the client. We adjust our rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. We record any cumulative effect of these adjustments against revenues as identified, and adjust our estimates prospectively to consider recurring matters. Adjustments generally result from contract changes with our clients or manufacturers, differences between the estimated and actual product mix subject to rebates or whether the product was included in the applicable formulary. We also deduct from our revenues pricing guarantees and guarantees regarding the level of service we will provide to the client or member as well as other payments made to our clients. Because the inputs to most of these estimates are not subject to a high degree of subjectivity or volatility, the effect of adjustments between estimated and actual amounts have not been material to our results of operations or financial position.

We participate in the federal government's Medicare Part D program as a PDP through our SilverScript subsidiary. Our net revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, but which is subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially deferred as accrued expenses and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

In addition to these premiums, our net revenues include co-payments, coverage gap benefits, deductibles and co-insurance (collectively, the "Member Co-Payments") related to PDP members' actual prescription claims. In certain cases, CMS subsidizes a portion of these Member Co-Payments and we are paid an estimated prospective Member Co-Payment subsidy, each month. The prospective Member Co-Payment subsidy amounts received from CMS are also included in our net revenues. We assume no risk for these amounts, which represented 5.9%, 6.3% and 6.4% of consolidated net revenues in 2016, 2015 and 2014, respectively. If the prospective Member Co-Payment subsidies received differ from the amounts based on actual prescription claims, the difference is recorded in either accounts receivable or accrued expenses. We account for fully insured CMS obligations and Member Co-Payments (including the amounts subsidized by CMS) using the gross method consistent with our revenue recognition policies for Mail Co-Payments and Retail Co-Payments. We have recorded estimates of various assets and liabilities arising from our participation in the Medicare Part D program based on information in our claims management and enrollment systems. Significant estimates arising from our participation in the Medicare Part D program include: (i) estimates of low-income cost subsidy, reinsurance amounts and coverage gap discount amounts ultimately payable to or receivable from CMS based on a detailed claims reconciliation, (ii) an estimate of amounts payable to CMS under a risk-sharing feature of the Medicare Part D program design, referred to as the risk corridor and (iii) estimates for claims that have been reported and are in the process of being paid or contested and for our estimate of claims that have been incurred but have not yet been reported. Actual amounts of Medicare Part D-related assets and liabilities could differ significantly from amounts recorded. Historically, the effect of these adjustments has not been material to our results of operations or financial position.

Retail/LTC Segment

Retail Pharmacy - We recognize revenue from the sale of front store merchandise at the time the merchandise is purchased by the retail customer and recognize revenue from the sale of prescription drugs when the prescription is picked up by the customer. Customer returns are not material. Sales taxes are not included in revenue.

Long-term Care - We recognize revenue when products are delivered or services are rendered or provided to our customers, prices are fixed and determinable, and collection is reasonably assured. A significant portion of our revenues from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. Payments for services rendered to patients covered by these programs are generally less than billed charges. We monitor our revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and record an estimated contractual allowance for sales and receivable balances at the revenue recognition date, to properly account for anticipated differences between billed and reimbursed amounts. Accordingly, the total net revenues and receivables reported in our consolidated financial statements are recorded at the amount expected to be ultimately received from these payors. Since billing functions for a portion of our revenue systems are largely computerized, enabling on-line adjudication at the time of sale to record net revenues, our exposure in connection with estimating contractual allowance adjustments is limited primarily to unbilled and initially rejected Medicare, Medicaid and third party claims (typically approved for reimbursement once additional information is provided to the payor). For the remaining portion of our revenue systems, the contractual allowance is estimated for all billed, unbilled and initially rejected Medicare, Medicaid and third party claims. We evaluate several criteria in developing the estimated contractual allowances on a monthly basis, including historical trends based on actual claims paid, current contract and reimbursement terms, and changes in customer base and payor/product mix. Contractual allowance estimates are adjusted to actual amounts as cash is received and claims are settled, and the aggregate impact of these resulting adjustments was not significant to our results of operations. Further, we do not expect the impact of

changes in estimates related to unsettled contractual allowance amounts from Medicare, Medicaid and third party payors as of December 31, 2016 to be significant to our future consolidated results of operations, financial position and cash flows.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors are typically not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of our normal billing procedures and subject to our normal accounts receivable collections procedures.

Health Care Clinics - for services provided by our health care clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Loyalty Program - our customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings coupons redeemed by customers are recorded as a reduction of revenue when redeemed. ExtraBucks Rewards are accrued as a charge to cost of revenues when earned, net of estimated breakage. We determine breakage based on our historical redemption patterns.

Allowances for Doubtful Accounts

Accounts receivable primarily includes amounts due from third party providers (e.g., pharmacy benefit managers, insurance companies, governmental agencies and long-term care facilities), clients, members and private pay customers, as well as vendors and manufacturers. We provide a reserve for accounts receivable considered to be at increased risk of becoming uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. We establish this allowance for doubtful accounts and consider such factors as historical collection experience, (i.e., payment history and credit losses) and creditworthiness, specifically identified credit risks, aging of accounts receivable by payor category, current and expected economic conditions and other relevant factors. We regularly review our allowance for doubtful accounts for appropriateness. Judgment is used to assess the collectability of account balances and the economic ability of a customer to pay.

Our allowance for doubtful accounts as of December 31, 2016 was $286 million , compared with $161 million as of December 31, 2015. Our allowance for doubtful accounts represented 2.3% and 1.3% of gross receivables (net of contractual allowance adjustments) as of December 31, 2016 and 2015, respectively. Unforeseen future developments could lead to changes in our provision for doubtful accounts levels and future allowance for doubtful accounts percentages. For example, a one percentage point increase in the allowance for doubtful accounts as a percentage of gross receivables as of December 31, 2016 would result in an increase to the provision of doubtful accounts of approximately $126 million.

Given our experience, we believe that our aggregate reserves for potential losses are adequate, but if any of our larger customers were to unexpectedly default on their obligations, our overall allowances for doubtful accounts may prove to be inadequate. In particular, if economic conditions worsen, the payor mix shifts significantly or reimbursement rates are adversely affected, we may adjust our allowance for doubtful accounts accordingly, and our accounts receivable collections, cash flows, financial position and results of operations could be adversely affected.

Vendor Allowances and Purchase Discounts

Pharmacy Services Segment

Our Pharmacy Services Segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services Segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the results of operations. We account for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services Segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services Segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of "Cost of revenues".

Retail/LTC Segment

Vendor allowances received by the Retail/LTC Segment reduce the carrying cost of inventory and are recognized in cost of revenues when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of revenues over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of revenues on a straight-line basis over the life of the related contract.

We have not made any material changes in the way we account for vendor allowances and purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or market using the weighted average cost method.

We reduce the value of our ending inventory for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each store and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. The accounting for inventory contains uncertainty since we must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, we consider a number of factors, which include, but are not limited to, historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

Our total reserve for estimated inventory losses covered by this critical accounting policy was $283 million as of December 31, 2016. Although we believe we have sufficient current and historical information available to us to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help you assess the aggregate risk, if any, associated with the uncertainties discussed above, a ten percent (10%) pre-tax change in our estimated inventory losses, which we believe is a reasonably likely change, would increase or decrease our total reserve for estimated inventory losses by about $28 million as of December 31, 2016.

Although we believe that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from our estimates, and such differences could be material.

Goodwill and Intangible Assets

Identifiable intangible assets consist primarily of trademarks, client contracts and relationships, favorable leases and covenants not to compete. These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition.

Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates. Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired.

We evaluate the recoverability of certain long-lived assets, including intangible assets with finite lives, but excluding goodwill and intangible assets with indefinite lives which are tested for impairment using separate tests, whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. We group and evaluate these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. When evaluating these long-lived assets for potential impairment, we first compare the carrying amount of the asset group to the asset group's estimated future cash flows (undiscounted and without interest charges). If the estimated future cash flows are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an

impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges). Our long-lived asset impairment loss calculation contains uncertainty since we must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, we consider historical results and current operating trends and our consolidated sales, profitability and cash flow results and forecasts.

These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable.

Indefinitely-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized and the asset is written down to its estimated fair value.

Our indefinitely-lived intangible asset impairment loss calculation contains uncertainty since we must use judgment to estimate the fair value based on the assumption that in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including, but not limited to, general economic conditions, availability of market information as well as the profitability of the Company.

Goodwill is tested for impairment on a reporting unit basis using a two-step process. The first step of the impairment test is to identify potential impairment by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of our reporting units is estimated using a combination of the discounted cash flow valuation model and comparable market transaction models. If the fair value of the reporting unit exceeds its carrying amount, the reporting unit's goodwill is not considered to be impaired and the second step of the impairment test is not performed. If the carrying amount of the reporting unit exceeds its fair value, the second step of the impairment test is performed to measure the amount of impairment loss, if any. The second step of the impairment test compares the implied fair value of the reporting unit's goodwill with the carrying amount of the goodwill. If the carrying amount of the reporting unit's goodwill exceeds the implied fair value of the goodwill, an impairment loss is recognized in an amount equal to that excess.

The determination of the fair value of our reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include, but are not limited to, the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates, terminal growth rates; and forecasts of revenue, operating profit, depreciation and amortization, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, we consider each reporting unit's historical results and current operating trends and our consolidated revenues, profitability and cash flow results, forecasts and industry trends. Our estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, our market capitalization, efforts of third party organizations to reduce their prescription drug costs and/or increase member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

The carrying value of goodwill and other intangible assets covered by this critical accounting policy was $38.2 billion and $13.5 billion as of December 31, 2016, respectively. We did not record any impairment losses related to goodwill or other intangible assets during 2016, 2015 or 2014. During the third quarter of 2016, we performed our required annual impairment tests of goodwill and indefinitely-lived trademarks. The goodwill impairment tests resulted in the fair values of our Pharmacy Services and Retail Pharmacy reporting units exceeding their carrying values by significant margins. The fair values of our LTC and RxCrossroads reporting units exceeded their carrying values by 7% and 12%, respectively. The balance of goodwill for our LTC and RxCrossroads reporting units at December 31, 2016 was approximately $6.4 billion and $0.6 billion, respectively.

Although we believe we have sufficient current and historical information available to us to test for impairment, it is possible that actual results could differ from the estimates used in our impairment tests.

We have not made any material changes in the methodologies utilized to test the carrying values of goodwill and intangible assets for impairment during the past three years.

Closed Store Lease Liability

We account for closed store lease termination costs when a leased store is closed. When a leased store is closed, we record a liability for the estimated present value of the remaining obligation under the noncancelable lease, which includes future real estate taxes, common area maintenance and other charges, if applicable. The liability is reduced by estimated future sublease income.

The initial calculation and subsequent evaluations of our closed store lease liability contain uncertainty since we must use judgment to estimate the timing and duration of future vacancy periods, the amount and timing of future lump sum settlement payments and the amount and timing of potential future sublease income. When estimating these potential termination costs and their related timing, we consider a number of factors, which include, but are not limited to, historical settlement experience, the owner of the property, the location and condition of the property, the terms of the underlying lease, the specific marketplace demand and general economic conditions.

Our total closed store lease liability covered by this critical accounting policy was $183 million as of December 31, 2016. This amount is net of $98 million of estimated sublease income that is subject to the uncertainties discussed above. Although we believe we have sufficient current and historical information available to us to record reasonable estimates for sublease income, it is possible that actual results could differ.

In order to help you assess the risk, if any, associated with the uncertainties discussed above, a ten percent (10%) pre-tax change in our estimated sublease income, which we believe is a reasonably likely change, would increase or decrease our total closed store lease liability by about $10 million as of December 31, 2016.

We have not made any material changes in the reserve methodology used to record closed store lease reserves during the past three years.

During the year ending December 31, 2017, we intend to close approximately 70 retail stores and expect to take a charge of approximately $225 million associated with the remaining lease obligations of such stores.

Self-Insurance Liabilities

We are self-insured for certain losses related to general liability, workers' compensation and auto liability, although we maintain stop loss coverage with third party insurers to limit our total liability exposure. We are also self-insured for certain losses related to health and medical liabilities.

The estimate of our self-insurance liability contains uncertainty since we must use judgment to estimate the ultimate cost that will be incurred to settle reported claims and unreported claims for incidents incurred but not reported as of the balance sheet date. When estimating our self-insurance liability, we consider a number of factors, which include, but are not limited to, historical claim experience, demographic factors, severity factors and other standard insurance industry actuarial assumptions. On a quarterly basis, we review our self-insurance liability to determine if it is adequate as it relates to our general liability, workers' compensation and auto liability. Similar reviews are conducted semi-annually to determine if our self-insurance liability is adequate for our health and medical liability.

Our total self-insurance liability covered by this critical accounting policy was $670 million as of December 31, 2016. Although we believe we have sufficient current and historical information available to us to record reasonable estimates for our self-insurance liability, it is possible that actual results could differ. In order to help you assess the risk, if any, associated with the uncertainties discussed above, a ten percent (10%) pre-tax change in our estimate for our self-insurance liability, which we believe is a reasonably likely change, would increase or decrease our self-insurance liability by about $67 million as of December 31, 2016.

We have not made any material changes in the accounting methodology used to establish our self-insurance liability during the past three years.

Income Taxes

Income taxes are accounted for using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. The deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain.

Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, our tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although we believe that our estimates are reasonable and are based on the best available information at the time we prepare the provision, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in our consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement. Interest and/or penalties related to uncertain tax positions are recognized in income tax expense. Significant judgment is required in determining our uncertain tax positions. We have established accruals for uncertain tax positions using our best judgment and adjust these accruals, as warranted, due to changing facts and circumstances.

New Accounting Pronouncements

See Note 1 “Significant Accounting Policies” to the consolidated financial statements for a description of New Accounting Pronouncements applicable to the Company.

Cautionary Statement Concerning Forward-Looking Statements

This annual report contains forward-looking statements within the meaning of the federal securities laws. In addition, the Company and its representatives may, from time to time, make written or verbal forward-looking statements, including statements contained in the Company's filings with the U.S. Securities and Exchange Commission ("SEC") and in its reports to stockholders, press releases, webcasts, conference calls, meetings and other communications. Generally, the inclusion of the words "believe," "expect," "intend," "estimate," "project," "anticipate," "will," "should" and similar expressions identify statements that constitute forward-looking statements. All statements addressing operating performance of CVS Health Corporation or any subsidiary, events or developments that the Company expects or anticipates will occur in the future, including statements relating to corporate strategy; revenue growth; earnings or earnings per common share growth; adjusted earnings or adjusted earnings per common share growth; free cash flow; debt ratings; inventory levels; inventory turn and loss rates; store development; relocations and new market entries; retail pharmacy business, sales trends and operations; PBM business, sales trends and operations; specialty pharmacy business, sales trends and operations; LTC pharmacy business, sales trends and operations; the Company's ability to attract or retain customers and clients; Medicare Part D competitive bidding, enrollment and operations; new product development; and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the federal securities laws.

The forward-looking statements are and will be based upon management's then-current views and assumptions regarding future events and operating performance, and are applicable only as of the dates of such statements. The Company undertakes no obligation to update or revise any forward-looking statements, whether as a result of new information, future events, or otherwise.

By their nature, all forward-looking statements involve risks and uncertainties. Actual results may differ materially from those contemplated by the forward-looking statements for a number of reasons as described in our SEC filings, including those set forth in the Risk Factors section within the 2016 Annual Report on Form 10-K, and including, but not limited to:

- *Risks relating to the health of the economy in general and in the markets we serve, which could impact consumer purchasing power, preferences and/or spending patterns, drug utilization trends, the financial health of our PBM and LTC clients, retail and specialty pharmacy payors or other payors doing business with the Company and our ability to secure necessary financing, suitable store locations and sale-leaseback transactions on acceptable terms.*

- *Efforts to reduce reimbursement levels and alter health care financing practices, including pressure to reduce reimbursement levels for generic drugs.*

- *The possibility of PBM and LTC client loss and/or the failure to win new PBM and LTC business, including as a result of failure to win renewal of expiring contracts, contract termination rights that may permit clients to terminate a contract prior to expiration and early or periodic renegotiation of pricing by clients prior to expiration of a contract.*

- *The possibility of loss of Medicare Part D business and/or failure to obtain new Medicare Part D business, whether as a result of the annual Medicare Part D competitive bidding process or otherwise.*

- *Risks related to the frequency and rate of the introduction of generic drugs and brand name prescription products.*

- *Risks of declining gross margins attributable to increased competitive pressures, increased client demand for lower prices, enhanced service offerings and/or higher service levels and market dynamics and, with respect to the PBM industry, regulatory changes that impact our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread" or the use of maximum allowable cost pricing.*

- *Regulatory changes, business changes and compliance requirements and restrictions that may be imposed by Centers for Medicare and Medicaid Services ("CMS"), Office of Inspector General or other government agencies relating to the Company's participation in Medicare, Medicaid and other federal and state government-funded programs, including sanctions and remedial actions that may be imposed by CMS on our Medicare Part D business.*

- *Risks and uncertainties related to the timing and scope of reimbursement from Medicare, Medicaid and other government-funded programs, including the possible impact of sequestration, the impact of other federal budget, debt and deficit negotiations and legislation that could delay or reduce reimbursement from such programs and the impact of any closure, suspension or other changes affecting federal or state government funding or operations.*

- *Possible changes in industry pricing benchmarks used to establish pricing in many of our PBM and LTC client contracts, pharmaceutical purchasing arrangements, retail network contracts, specialty payor agreements and other third party payor contracts.*

- *Efforts to increase reimbursement rates in PBM pharmacy networks and to inhibit the ability of PBMs to audit network pharmacies for fraud, waste and abuse.*

- *Risks related to increasing oversight of PBM activities by state departments of insurance.*

- *A highly competitive business environment, including the uncertain impact of increased consolidation in the PBM industry, the possibility of combinations, joint ventures or other collaboration between PBMs and retailers, uncertainty concerning the ability of our retail pharmacy business to secure and maintain contractual relationships with PBMs and other payors on acceptable terms, uncertainty concerning the ability of our PBM business to secure and maintain competitive access, pricing and other contract terms from retail network pharmacies in an environment where some PBM clients are willing to consider adopting narrow or more restricted retail pharmacy networks, and the possibility of our retail stores or specialty pharmacies being excluded from narrow or restricted networks.*

- *The Company's ability to timely identify or effectively respond to changing consumer preferences and spending patterns, an inability to expand the products being purchased by our customers, or the failure or inability to obtain or offer particular categories of products.*

- *Risks relating to our ability to secure timely and sufficient access to the products we sell from our domestic and/or international suppliers, including limited distribution drugs.*

- *Reform of the U.S. health care system, including ongoing implementation of ACA and the possible repeal and replacement of all or parts of ACA, continuing legislative efforts, regulatory changes and judicial interpretations impacting our health care system and the possibility of shifting political and legislative priorities related to reform of the health care system in the future.*

- *Risks related to changes in legislation, regulation and government policy (including through the use of Executive Orders) that could significantly impact our business and the health care and retail industries, including the possibility of major developments in tax policy or trade relations, such as the disallowance of tax deductions for imported merchandise or the imposition of unilateral tariffs on imported products.*

- *Risks relating to any failure to properly maintain our information technology systems, our information security systems and our infrastructure to support our business and to protect the privacy and security of sensitive customer and business information.*

- *Risks related to compliance with a broad and complex regulatory framework, including compliance with new and existing federal, state and local laws and regulations relating to health care, network pharmacy reimbursement and auditing, accounting standards, corporate securities, tax, environmental and other laws and regulations affecting our business.*

- *Risks related to litigation, government investigations and other legal proceedings as they relate to our business, the pharmacy services, retail pharmacy, LTC pharmacy or retail clinic industries, or to the health care industry generally.*

- *The risk that any condition related to the closing of any proposed acquisition may not be satisfied on a timely basis or at all, including the inability to obtain required regulatory approvals of any proposed acquisition, or on the terms desired or anticipated; the risk that such approvals may result in the imposition of conditions that could adversely affect the resulting combined company or the expected benefits of any proposed transaction; and the risk that the proposed transactions fail to close for any other reason.*

- *The possibility that the anticipated synergies and other benefits from any acquisition by us will not be realized, or will not be realized within the expected time periods.*

- *The risks and uncertainties related to our ability to integrate the operations, products, services and employees of any entities acquired by us and the effect of the potential disruption of management's attention from ongoing business operations due to any pending acquisitions.*

- *The accessibility or availability of adequate financing on a timely basis and on reasonable terms.*

- *Risks related to the outcome of any legal proceedings related to, or involving any entity that is a part of, any proposed acquisition contemplated by us.*
- *Other risks and uncertainties detailed from time to time in our filings with the SEC.*

The foregoing list is not exhaustive. There can be no assurance that the Company has correctly identified and appropriately assessed all factors affecting its business. Additional risks and uncertainties not presently known to the Company or that it currently believes to be immaterial also may adversely impact the Company. Should any risks and uncertainties develop into actual events, these developments could have a material adverse effect on the Company's business, financial condition and results of operations. For these reasons, you are cautioned not to place undue reliance on the Company's forward-looking statements.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining adequate internal control over financial reporting. Our Company's internal control over financial reporting includes those policies and procedures that pertain to the Company's ability to record, process, summarize and report a system of internal accounting controls and procedures to provide reasonable assurance, at an appropriate cost/benefit relationship, that the unauthorized acquisition, use or disposition of assets are prevented or timely detected and that transactions are authorized, recorded and reported properly to permit the preparation of financial statements in accordance with generally accepted accounting principles (GAAP) and receipts and expenditures are duly authorized. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such controls and did so most recently for its financial reporting as of December 31, 2016.

We conducted an assessment of the effectiveness of our internal controls over financial reporting based on the criteria set forth in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. Our system of internal control over financial reporting is enhanced by periodic reviews by our internal auditors, written policies and procedures and a written Code of Conduct adopted by our Company's Board of Directors, applicable to all employees of our Company. In addition, we have an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of our disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal controls over financial reporting.

Based on our assessment, we conclude our Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2016.

Ernst & Young LLP, independent registered public accounting firm, is appointed by the Board of Directors and ratified by our Company's shareholders. They were engaged to render an opinion regarding the fair presentation of our consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their accompanying reports are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

February 9, 2017

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders of CVS Health Corporation

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). CVS Health Corporation's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, CVS Health Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of CVS Health Corporation as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2016 of CVS Health Corporation and our report dated February 9, 2017 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 9, 2017

Consolidated Statements of Income

In millions, except per share amounts	Year Ended December 31, 2016	2015	2014
Net revenues	$ 177,526	$ 153,290	$ 139,367
Cost of revenues	148,669	126,762	114,000
Gross profit	28,857	26,528	25,367
Operating expenses	18,519	17,074	16,568
Operating profit	10,338	9,454	8,799
Interest expense, net	1,058	838	600
Loss on early extinguishment of debt	643	—	521
Income before income tax provision	8,637	8,616	7,678
Income tax provision	3,317	3,386	3,033
Income from continuing operations	5,320	5,230	4,645
Income (loss) from discontinued operations, net of tax	(1)	9	(1)
Net income	5,319	5,239	4,644
Net income attributable to noncontrolling interest	(2)	(2)	—
Net income attributable to CVS Health	$ 5,317	$ 5,237	$ 4,644
Basic earnings per share:			
Income from continuing operations attributable to CVS Health	$ 4.93	$ 4.65	$ 3.98
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ 0.01	$ —
Net income attributable to CVS Health	$ 4.93	$ 4.66	$ 3.98
Weighted average shares outstanding	1,073	1,118	1,161
Diluted earnings per share:			
Income from continuing operations attributable to CVS Health	$ 4.91	$ 4.62	$ 3.96
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ 0.01	$ —
Net income attributable to CVS Health	$ 4.90	$ 4.63	$ 3.96
Weighted average shares outstanding	1,079	1,126	1,169
Dividends declared per share	$ 1.70	$ 1.40	$ 1.10

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income

In millions	Year Ended December 31, 2016	2015	2014
Net income	$ 5,319	$ 5,239	$ 4,644
Other comprehensive income (loss):			
Foreign currency translation adjustments, net of tax	38	(100)	(35)
Net cash flow hedges, net of tax	2	2	4
Pension and other postretirement benefits, net of tax	13	(43)	(37)
Total other comprehensive income (loss)	53	(141)	(68)
Comprehensive income	5,372	5,098	4,576
Comprehensive income attributable to noncontrolling interest	(2)	(2)	—
Comprehensive income attributable to CVS Health	$ 5,370	$ 5,096	$ 4,576

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	December 31, 2016	December 31, 2015
Assets:		
Cash and cash equivalents	$ 3,371	$ 2,459
Short-term investments	87	88
Accounts receivable, net	12,164	11,888
Inventories	14,760	14,001
Other current assets	660	722
Total current assets	31,042	29,158
Property and equipment, net	10,175	9,855
Goodwill	38,249	38,106
Intangible assets, net	13,511	13,878
Other assets	1,485	1,440
Total assets	$ 94,462	$ 92,437
Liabilities:		
Accounts payable	$ 7,946	$ 7,490
Claims and discounts payable	9,451	7,653
Accrued expenses	6,937	6,829
Short-term debt	1,874	—
Current portion of long-term debt	42	1,197
Total current liabilities	26,250	23,169
Long-term debt	25,615	26,267
Deferred income taxes	4,214	4,217
Other long-term liabilities	1,549	1,542
Commitments and contingencies (Note 11)	—	—
Redeemable noncontrolling interest	—	39
Shareholders' equity:		
CVS Health shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,705 shares issued and 1,061 shares outstanding at December 31, 2016 and 1,699 shares issued and 1,101 shares outstanding at December 31, 2015	17	17
Treasury stock, at cost: 643 shares at December 31, 2016 and 597 shares at December 31, 2015	(33,452)	(28,886)
Shares held in trust: 1 share at December 31, 2016 and 2015	(31)	(31)
Capital surplus	31,618	30,948
Retained earnings	38,983	35,506
Accumulated other comprehensive income (loss)	(305)	(358)
Total CVS Health shareholders' equity	36,830	37,196
Noncontrolling interest	4	7
Total shareholders' equity	36,834	37,203
Total liabilities and shareholders' equity	$ 94,462	$ 92,437

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	Year Ended December 31, 2016	2015	2014
Cash flows from operating activities:			
Cash receipts from customers	$ 172,310	$ 148,954	$ 132,406
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(142,511)	(122,498)	(105,362)
Cash paid to other suppliers and employees	(15,550)	(14,162)	(15,344)
Interest received	20	21	15
Interest paid	(1,140)	(629)	(647)
Income taxes paid	(3,060)	(3,274)	(2,931)
Net cash provided by operating activities	10,069	8,412	8,137
Cash flows from investing activities:			
Purchases of property and equipment	(2,224)	(2,367)	(2,136)
Proceeds from sale-leaseback transactions	230	411	515
Proceeds from sale of property and equipment and other assets	37	35	11
Acquisitions (net of cash acquired) and other investments	(539)	(11,475)	(2,439)
Purchase of available-for-sale investments	(65)	(267)	(157)
Maturity of available-for-sale investments	91	243	161
Net cash used in investing activities	(2,470)	(13,420)	(4,045)
Cash flows from financing activities:			
Increase (decrease) in short-term debt	1,874	(685)	685
Proceeds from issuance of long-term debt	3,455	14,805	1,483
Repayments of long-term debt	(5,943)	(2,902)	(3,100)
Purchase of noncontrolling interest in subsidiary	(39)	—	—
Payment of contingent consideration	(26)	(58)	—
Dividends paid	(1,840)	(1,576)	(1,288)
Proceeds from exercise of stock options	224	299	421
Excess tax benefits from stock-based compensation	72	127	106
Repurchase of common stock	(4,461)	(5,001)	(4,001)
Other	(5)	(3)	—
Net cash (used in) provided by financing activities	(6,689)	5,006	(5,694)
Effect of exchange rate changes on cash and cash equivalents	2	(20)	(6)
Net increase (decrease) in cash and cash equivalents	912	(22)	(1,608)
Cash and cash equivalents at the beginning of the year	2,459	2,481	4,089
Cash and cash equivalents at the end of the year	$ 3,371	$ 2,459	$ 2,481
Reconciliation of net income to net cash provided by operating activities:			
Net income	$ 5,319	$ 5,239	$ 4,644
Adjustments required to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	2,475	2,092	1,931
Stock-based compensation	222	230	165
Loss on early extinguishment of debt	643	—	521
Deferred income taxes and other noncash items	153	(266)	(58)
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(243)	(1,594)	(737)
Inventories	(742)	(1,141)	(770)
Other current assets	35	355	(383)
Other assets	(43)	2	9
Accounts payable and claims and discounts payable	2,189	2,834	1,742
Accrued expenses	59	765	1,060
Other long-term liabilities	2	(104)	13
Net cash provided by operating activities	$ 10,069	$ 8,412	$ 8,137

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

	Shares			Dollars		
	Year Ended December 31,			Year Ended December 31,		
In millions	2016	2015	2014	2016	2015	2014
Common stock:						
Beginning of year	1,699	1,691	1,680	$ 17	$ 17	$ 17
Stock options exercised and issuance of stock awards	6	8	11	—	—	—
End of year	1,705	1,699	1,691	$ 17	$ 17	$ 17
Treasury stock:						
Beginning of year	(597)	(550)	(500)	$ (28,886)	$ (24,078)	$ (20,169)
Purchase of treasury shares	(47)	(48)	(51)	(4,606)	(4,856)	(4,001)
Employee stock purchase plan issuances	1	1	1	40	48	92
End of year	(643)	(597)	(550)	$ (33,452)	$ (28,886)	$ (24,078)
Shares held in trust:						
Balance at beginning and end of year	(1)	(1)	(1)	$ (31)	$ (31)	$ (31)
Capital surplus:						
Beginning of year				$ 30,948	$ 30,418	$ 29,777
Stock option activity, stock awards and other				449	533	535
Excess tax benefit on stock options and stock awards				76	142	106
2015 accelerated share repurchase not settled until 2016				145	(145)	—
End of year				$ 31,618	$ 30,948	$ 30,418
Retained earnings:						
Beginning of year				$ 35,506	$ 31,849	$ 28,493
Changes in inventory accounting principles				—	(4)	—
Net income attributable to CVS Health				5,317	5,237	4,644
Common stock dividends				(1,840)	(1,576)	(1,288)
End of year				$ 38,983	$ 35,506	$ 31,849
Accumulated other comprehensive loss:						
Beginning of year				$ (358)	$ (217)	$ (149)
Foreign currency translation adjustments, net of tax				38	(100)	(35)
Net cash flow hedges, net of tax				2	2	4
Pension and other postretirement benefits, net of tax				13	(43)	(37)
End of year				$ (305)	$ (358)	$ (217)
Total CVS Health shareholders ' equity				$ 36,830	$ 37,196	$ 37,958
Noncontrolling interest:						
Beginning of year				$ 7	$ 5	$ —
Business combinations				—	1	5
Capital contributions				1	2	—
Net income attributable to noncontrolling interest [1]				1	1	—
Distributions				(5)	(2)	—
End of year				$ 4	$ 7	$ 5
Total shareholders' equity				$ 36,834	$ 37,203	$ 37,963

(1) Excludes $1 million attributable to redeemable noncontrolling interest in 2016 and 2015 (See Note 1 "Significant Accounting Policies").

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1 Significant Accounting Policies

Description of business - CVS Health Corporation and its subsidiaries (the "Company") is the largest integrated pharmacy health care provider in the United States based upon revenues and prescriptions filled. The Company currently has three reportable business segments, Pharmacy Services, Retail/LTC and Corporate, which are described below.

Pharmacy Services Segment (the "PSS") - The PSS provides a full range of pharmacy benefit management services including plan design offerings and administration, formulary management, Medicare Part D services, mail order, specialty pharmacy and infusion services, retail pharmacy network management services, prescription management systems, clinical services, disease management services and medical spend management. The Company's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D, Managed Medicaid plans, plans offered on the public and private exchanges, and other sponsors of health benefit plans and individuals throughout the United States.

As a pharmacy benefits manager, the PSS manages the dispensing of pharmaceuticals through the Company's mail order pharmacies and national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies and 27,000 independent pharmacies, to eligible members in the benefits plans maintained by the Company's clients and utilizes its information systems to perform, among other things, safety checks, drug interaction screenings and brand to generic substitutions.

The PSS' specialty pharmacies support individuals that require complex and expensive drug therapies. The specialty pharmacy business includes mail order and retail specialty pharmacies that operate under the CVS Caremark ®, CarePlus CVS Pharmacy ™, Navarro ® Health Services and Advanced Care Scripts ("ACS Pharmacy") names. In January 2014, the Company enhanced its offerings of specialty infusion services and began offering enteral nutrition services through Coram LLC and its subsidiaries (collectively, "Coram"). In August 2015, the Company further expanded its specialty offerings with the acquisition of ACS Pharmacy which was part of the Omnicare, Inc. ("Omnicare") acquisition. See Note 2 "Acquisitions."

The PSS also provides health management programs, which include integrated disease management for 18 conditions, through the Company's Accordant ® rare disease management offering.

In addition, through the Company's SilverScript Insurance Company ("SilverScript") subsidiary, the PSS is a national provider of drug benefits to eligible beneficiaries under the federal government's Medicare Part D program.

The PSS generates net revenues primarily by contracting with clients to provide prescription drugs to plan members. Prescription drugs are dispensed by the mail order pharmacies, specialty pharmacies and national network of retail pharmacies. Net revenues are also generated by providing additional services to clients, including administrative services such as claims processing and formulary management, as well as health care related services such as disease management.

The PSS operates under the CVS Caremark ® Pharmacy Services, Caremark ®, CVS Caremark ™, CarePlus CVS Pharmacy ™, Accordant ®, SilverScript ®, Coram ®, CVS Specialty ™, NovoLogix ®, Navarro ® Health Services and ACS Pharmacy names. As of December 31, 2016, the PSS operated 23 retail specialty pharmacy stores, 13 specialty mail order pharmacies and four mail order dispensing pharmacies, and 84 branches for infusion and enteral services, including 73 ambulatory infusion suites and three centers of excellence, located in 41 states, Puerto Rico and the District of Columbia.

Retail/LTC Segment (the "RLS") - The RLS sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products and cosmetics, personal care products, convenience foods, photo finishing services, seasonal merchandise, and greeting cards, through the Company's CVS Pharmacy ®, CVS ®, CVS Pharmacy y más ®, Longs Drugs ®, Navarro Discount Pharmacy ® and Drogaria Onofre ™ retail stores and online through CVS.com ®, Navarro.com and Onofre.com.br.

The RLS also provides health care services through its MinuteClinic ® health care clinics. MinuteClinics are staffed by nurse practitioners and physician assistants who utilize nationally recognized protocols to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions and deliver vaccinations.

With the acquisition of Omnicare, the RLS now provides long-term care ("LTC") operations, which is comprised of providing the distribution of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings, as well as commercialization services which are provided under the name RxCrossroads ®. With the December

2015 acquisition of the pharmacies and clinics of Target Corporation ("Target"), the Company added 1,672 pharmacies and approximately 79 clinics.

As of December 31, 2016, the retail pharmacy business included 9,709 retail stores (of which 7,980 were our stores that operated a pharmacy and 1,674 were our pharmacies located within a Target store) located in 49 states, the District of Columbia, Puerto Rico and Brazil operating primarily under the CVS Pharmacy, CVS, CVS Pharmacy y más ®, Longs Drugs, Navarro Discount Pharmacy and Drogaria Onofre names, the online retail websites, CVS.com, Navarro.com and Onofre.com.br, and 1,139 retail health care clinics operating under the MinuteClinic name (of which 1,053 were located in our retail pharmacy stores, 79 were located in Target stores and seven were located in corporate campuses or other locations). LTC operations is comprised of 152 spoke pharmacies that primarily handle new prescription orders and 32 hub pharmacies that use proprietary automation to support spoke pharmacies with refill prescriptions. LTC operates primarily under the Omnicare ® and NeighborCare ® names.

Corporate Segment - The Corporate Segment provides management and administrative services to support the Company. The Corporate Segment consists of certain aspects of the Company's executive management, corporate relations, legal, compliance, human resources, information technology and finance departments.

Principles of consolidation - The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

The Company continually evaluates its investments to determine if they represent variable interests in a VIE. If the Company determines that it has a variable interest in a VIE, the Company then evaluates if it is the primary beneficiary of the VIE. The evaluation is a qualitative assessment as to whether the Company has the ability to direct the activities of a VIE that most significantly impact the entity's economic performance. The Company consolidates a VIE if it is considered to be the primary beneficiary.

Assets and liabilities of VIEs for which the Company is the primary beneficiary were not significant to the Company's consolidated financial statements. VIE creditors do not have recourse against the general credit of the Company.

Use of estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Fair value hierarchy - The Company utilizes the three-level valuation hierarchy for the recognition and disclosure of fair value measurements. The categorization of assets and liabilities within this hierarchy is based upon the lowest level of input that is significant to the measurement of fair value. The three levels of the hierarchy consist of the following:

- Level 1 - Inputs to the valuation methodology are unadjusted quoted prices in active markets for identical assets or liabilities that the Company has the ability to access at the measurement date.

- Level 2 - Inputs to the valuation methodology are quoted prices for similar assets and liabilities in active markets, quoted prices in markets that are not active or inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the instrument.

- Level 3 - Inputs to the valuation methodology are unobservable inputs based upon management's best estimate of inputs market participants could use in pricing the asset or liability at the measurement date, including assumptions about risk.

Cash and cash equivalents - Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash. These investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices.

Short-term investments - The Company's short-term investments consist of certificates of deposit with initial maturities of greater than three months when purchased that mature in less than one year from the balance sheet date. These investments, which were classified as available-for-sale within Level 1 of the fair value hierarchy, were carried at fair value, which approximated their historical cost at December 31, 2016 and 2015.

Fair value of financial instruments - As of December 31, 2016, the Company's financial instruments include cash and cash equivalents, short-term and long-term investments, accounts receivable, accounts payable, contingent consideration liability and short-term debt. Due to the nature of these instruments, the Company's carrying value approximates fair value. The carrying amount and estimated fair value of total long-term debt was $25.7 billion and $26.5 billion , respectively, as of December 31, 2016. The fair value of the Company's long-term debt was estimated based on quoted rates currently offered in active markets for the Company's debt, which is considered Level 1 of the fair value hierarchy. There were no outstanding derivative financial instruments as of December 31, 2016 and 2015.

Foreign currency translation and transactions - For local currency functional currency, assets and liabilities are translated at end-of-period rates while revenues and expenses are translated at average rates in effect during the period. Equity is translated at historical rates and the resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for non-monetary balance sheet accounts, which are remeasured at historical exchange rates. Revenue and expense are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts, which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in income.

Gains and losses arising from foreign currency transactions and the effects of remeasurements were not material for all periods presented.

Accounts receivable - Accounts receivable are stated net of an allowance for doubtful accounts. The accounts receivable balance primarily includes amounts due from third party providers (e.g., pharmacy benefit managers, insurance companies, governmental agencies and long-term care facilities), clients, members and private pay customers, as well as vendors and manufacturers. Charges to bad debt are based on both historical write-offs and specifically identified receivables.

The activity in the allowance for doubtful accounts receivable for the years ended December 31 is as follows:

In millions	**2016**	**2015**	**2014**
Beginning balance	$ 161	$ 256	$ 256
Additions charged to bad debt expense	221	216	185
Write-offs charged to allowance	(96)	(311)	(185)
Ending balance	$ 286	$ 161	$ 256

Inventories - Inventories are stated at the lower of weighted average cost or market. Physical inventory counts are taken on a regular basis in each retail store and long-term care pharmacy and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current trends.

Property and equipment - Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 10 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

The following are the components of property and equipment at December 31:

In millions	2016	2015
Land	$ 1,734	$ 1,635
Building and improvements	3,226	3,168
Fixtures and equipment	10,956	10,001
Leasehold improvements	4,494	4,015
Software	2,392	2,217
	22,802	21,036
Accumulated depreciation and amortization	(12,627)	(11,181)
Property and equipment, net	$ 10,175	$ 9,855

The gross amount of property and equipment under capital leases was $547 million and $528 million as of December 31, 2016 and 2015, respectively. Accumulated amortization of property and equipment under capital lease was $119 million and $97 million as of December 31, 2016 and 2015, respectively. Amortization of property and equipment under capital lease is included within depreciation expense. Depreciation expense totaled $1.7 billion in 2016, $1.5 billion in 2015 and $1.4 billion in 2014.

Goodwill and other indefinitely-lived assets - Goodwill and other indefinitely-lived assets are not amortized, but are subject to impairment reviews annually, or more frequently if necessary. See Note 3 “Goodwill and Other Intangibles” for additional information on goodwill and other indefinitely-lived assets.

Intangible assets - Purchased customer contracts and relationships are amortized on a straight-line basis over their estimated useful lives between 9 and 20 years. Purchased customer lists are amortized on a straight-line basis over their estimated useful lives of up to 10 years. Purchased leases are amortized on a straight-line basis over the remaining life of the lease. See Note 3 “Goodwill and Other Intangibles” for additional information about intangible assets.

Impairment of long-lived assets - The Company groups and evaluates fixed and finite-lived intangible assets for impairment at the lowest level at which individual cash flows can be identified, whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group’s estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group’s carrying value that exceeds the asset group’s estimated future cash flows (discounted and with interest charges).

Redeemable noncontrolling interest - As a result of the acquisition of Omnicare in August 2015, the Company obtained a 73% ownership interest in limited liability company (“LLC”). Due to the change in control in Omnicare, the noncontrolling member of the LLC had the contractual right to put its membership interest to the Company at fair value. Consequently, the noncontrolling interest in the LLC was recorded as a redeemable noncontrolling interest at fair value. During 2016, the noncontrolling shareholder of the LLC exercised its option to sell its ownership interest and the Company purchased the noncontrolling interest in the LLC for approximately $39 million .

Below is a summary of the changes in redeemable noncontrolling interest for the years ended December 31:

In millions	2016	2015
Beginning balance	$ 39	$ —
Acquisition of noncontrolling interest	—	39
Net income attributable to noncontrolling interest	1	1
Distributions	(2)	(1)
Purchase of noncontrolling interest	(39)	—
Reclassification to capital surplus in connection with purchase of noncontrolling interest	1	—
Ending balance	$ —	$ 39

Revenue Recognition

Pharmacy Services Segment

The PSS sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through its retail pharmacy network. The PSS recognizes revenue from prescription drugs sold by its mail service dispensing pharmacies and under retail pharmacy network contracts where it is the principal using the gross method at the contract prices negotiated with its clients. Net revenues include: (i) the portion of the price the client pays directly to the PSS, net of any volume-related or other discounts paid back to the client (see "Drug Discounts" below), (ii) the price paid to the PSS by client plan members for mail order prescriptions ("Mail Co-Payments") and the price paid to retail network pharmacies by client plan members for retail prescriptions ("Retail Co-Payments"), and (iii) administrative fees for retail pharmacy network contracts where the PSS is not the principal as discussed below. Sales taxes are not included in revenue.

Revenue is recognized when: (i) persuasive evidence of an arrangement exists, (ii) delivery has occurred or services have been rendered, (iii) the seller's price to the buyer is fixed or determinable, and (iv) collectability is reasonably assured. The following revenue recognition policies have been established for the PSS:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription is delivered. At the time of delivery, the PSS has performed substantially all of its obligations under its client contracts and does not experience a significant level of returns or reshipments.

- Revenues generated from prescription drugs sold by third party pharmacies in the PSS' retail pharmacy network and associated administrative fees are recognized at the PSS' point-of-sale, which is when the claim is adjudicated by the PSS online claims processing system.

The PSS determines whether it is the principal or agent for its retail pharmacy network transactions on a contract by contract basis. In the majority of its contracts, the PSS has determined it is the principal due to it: (i) being the primary obligor in the arrangement, (ii) having latitude in establishing the price, changing the product or performing part of the service, (iii) having discretion in supplier selection, (iv) having involvement in the determination of product or service specifications, and (v) having credit risk. The PSS' obligations under its client contracts for which revenues are reported using the gross method are separate and distinct from its obligations to the third party pharmacies included in its retail pharmacy network contracts. Pursuant to these contracts, the PSS is contractually required to pay the third party pharmacies in its retail pharmacy network for products sold, regardless of whether the PSS is paid by its clients. The PSS' responsibilities under its client contracts typically include validating eligibility and coverage levels, communicating the prescription price and the co-payments due to the third party retail pharmacy, identifying possible adverse drug interactions for the pharmacist to address with the prescriber prior to dispensing, suggesting generic alternatives where clinically appropriate and approving the prescription for dispensing. Although the PSS does not have credit risk with respect to Retail Co-Payments or inventory risk related to retail network claims, management believes that all of the other applicable indicators of gross revenue reporting are present. For contracts under which the PSS acts as an agent, revenue is recognized using the net method.

Drug Discounts - The PSS deducts from its revenues any rebates, inclusive of discounts and fees, earned by its clients. Rebates are paid to clients in accordance with the terms of client contracts, which are normally based on fixed rebates per prescription for specific products dispensed or a percentage of manufacturer discounts received for specific products dispensed. The liability for rebates due to clients is included in "Claims and discounts payable" in the accompanying consolidated balance sheets.

Medicare Part D - The PSS, through its SilverScript subsidiary, participates in the federal government's Medicare Part D program as a Prescription Drug Plan ("PDP"). Net revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with the Centers for Medicare and Medicaid Services ("CMS"). The insurance premiums include a direct premium paid by CMS and a beneficiary premium, which is the responsibility of the PDP member, but which is subsidized by CMS in the case of low-income members. Premiums collected in advance are initially deferred in accrued expenses and are then recognized in net revenues over the period in which members are entitled to receive benefits.

In addition to these premiums, net revenues include co-payments, coverage gap benefits, deductibles and co-insurance (collectively, the "Member Co-Payments") related to PDP members' actual prescription claims. In certain cases, CMS subsidizes a portion of these Member Co-Payments and pays the PSS an estimated prospective Member Co-Payment subsidy amount each month. The prospective Member Co-Payment subsidy amounts received from CMS are also included in net revenues. SilverScript assumes no risk for these amounts. If the prospective Member Co-Payment subsidies received differ

from the amounts based on actual prescription claims, the difference is recorded in either accounts receivable or accrued expenses.

The PSS accounts for CMS obligations and Member Co-Payments (including the amounts subsidized by CMS) using the gross method consistent with its revenue recognition policies for Mail Co-Payments and Retail Co-Payments (discussed previously in this document).

Retail/LTC Segment

Retail Pharmacy - The retail drugstores recognize revenue at the time the customer takes possession of the merchandise. Customer returns are not material. Revenue generated from the performance of services in the RLS' health care clinics is recognized at the time the services are performed. Sales taxes are not included in revenue.

Long-term Care - Revenue is recognized when products are delivered or services are rendered or provided to the customer, prices are fixed and determinable, and collection is reasonably assured. A significant portion of the revenues from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. Payments for services rendered to patients covered by these programs are generally less than billed charges. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and record an estimated contractual allowance for sales and receivable balances at the revenue recognition date, to properly account for anticipated differences between billed and reimbursed amounts. Accordingly, the total net sales and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors. Since billing functions for a portion of the Company's revenue systems are largely computerized, enabling on-line adjudication at the time of sale to record net revenues, the Company's exposure in connection with estimating contractual allowance adjustments is limited primarily to unbilled and initially rejected Medicare, Medicaid and third party claims (typically approved for reimbursement once additional information is provided to the payor). For the remaining portion of the Company's revenue systems, the contractual allowance is estimated for all billed, unbilled and initially rejected Medicare, Medicaid and third party claims. The Company evaluates several criteria in developing the estimated contractual allowances on a monthly basis, including historical trends based on actual claims paid, current contract and reimbursement terms, and changes in customer base and payor/product mix. Contractual allowance estimates are adjusted to actual amounts as cash is received and claims are settled, and the aggregate impact of these resulting adjustments was not significant to our results of operations for any of the periods presented.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors are typically not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of our normal billing procedures and subject to our normal accounts receivable collections procedures.

Health Care Clinics - For services provided by our health care clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Loyalty Program - The Company's customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings coupons redeemed by customers are recorded as a reduction of revenue when redeemed. ExtraBucks Rewards are accrued as a charge to cost of revenues when earned, net of estimated breakage. The Company determines breakage based on historical redemption patterns.

See Note 12 "Segment Reporting" for additional information about the revenues of the Company's business segments.

Cost of revenues

Pharmacy Services Segment - The PSS' cost of revenues includes: (i) the cost of prescription drugs sold during the reporting period directly through its mail service dispensing pharmacies and indirectly through its retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of its mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of revenues includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the PSS' mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor allowances and purchase discounts" below) and (ii) the cost of prescription drugs sold (including Retail Co-Payments) through the PSS' retail pharmacy network under contracts where it is the principal, net of any volume-related or other discounts.

Retail/LTC Segment - The RLS' cost of revenues includes: the cost of merchandise sold during the reporting period and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

See Note 12 "Segment Reporting" for additional information about the cost of revenues of the Company's business segments.

Vendor allowances and purchase discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment - The PSS receives purchase discounts on products purchased. The PSS' contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the PSS to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices, or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the PSS' results of operations. The PSS accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The PSS also receives additional discounts under its wholesaler contracts if it exceeds contractually defined annual purchase volumes. In addition, the PSS receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of "Cost of revenues".

Retail/LTC Segment - Vendor allowances received by the RLS reduce the carrying cost of inventory and are recognized in cost of revenues when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of revenues over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of revenues on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the accompanying consolidated financial statements.

Insurance - The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience.

Facility opening and closing costs - New facility opening costs, other than capital expenditures, are charged directly to expense when incurred. When the Company closes a facility, the present value of estimated unrecoverable costs, including the remaining lease obligation less estimated sublease income and the book value of abandoned property and equipment, are charged to expense. The long-term portion of the lease obligations associated with facility closings was $181 million and $217 million in 2016 and 2015, respectively.

Advertising costs - Advertising costs are expensed when the related advertising takes place. Advertising costs, net of vendor funding (included in operating expenses), were $216 million , $221 million and $212 million in 2016, 2015 and 2014, respectively.

Interest expense, net - The following are the components of net interest expense for the years ended December 31:

In millions	**2016**	**2015**	**2014**
Interest expense	$ 1,078	$ 859	$ 615
Interest income	(20)	(21)	(15)
Interest expense, net	$ 1,058	$ 838	$ 600

Capitalized interest totaled $13 million , $12 million and $19 million in 2016, 2015 and 2014, respectively.

Shares held in trust - The Company maintains grantor trusts, which held approximately one million shares of its common stock at December 31, 2016 and 2015, respectively. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Accumulated other comprehensive income - Accumulated other comprehensive income (loss) consists of changes in the net actuarial gains and losses associated with pension and other postretirement benefit plans, losses on derivatives from cash flow hedges executed in previous years associated with the issuance of long-term debt, and foreign currency translation adjustments. The amount included in accumulated other comprehensive loss related to the Company's pension and postretirement plans was $284 million pre-tax ($173 million after-tax) as of December 31, 2016 and $305 million pre-tax ($186 million after-tax) as of December 31, 2015. The net impact on cash flow hedges totaled $9 million pre-tax ($5 million after-tax) and $14 million pre-tax ($7 million after-tax) as of December 31, 2016 and 2015, respectively. Cumulative foreign currency translation adjustments at December 31, 2016 and 2015 were $127 million and $165 million , respectively.

Changes in accumulated other comprehensive income (loss) by component are shown below:

	Year Ended December 31, 2016 [1]			
In millions	**Foreign Currency**	**Losses on Cash Flow Hedges**	**Pension and Other Postretirement Benefits**	**Total**
Balance, December 31, 2015	$ (165)	$ (7)	$ (186)	$ (358)
Other comprehensive income before reclassifications	38	—	—	38
Amounts reclassified from accumulated other comprehensive income [2]	—	2	13	15
Net other comprehensive income	38	2	13	53
Balance, December 31, 2016	$ (127)	$ (5)	$ (173)	$ (305)

	Year Ended December 31, 2015 [1]			
	Foreign Currency	**Losses on Cash Flow Hedges**	**Pension and Other Postretirement Benefits**	**Total**
Balance, December 31, 2014	$ (65)	$ (9)	$ (143)	$ (217)
Other comprehensive income (loss) before reclassifications	(100)	—	(56)	(156)
Amounts reclassified from accumulated other comprehensive income [2]	—	2	13	15
Net other comprehensive income (loss)	(100)	2	(43)	(141)
Balance, December 31, 2015	$ (165)	$ (7)	$ (186)	$ (358)

(1) All amounts are net of tax.

(2) The amounts reclassified from accumulated other comprehensive income for cash flow hedges are recorded within interest expense, net on the consolidated statement of income. The amounts reclassified from accumulated other comprehensive income for pension and other postretirement benefits are included in operating expenses on the consolidated statement of income.

Stock-based compensation - Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the applicable requisite service period of the stock award (generally 3 to 5 years) using the straight-line method.

Variable interest entity - In July 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50% . The Red Oak arrangement has an initial term of ten years . Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company and minimal funding was provided to capitalize Red Oak.

The Company has determined that it is the primary beneficiary of this variable interest entity because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC Segment.

Cardinal is required to pay the Company 39 quarterly payments beginning in October 2014. As milestones are met, the quarterly payments increase. The Company received approximately $163 million , $122 million and $26 million from Cardinal during the years ended December 31, 2016, 2015 and 2014, respectively. The payments reduce the Company's carrying value of inventory and are recognized in cost of revenues when the related inventory is sold. Revenues associated with Red Oak expenses reimbursed by Cardinal for the years ended December 31, 2016, 2015 and 2014, as well as amounts due to or due from Cardinal at December 31, 2016 and 2015 were immaterial.

Related party transactions - The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. The Pharmacy Services and Retail/LTC segments utilize this clinical health information network in providing services to its client plan members and retail customers. The Company expensed fees of approximately $39 million in the year ended December 31, 2016, and $50 million in the years ended December 31, 2015 and 2014, for the use of this network. The Company's investment in and equity in earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services ("Heartland"). Heartland operates several long-term care pharmacies in four states. Heartland paid the Company approximately $140 million and $25 million for pharmaceutical inventory purchases during the years ended December 31, 2016 and 2015, respectively. Additionally, the Company performs certain collection functions for Heartland and then passes those customer cash collections to Heartland. The Company's investment in and equity in earnings of Heartland as of and for the years ended December 31, 2016 and 2015 is immaterial.

In 2016 and 2014, the Company made charitable contributions of $32 million and $25 million , respectively, to the CVS Foundation (the "Foundation") to fund future giving. The Foundation is a non-profit entity managed by employees of the Company that focuses on health, education and community involvement programs. The charitable contributions were recorded as operating expenses in the Company's consolidated statements of income for the years ended December 31, 2016 and 2014.

Income taxes - The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date.

The Company recognizes net deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and results of recent operations. To the extent that the Company does not consider it more likely than not that a deferred tax asset will be recovered, a valuation allowance is established.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in income tax expense.

Discontinued operations - In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Bob's Stores and Linens 'n Things which filed for bankruptcy in 2016 and 2008, respectively. The Company's loss from discontinued operations in 2016 and 2014 includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its lease guarantees. The Company's income from discontinued operations in 2015 of $9 million , net of tax, was related to the release of certain store lease guarantees due to a settlement with a landlord.

Below is a summary of the results of discontinued operations for the years ended December 31:

In millions	2016	2015	2014
Income (loss) from discontinued operations	$ (2)	$ 15	$ (1)
Income tax expense	1	(6)	—
Income (loss) from discontinued operations, net of tax	$ (1)	$ 9	$ (1)

Earnings per common share - Earnings per share is computed using the two-class method. Options to purchase 6.7 million , 2.7 million and 2.1 million shares of common stock were outstanding as of December 31, 2016, 2015 and 2014, respectively, but were not included in the calculation of diluted earnings per share because the options' exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive.

New accounting pronouncements - In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers* (Topic 606). ASU 2014-09 outlines a single comprehensive model for companies to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance. In March 2016, the FASB issued ASU 2016-08, " *Principal Versus Agent Considerations (Reporting Revenue Gross Versus Net)* ," which amends the principal-versus-agent implementation guidance and in April 2016 the FASB issued ASU 2016-10, " *Identifying Performance Obligations and Licensing* ," which amends the guidance in those areas in the new revenue recognition standard. Both ASU's were issued in response to feedback received from the FASB-International Accounting Standards Board joint revenue recognition transition resource group. This new standard could impact the timing and amounts of revenue recognized. The new revenue standard is effective for annual reporting periods (including interim reporting periods within those periods) beginning January 1, 2018. Early adoption of the standard in 2017 is permitted; however, the Company does not intend to early adopt the new standard. Companies have the option of using either a full retrospective or a modified retrospective approach to adopt the guidance. The Company formed a project team to assess and implement the new standard. While the Company is continuing to assess all of the potential impacts of the new standard including the potential impact from recent acquisitions, the Company does not expect the implementation of the standard will have a material effect on the Company's consolidated results of operations, cash flows or financial position. The Company intends to adopt the new standard on a modified retrospective basis.

In July 2015, the FASB issued ASU 2015-11, *Inventory* , which amends ASU Topic 330. This ASU simplifies current accounting treatments by requiring entities to measure most inventories at "the lower of cost and net realizable value" rather than using lower of cost or market. This guidance does not apply to inventories measured using the last-in, first-out method or the retail inventory method. This ASU is effective prospectively for annual periods beginning after December 15, 2016 and interim periods thereafter with early adoption permitted. Upon transition, entities must disclose the accounting change. The Company is evaluating the effect of adopting this new accounting guidance but does not expect the adoption will have a material impact on the Company's results of operations, financial position or cash flows.

In November 2015, the FASB issued ASU 2015-17, *Income Taxes* (Topic 740). The new guidance simplifies the presentation of deferred income taxes by requiring that deferred tax assets and liabilities be classified as noncurrent in a classified statement of financial position. The updated standard is effective for the Company beginning on January 1, 2017 with early application permitted as of the beginning of any interim or annual reporting period. The Company elected to early adopt this standard as of January 1, 2016 and has, accordingly, reclassified the current deferred tax assets to noncurrent deferred tax liabilities for all periods presented. The following is a reconciliation of the effect of the reclassification on the Company's consolidated balance sheet as of December 31, 2015 :

In millions	As Previously Reported	Adjustments	As Revised
Deferred tax assets - current	$ 1,220	$ (1,220)	$ —
Total current assets	30,378	(1,220)	29,158
Total assets	93,657	(1,220)	92,437
Deferred tax liabilities - noncurrent	5,437	(1,220)	4,217
Total liabilities and shareholders' equity	93,657	(1,220)	92,437

In February 2016, the FASB issued ASU 2016-02, *Leases* (Topic 842). Lessees will be required to recognize a right-of-use asset and a lease liability for virtually all of their leases (other than leases that meet the definition of a short-term lease). The liability will be equal to the present value of lease payments. The asset will be based on the liability, subject to adjustment, such

as for initial direct costs. For income statement purposes, a dual model was retained, requiring leases to be classified as either operating or finance leases. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). Lessor accounting is similar to the current model, but updated to align with certain changes to the lessee model (e.g., certain definitions, such as initial direct costs, have been updated) and the new revenue recognition standard. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2018. Early adoption is permitted. The Company believes that the new standard will have a material impact on its consolidated balance sheet. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial position and related disclosures.

In March 2016, the FASB issued ASU No. 2016-09, *Improvements to Employee Share-Based Payment Accounting* , which amends Accounting Standard Codification Topic 718, *Compensation - Stock Compensation* , in three areas. (1) The new guidance eliminates accounting for tax benefits and deficiencies through equity to the extent of previous windfalls, and then to the income statement. The new requirement is to record all tax benefits and deficiencies through the income statement. This amendment is required to be applied prospectively. The amendment also requires the presentation of excess tax benefits on the statements of cash flows as operating activities, a change which may be applied prospectively or retrospectively at the election of the Company. The amendment requires the presentation of employee taxes paid on the statement of cash flows when an employer withholds shares for tax withholding purposes as financing activities, a change which must be applied retrospectively. (2) The new guidance also permits companies to withhold an amount up to the employees' maximum individual tax rate in the relevant jurisdiction without resulting in liability classification of the award. (3) Finally, the new guidance provides companies with an accounting policy election for the impact of forfeitures on the recognition of expense for share-based payment awards. Forfeitures can be estimated, as required today, or recognized when they occur. If elected, the change to recognize forfeitures when they occur needs to be adopted using a modified retrospective approach, with a cumulative effect adjustment recorded to beginning retained earnings. The ASU is effective for annual reporting periods beginning after December 15, 2016, including interim periods within that annual reporting period. The Company is currently evaluating the effect of adopting this new accounting guidance.

In August 2016, the FASB issued ASU No. 2016-15, *Classification of Certain Cash Receipts and Cash Payments.* ASU 2016-15 is intended to add or clarify guidance on the classification of certain cash receipts and payments in the statement of cash flows and to eliminate the diversity in practice related to such classifications. The guidance in ASU 2016-15 is required for annual reporting periods beginning after December 15, 2017, with early adoption permitted. The Company is currently evaluating the effect on its consolidated statement of cash flows of adopting this new accounting guidance.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows* , which amends ASU Topic 230. This ASU requires entities to show the changes in the total of cash, cash equivalents, restricted cash and restricted cash equivalents in the statement of cash flows. As a result, entities will no longer be required to present transfers between cash and cash equivalents and restricted cash and restricted cash equivalents in the statement of cash flows. When cash, cash equivalents, restricted cash and restricted cash equivalents are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Entities will also have to disclose the nature of their restricted cash and restricted cash equivalent balances. The guidance is effective for fiscal years beginning after December 15, 2017 and interim periods within those years. Early adoption is permitted. Entities are required to apply the guidance retrospectively. The Company is currently evaluating the effect of adopting this new accounting guidance.

2 Acquisitions

Omnicare Acquisition

On August 18, 2015 , the Company acquired 100% of the outstanding common shares and voting interests of Omnicare, for $98 per share for a total of $9.6 billion and assumed long-term debt with a fair value of approximately $3.1 billion . Omnicare is a leading health care services company that specializes in the management of complex pharmaceutical care. Omnicare’s long-term care (“LTC”) business is the nation’s largest provider of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. In addition, Omnicare has a specialty pharmacy business operating primarily under the name of ACS Pharmacy, and provides commercialization services under the name of RxCrossroads ® . The Company includes LTC and the commercialization services business in the Retail/LTC Segment, and includes the specialty pharmacy business in its Pharmacy Services Segment. The Company acquired Omnicare to expand its operations in dispensing prescription drugs to assisted-living and long-term care facilities, and to broaden its presence in the specialty pharmacy business as the Company seeks to serve a greater percentage of the growing senior patient population in the United States.

The following table summarizes the fair values of the assets acquired and liabilities assumed at the date of acquisition:

(In millions)	
Current assets (including cash of $298)	$ 1,657
Property and equipment	313
Goodwill	9,139
Intangible assets	3,962
Other noncurrent assets	63
Current liabilities	(773)
Long-term debt	(3,110)
Deferred income tax liabilities	(1,498)
Other noncurrent liabilities	(69)
Redeemable noncontrolling interest	(39)
Total consideration	$ 9,645

The goodwill represents future economic benefits expected to arise from the Company's expanded presence in the pharmaceutical care market, the assembled workforce acquired, expected purchasing and revenue synergies, as well as operating efficiencies and cost savings. Goodwill of $8.7 billion was allocated to the Retail/LTC Segment and the remaining goodwill of $0.4 billion was allocated to the Pharmacy Services Segment. Approximately $0.4 billion of the goodwill is deductible for income tax purposes. Intangible assets acquired include customer relationships and trade names of $3.9 billion and $74 million , respectively, with estimated weighted average useful lives of 19.1 and 2.9 years, respectively, and 18.8 years in total.

During the year ended December 31, 2015, the Company incurred transaction costs of $70 million associated with the acquisition of Omnicare that were recorded within operating expenses.

The Company's consolidated results of operations for the year ended December 31, 2015, include $2.6 billion of net revenues and net income of $61 million associated with the operating results of Omnicare from August 18, 2015 to December 31, 2015. These Omnicare operating results include severance costs and accelerated stock-based compensation.

The following unaudited pro forma information presents a summary of the Company's combined results of operations for the years ended December 31, 2015 and 2014 as if the Omnicare acquisition and the related financing transactions had occurred on January 1, 2014. The following pro forma financial information is not necessarily indicative of the results of operations as they would have been had the transactions been effected on the assumed date, nor is it necessarily an indication of trends in future results for a number of reasons, including, but not limited to, differences between the assumptions used to prepare the pro forma information, basic shares outstanding and dilutive equivalents, cost savings from operating efficiencies, potential synergies, and the impact of incremental costs incurred in integrating the businesses.

	Year Ended December 31,	
(In millions, except per share data)	2015	2014
Total revenues	$ 156,798	$ 144,836
Income from continuing operations	5,277	4,522
Basic earnings per share from continuing operations	$ 4.70	$ 3.88
Diluted earnings per share from continuing operations	$ 4.66	$ 3.85

Pro forma income from continuing operations for the year ended December 31, 2015, excludes $135 million related to severance costs, accelerated stock-based compensation and transaction costs incurred in connection with the Omnicare acquisition. Pro forma income from continuing operations for the year ended December 31, 2014, includes a $521 million loss on the early extinguishment of debt recorded by CVS Health.

Target Pharmacy Acquisition

On December 16, 2015 , the Company acquired the pharmacy and clinic businesses of Target for approximately $1.9 billion , plus contingent consideration of up to $60 million based on future prescription growth over a three year period. The Company acquired Target's 1,672 pharmacies which operate in 47 states and will operate them through a store-within-a-store format, branded as CVS Pharmacy. The Company also acquired 79 Target clinic locations which were rebranded as MinuteClinic. The Company acquired the Target pharmacy and clinic businesses primarily to expand the geographic reach of its retail pharmacy business.

The fair values of the assets acquired at the date of acquisition were approximately as follows:

In millions		
Accounts receivable	$	2
Inventories		467
Property and equipment		9
Intangible assets		490
Goodwill		900
Total cash consideration	$	1,868

Intangible assets acquired include customer relationships with an estimated useful life of 13 years. The goodwill represents future economic benefits expected to arise from the Company's expanded geographic presence in the retail pharmacy market, the assembled workforce acquired, expected purchasing and revenue synergies, as well as operating efficiencies and cost savings. The goodwill is deductible for income tax purposes. No liability for any potential contingent consideration has been recorded based on current projections for future prescription growth over the relevant period.

In connection with the closing of the transaction, the Company and Target entered into pharmacy and clinic operating and master lease agreements. See Note 6 "Leases" of the consolidated financial statements for disclosures of the Company's leasing arrangements.

During the year ended December 31, 2015, the Company incurred transaction costs of approximately $26 million associated with the acquisition that were recorded within operating expenses. The results of the Target pharmacies and clinics are included in the Company's Retail/LTC Segment beginning on December 16, 2015 . Pro forma financial information for this acquisition is not presented as such results are immaterial to the Company's consolidated financial statements.

3 Goodwill and Other Intangibles

Goodwill and other indefinitely-lived assets are not amortized, but are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate an impairment may exist.

When evaluating goodwill for potential impairment, the Company first compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a future discounted cash flow valuation model and a comparable market transaction model. If the estimated fair value of the reporting unit is less than its carrying amount, an impairment loss calculation is prepared. The impairment loss calculation compares the implied fair value of a reporting unit's goodwill with the carrying amount of its goodwill. If the carrying amount of the goodwill exceeds the implied fair value, an impairment loss is recognized in an amount equal to the excess. During the third quarter of 2016, the Company performed its required annual goodwill impairment tests. The Company concluded there were no goodwill impairments as of the testing date.

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2016 and 2015:

In millions	Pharmacy Services	Retail/LTC	Total
Balance, December 31, 2014	$ 21,234	$ 6,908	$ 28,142
Acquisitions	452	9,554	10,006
Foreign currency translation adjustments	—	(40)	(40)
Other [1]	(1)	(1)	(2)
Balance, December 31, 2015	21,685	16,421	38,106
Acquisitions	—	126	126
Foreign currency translation adjustments	—	17	17
Other [1]	(48)	48	—
Balance, December 31, 2016	$ 21,637	$ 16,612	$ 38,249

(1) "Other" represents immaterial purchase accounting adjustments for acquisitions.

Indefinitely-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinitely-lived trademark using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized and the asset is written down to its estimated fair value. During the third quarter of 2016, the Company performed its annual impairment test of the indefinitely-lived trademark and concluded there was no impairment as of the testing date. The carrying amount of its indefinitely-lived trademark was $6.4 billion as of December 31, 2016 and 2015.

The Company amortizes intangible assets with finite lives over the estimated useful lives of the respective assets, which have a weighted average useful life of 15.5 years. The weighted average useful life of the Company's customer contracts and relationships and covenants not to compete is 15.5 years. The weighted average life of the Company's favorable leases and other intangible assets is 15.9 years. Amortization expense for intangible assets totaled $795 million , $611 million and $518 million in 2016, 2015 and 2014, respectively. The anticipated annual amortization expense for these intangible assets for the next five years is as follows:

In millions	
2017	$ 780
2018	748
2019	704
2020	534
2021	473

The following table is a summary of the Company's intangible assets as of December 31:

	2016			2015		
In millions	**Gross Carrying Amount**	**Accumulated Amortization**	**Net Carrying Amount**	**Gross Carrying Amount**	**Accumulated Amortization**	**Net Carrying Amount**
Trademark (indefinitely-lived)	$ 6,398	$ —	$ 6,398	$ 6,398	$ —	$ 6,398
Customer contracts and relationships and covenants not to compete	11,485	(4,802)	6,683	10,594	(4,092)	6,502
Favorable leases and other	1,123	(693)	430	1,595	(617)	978
	$ 19,006	$ (5,495)	$ 13,511	$ 18,587	$ (4,709)	$ 13,878

4 Share Repurchase Programs

The following share repurchase programs were authorized by the Company's Board of Directors:

In billions Authorization Date	Authorized	Remaining
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 15.0
December 15, 2014 ("2014 Repurchase Program")	$ 10.0	$ 3.2
December 17, 2013 ("2013 Repurchase Program")	$ 6.0	$ —
September 19, 2012 ("2012 Repurchase Program")	$ 6.0	$ —

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2016 and 2014 Repurchase Programs may be modified or terminated by the Board of Directors at any time.

Pursuant to the authorization under the 2014 Repurchase Program, effective August 29, 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion . Upon payment of the $3.6 billion purchase price on January 6, 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares at a price of $80.34 per share, which were placed into treasury stock in January 2017. At the conclusion of the ASRs, the Company may receive additional shares equal to the remaining 20% of the $3.6 billion notional amount. The ultimate number of shares the Company may receive will fluctuate based on changes in the daily volume-weighted average price of the Company's stock over a period beginning on January 6, 2017 and ending on or before July 6, 2017. If the mean daily volume-weighted average price of the Company's common stock, less a discount (the "forward price"), during the ASRs falls below $80.34 per share, the Company will receive a higher number of shares from Barclays. If the forward price rises above $80.34 per share, the Company will either receive fewer shares from Barclays or, potentially have an obligation to Barclays which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASRs, the maximum number of shares that could be received or delivered is 90.1 million .

Pursuant to the authorization under the 2014 Repurchase Program, effective December 11, 2015, the Company entered into a $725 million fixed dollar ASR with Barclays. Upon payment of the $725 million purchase price on December 14, 2015, the Company received a number of shares of its common stock equal to 80% of the $725 million notional amount of the ASR or approximately 6.2 million shares. The initial 6.2 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in December 2015. The ASR was accounted for as an initial treasury stock transaction of $580 million and a forward contract of $145 million . The forward contract was classified as an equity instrument and was recorded within capital surplus on the consolidated balance sheet. On January 28, 2016, the Company received 1.4 million shares of common stock, representing the remaining 20% of the $725 million notional amount of the ASR, thereby concluding the ASR. The remaining 1.4 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in January 2016 and the forward contract was reclassified from capital surplus to treasury stock.

Pursuant to the authorization under the 2013 Repurchase Programs, effective January 2, 2015, the Company entered into a $2.0 billion fixed dollar ASR agreement with J.P. Morgan Chase Bank ("JP Morgan"). Upon payment of the $2.0 billion purchase price on January 5, 2015, the Company received a number of shares of its common stock equal to 80% of the $2.0 billion notional amount of the ASR agreement or approximately 16.8 million shares, which were placed into treasury stock in January 2015. On May 1, 2015, the Company received approximately 3.1 million shares of common stock, representing the remaining 20% of the $2.0 billion notional amount of the ASR, thereby concluding the ASR. The remaining 3.1 million shares of common stock delivered to the Company by JP Morgan were placed into treasury stock in May 2015. The ASR was accounted for as an initial treasury stock transaction of $1.6 billion and a forward contract of $0.4 billion . The forward contract was classified as an equity instrument and was initially recorded within capital surplus on the consolidated balance sheet and was reclassified to treasury stock upon the settlement of the ASR in May 2015.

In the ASR transactions described above, the initial repurchase of the shares and delivery of the remainder of the shares to conclude the ASR, resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

During the year ended December 31, 2016, the Company repurchased an aggregate of 47.5 million shares of common stock for approximately $4.5 billion under the 2014 Repurchase Program. As of December 31, 2016, there remained an aggregate of approximately $18.2 billion available for future repurchases under the 2016 and 2014 Repurchase Programs.

During the year ended December 31, 2015, the Company repurchased an aggregate of 48.0 million shares of common stock for approximately $5.0 billion under the 2013 and 2014 Repurchase Programs. As of December 31, 2015, there remained an aggregate of approximately $7.7 billion available for future repurchases under the 2014 Repurchase Program and the 2013 Repurchase Program was complete.

During the year ended December 31, 2014, the Company repurchased an aggregate of 51.4 million shares of common stock for approximately $4.0 billion under the 2013 and 2012 Repurchase Programs. As of December 31, 2014, there remained an aggregate of approximately $12.7 billion available for future repurchases under the 2014 and 2013 Repurchase Programs. As of December 31, 2014, the 2012 Repurchase Program was complete.

5 Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31:

In millions	2016	2015
Short-term debt		
Commercial paper	$ 1,874	$ —
Long-term debt		
1.2% senior notes due 2016	—	750
6.125% senior notes due 2016	—	421
5.75% senior notes due 2017	—	1,080
1.9% senior notes due 2018	2,250	2,250
2.25% senior notes due 2018	1,250	1,250
2.25% senior notes due 2019	850	850
6.6% senior notes due 2019	—	394
2.8% senior notes due 2020	2,750	2,750
4.75% senior notes due 2020	—	450
2.125% senior notes due 2021	1,750	—
4.125% senior notes due 2021	550	550
2.75% senior notes due 2022	1,250	1,250
3.5% senior notes due 2022	1,500	1,500
4.75% senior notes due 2022	399	400
4% senior notes due 2023	1,250	1,250
3.375% senior notes due 2024	650	650
5% senior notes due 2024	299	300
3.875% senior notes due 2025	2,828	3,000
2.875% senior notes due 2026	1,750	—
6.25% senior notes due 2027	372	453
3.25% senior exchange debentures due 2035	1	5
4.875% senior notes due 2035	652	2,000
6.125% senior notes due 2039	447	734
5.75% senior notes due 2041	133	493
5.3% senior notes due 2043	750	750
5.125% senior notes due 2045	3,500	3,500
Capital lease obligations	648	644
Other	23	20
Total debt principal	27,726	27,694
Debt premiums	33	39
Debt discounts and deferred financing costs	(228)	(269)
	27,531	27,464
Less:		
Short-term debt (commercial paper)	(1,874)	—
Current portion of long-term debt	(42)	(1,197)
Long-term debt	$ 25,615	$ 26,267

The Company had approximately $1.9 billion of commercial paper outstanding at a weighted average interest rate of 1.22% as of December 31, 2016. In connection with its commercial paper program, the Company maintains a $1.0 billion , five -year unsecured back-up credit facility, which expires on May 23, 2018, a $1.25 billion , five -year unsecured back-up credit facility, which expires on July 24, 2019, and a $1.25 billion , five -year unsecured back-up credit facility, which expires on July 1, 2020. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03% , regardless of usage. As of December 31, 2016, there were no borrowings outstanding under the back-up credit facilities.

On January 3, 2017, the Company entered into a $2.5 billion revolving credit facility. The credit facility allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03% , regardless of usage. The maximum available under the credit facility decreases by $750 million on both March 31, 2017 and June 30, 2017 and by $500 million on September 30, 2017. The credit facility expires on December 31, 2017.

On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the "2016 Notes") for total proceeds of approximately $3.5 billion , net of discounts and underwriting fees. The 2016 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

On May 16, 2016, the Company announced tender offers for (1) any and all of its 5.75% Senior Notes due 2017, its 6.60% Senior Notes due 2019 and its 4.75% Senior Notes due 2020 (collectively, the "Any and All Notes") and (2) up to $1.5 billion aggregate principal amount of its 6.25% Senior Notes due 2027, its 6.125% Senior Notes due 2039, its 5.75% Senior Notes due 2041, the 5.00% Senior Notes due 2024 issued by its wholly-owned subsidiary, Omnicare, Inc. ("Omnicare"), the 4.75% Senior Notes due 2022 issued by Omnicare, its 4.875% Senior Notes due 2035 and its 3.875% Senior Notes due 2025 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion . The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. The Company paid a premium of $486 million in excess of the debt principal in connection with the purchase of the Notes, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on the early extinguishment of debt of $542 million which was recorded in income from continuing operations in the consolidated statement of income for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. The Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of debt of $101 million during the year ended December 31, 2016.

The Company recorded a total loss on the early extinguishment of debt of $643 million which was recorded in the income from continuing operations in the consolidated statement of income for the year ended December 31, 2016.

On May 20, 2015, in connection with the acquisition of Omnicare, the Company entered into a $13 billion unsecured bridge loan facility. The Company paid approximately $52 million in fees in connection with the facility. The fees were capitalized and amortized as interest expense over the period the bridge facility was outstanding. The bridge loan facility expired on July 20, 2015 upon the Company's issuance of unsecured senior notes with an aggregate principal of $15 billion as discussed below. The bridge loan facility fees became fully amortized in July 2015.

On July 20, 2015, the Company issued an aggregate of $2.25 billion of 1.9% unsecured senior notes due 2018 ("2018 Notes"), an aggregate of $2.75 billion of 2.8% unsecured senior notes due 2020 ("2020 Notes"), an aggregate of $1.5 billion of 3.5% unsecured senior notes due 2022 ("2022 Notes"), an aggregate of $3 billion of 3.875% unsecured senior notes due 2025 ("2025 Notes"), an aggregate of $2 billion of 4.875% unsecured senior notes due 2035 ("2035 Notes"), and an aggregate of $3.5 billion of 5.125% unsecured senior notes due 2045 ("2045 Notes" and, together with the 2018 Notes, 2020 Notes, 2022 Notes, 2025 Notes and 2035 Notes, the "Notes") for total proceeds of approximately $14.8 billion , net of discounts and underwriting fees. The Notes pay interest semi-annually and contain redemption terms which allow or require the Company to redeem the Notes at a defined redemption price plus accrued and unpaid interest at the redemption date. The net proceeds of the Notes were used to fund the Omnicare acquisition and the acquisition of the pharmacies and clinics of Target. The remaining proceeds were used for general corporate purposes.

Upon the closing of the Omnicare acquisition in August 2015, the Company assumed the long-term debt of Omnicare that had a fair value of approximately $3.1 billion , $2.0 billion of which was previously convertible into Omnicare shares that holders were able to redeem subsequent to the acquisition. During the period from August 18, 2015 to December 31, 2015, all but $5

million of the $2.0 billion of previously convertible debt was redeemed and repaid and approximately $0.4 billion in Omnicare term debt assumed was repaid for total repayments of Omnicare debt of approximately $2.4 billion in 2015.

The remaining principal of the Omnicare debt assumed was comprised of senior unsecured notes with an aggregate principal amount of $700 million ($400 million of 4.75% senior notes due 2022 and $300 million of 5% senior notes due 2024). In September 2015, the Company commenced exchange offers for the 4.75% senior notes due 2022 and the 5% senior notes due 2024 to exchange all validly tendered and accepted notes issued by Omnicare for notes to be issued by the Company. This offer expired on October 20, 2015 and the aggregate principal amounts of $388 million of the 4.75% senior notes due 2022 and $296 million of the 5% senior notes due 2024 were validly tendered and exchanged for notes issued by the Company. The Company recorded this exchange transaction as a modification of the original debt instruments. Consequently, no gain or loss on extinguishment was recognized in the Company's consolidated income statement as a result of this exchange transaction and the issuance costs of the new debt were expensed as incurred.

On August 7, 2014, the Company issued $850 million of 2.25% unsecured senior notes due August 12, 2019 and $650 million of 3.375% unsecured senior notes due August 12, 2024 (collectively, the “2014 Notes”) for total proceeds of approximately $1.5 billion , net of discounts and underwriting fees. The 2014 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company’s option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2014 Notes were used for general corporate purposes and to repay certain corporate debt.

On August 7, 2014, the Company announced tender offers for any and all of the 6.25% Senior Notes due 2027, and up to a maximum amount of the 6.125% Senior Notes due 2039, the 5.75% Senior Notes due 2041 and the 5.75% Senior Notes due 2017, for up to an aggregate principal amount of $1.5 billion . On August 21, 2014, the Company increased the aggregate principal amount of the tender offers to $2.0 billion and completed the repurchase for the maximum amount on September 4, 2014. The Company paid a premium of $490 million in excess of the debt principal in connection with the tender offers, wrote off $26 million of unamortized deferred financing costs and incurred $5 million in fees, for a total loss on the early extinguishment of debt of $521 million . The loss was recorded in income from continuing operations in the consolidated statement of income for the year ended December 31, 2014.

During the year ended December 31, 2014, the Company repurchased the remaining $41 million of outstanding Enhanced Capital Advantage Preferred Securities (“ECAPS”) at par. The fees and write-off of deferred issuance costs associated with the early extinguishment of the ECAPS were immaterial.

The credit facilities, back-up credit facilities and unsecured senior notes contain customary restrictive financial and operating covenants. The covenants do not materially affect the Company’s financial or operating flexibility. As of December 31, 2016, the Company is in compliance with all debt covenants.

The following is a summary of the Company's required principal debt repayments, excluding unamortized debt discounts, deferred financing costs and debt premiums, due during each of the next five years and thereafter, as of December 31, 2016:

In millions		
2017	$	1,916
2018		3,521
2019		872
2020		2,774
2021		2,326
Thereafter		16,317
Total	$	27,726

6 Leases

The Company leases most of its retail and mail order locations, 11 of its distribution centers and certain corporate offices under noncancelable operating leases, typically with initial terms of 15 to 25 years and with options that permit renewals for additional periods. The Company also leases certain equipment and other assets under noncancelable operating leases, typically with initial terms of 3 to 10 years. In December 2015, in connection with the acquisition of the pharmacy and clinic businesses of Target, the Company entered into lease agreements with Target for the pharmacy and clinic space within Target stores. Given

that the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings being leased, the Company concluded for accounting purposes that the lease term was the remaining economic life of the buildings. Consequently, most of the individual pharmacy leases are capital leases. Approximately $0.3 billion of capital lease obligations were recorded in connection with this transaction.

Minimum rent on operating leases is expensed on a straight-line basis over the term of the lease. In addition to minimum rental payments, certain leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed when incurred.

The following table is a summary of the Company's net rental expense for operating leases for the years ended December 31:

In millions	**2016**	**2015**	**2014**
Minimum rentals	$ 2,418	$ 2,317	$ 2,320
Contingent rentals	35	34	36
	2,453	2,351	2,356
Less: sublease income	(24)	(22)	(21)
	$ 2,429	$ 2,329	$ 2,335

The following table is a summary of the future minimum lease payments under capital and operating leases as of December 31, 2016:

In millions	**Capital Leases**	**Operating Leases [1]**
2017	$ 74	$ 2,458
2018	72	2,361
2019	71	2,209
2020	71	2,040
2021	70	1,910
Thereafter	956	16,368
Total future lease payments [2]	1,314	$ 27,346
Less: imputed interest	(666)	
Present value of capital lease obligations	$ 648	

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $176 million due in the future under noncancelable subleases.
(2) The Company leases pharmacy and clinic space from Target. Amounts related to such capital and operating leases are reflected above. Amounts due in excess of the remaining estimated economic life of the buildings of approximately $1.7 billion are not reflected herein since the estimated economic life of the buildings is shorter than the contractual term of the lease arrangement.

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the above table. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. Proceeds from sale-leaseback transactions totaled $230 million in 2016, $411 million in 2015 and $515 million in 2014.

7 Medicare Part D

The Company offers Medicare Part D benefits through SilverScript, which has contracted with CMS to be a PDP and, pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, must be a risk-bearing entity regulated under state insurance laws or similar statutes.

SilverScript is a licensed domestic insurance company under the applicable laws and regulations. Pursuant to these laws and regulations, SilverScript must file quarterly and annual reports with the National Association of Insurance Commissioners ("NAIC") and certain state regulators, must maintain certain minimum amounts of capital and surplus under a formula established by the NAIC and must, in certain circumstances, request and receive the approval of certain state regulators before making dividend payments or other capital distributions to the Company. The Company does not believe these limitations on dividends and distributions materially impact its financial position.

The Company has recorded estimates of various assets and liabilities arising from its participation in the Medicare Part D program based on information in its claims management and enrollment systems. Significant estimates arising from its participation in this program include: (i) estimates of low-income cost subsidy, reinsurance amounts, and coverage gap discount amounts ultimately payable to or receivable from CMS based on a detailed claims reconciliation that will occur in the following year; (ii) an estimate of amounts receivable from or payable to CMS under a risk-sharing feature of the Medicare Part D program design, referred to as the risk corridor and (iii) estimates for claims that have been reported and are in the process of being paid or contested and for our estimate of claims that have been incurred but have not yet been reported.

8 Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

The Company sponsors voluntary 401(k) savings plans that cover all employees who meet plan eligibility requirements. The Company makes matching contributions consistent with the provisions of the plans.

At the participant's option, account balances, including the Company's matching contribution, can be transferred without restriction among various investment options, including the Company's common stock fund under one of the defined contribution plans. The Company also maintains a nonqualified, unfunded deferred compensation plan for certain key employees. This plan provides participants the opportunity to defer portions of their eligible compensation and receive matching contributions equivalent to what they could have received under the CVS Health 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under the above defined contribution plans were $295 million , $251 million and $238 million in 2016, 2015 and 2014, respectively.

Defined Benefit Pension Plans

As of December 31, 2016 and 2015, the Company sponsored seven defined benefit pension plans. Two of the plans are tax-qualified plans that are funded based on actuarial calculations and applicable federal laws and regulations. The other five plans are unfunded nonqualified supplemental retirement plans. As of December 31, 2014, the Company sponsored nine defined benefit pension plans. Four of the plans were tax-qualified plans and the other five plans were unfunded nonqualified supplemental retirement plans. Most of the plans were frozen in prior periods.

On September 30, 2015, the Company's Board of Directors approved a resolution to merge the four tax-qualified defined benefit plans that existed in 2014 and terminate the resulting merged plan. The merger was effective September 30, 2015 and the merged plan termination was effective December 31, 2015. The settlement of the terminated plan is expected to occur around the third quarter of 2017. The pension liability for the terminated plan will be settled in either lump sum payments or purchased annuities. Since the amount of the settlement depends on a number of factors determined as of the liquidation date, including the annuity pricing interest rate environment, lump sum election rates, and asset experience, the Company is currently unable to determine the ultimate cost of the settlement. However, based on current market rates the one-time settlement charge at final liquidation is estimated to be in the range of approximately $175 million to $225 million .

The following tables outline the change in benefit obligations and plan assets over the comparable periods:

In millions	**2016**	**2015**
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 844	$ 796
Acquisition	—	8
Interest cost	27	31
Actuarial loss	13	45
Benefit payments	(37)	(36)
Settlements	(3)	—
Benefit obligation at end of year	$ 844	$ 844

In millions	2016	2015
Change in plan assets:		
Fair value of plan assets at the beginning of the year	$ 613	$ 635
Acquisitions	—	5
Actual return on plan assets	26	(13)
Employer contributions	25	22
Benefit payments	(37)	(36)
Settlements	(3)	—
Fair value of plan assets at the end of the year	624	613
Funded status	$ (220)	$ (231)

The components of net periodic benefit costs for the years ended December 31 are shown below:

In millions	2016	2015	2014
Components of net periodic benefit cost:			
Interest cost	$ 27	$ 31	$ 32
Expected return on plan assets	(32)	(33)	(31)
Amortization of net loss	32	21	16
Settlement loss	—	—	3
Service cost	—	—	1
Net periodic pension cost	$ 27	$ 19	$ 21

Pension Plan Assumptions

The Company uses a series of actuarial assumptions to determine the benefit obligations and the net benefit costs. The discount rate is determined by examining the current yields observed on the measurement date of fixed-interest, high quality investments expected to be available during the period to maturity of the related benefits on a plan by plan basis. The discount rate for the merged qualified plan that has been terminated is determined by examining the current assumed lump sum and annuity purchase rates. The expected long-term rate of return on plan assets is determined by using the plan's target allocation and historical returns for each asset class on a plan by plan basis. Certain of the Company's pension plans use assumptions on expected compensation increases of plan participants. These increases are determined by an actuarial analysis of the plan participants, their expected compensation increases, and the duration of their earnings period until retirement. Each of these assumptions is reviewed as plan characteristics change and on an annual basis with input from senior pension and financial executives and the Company's external actuarial consultants.

The discount rate for determining plan benefit obligations was 4.0% in 2016 and 4.25% in 2015 for all plans except the terminated qualified plan. The discount rate for the terminated qualified plan was 3.09% and 3.25% in 2016 and 2015, respectively. The expected long-term rate of return for the plans ranged from 4.0% to 5.5% in 2016 and ranged from 5.75% to 6.75% in 2015. The rate of compensation increases for certain of the plans with active participants ranged from 4.0% to 6.0% in 2016 and 2015.

Return on Plan Assets

The Company's investment strategy is liability management driven. The qualified pension plan asset allocations targets are to hold fixed income investments based upon this strategy. As of December 31, 2016, investment allocations for the two qualified defined benefit plans range from 80% to 100% in fixed income and 0% to 20% in equities. The following tables show the fair value allocation of plan assets by asset category as of December 31, 2016 and 2015.

In millions	Fair value of plan assets at December 31, 2016			
	Level 1	Level 2	Level 3	Total
Cash and money market funds	$ 8	$ —	$ —	$ 8
Fixed income funds	3	580	—	583
Equity mutual funds	33	—	—	33
Total assets at fair value	$ 44	$ 580	$ —	$ 624

	Fair value of plan assets at December 31, 2015			
	Level 1	Level 2	Level 3	Total
Cash and money market funds	$ 10	$ —	$ —	$ 10
Fixed income funds	4	484	—	488
Equity mutual funds	115	—	—	115
Total assets at fair value	$ 129	$ 484	$ —	$ 613

As of December 31, 2016, the Company's qualified defined benefit pension plan assets consisted of 5% equity, 94% fixed income and 1% money market securities of which 7% were classified as Level 1 and 93% as Level 2 in the fair value hierarchy. The Company's qualified defined benefit pension plan assets as of December 31, 2015 consisted of 19% equity, 79% fixed income and 2% money market securities of which 21% were classified as Level 1 and 79% as Level 2 in the fair value hierarchy.

The Company continued to have no investments in Level 3 alternative investments during the years ended December 31, 2016 and 2015.

Cash Flows

The Company contributed $25 million , $22 million and $42 million to the pension plans during 2016, 2015 and 2014, respectively. The Company plans to make approximately $39 million in contributions to the pension plans during 2017. These contributions include contributions made to certain nonqualified benefit plans for which there is no funding requirement. The Company estimates the following future benefit payments which are calculated using the same actuarial assumptions used to measure the benefit obligation as of December 31, 2016:

In millions	
2017 [1]	$ 39
2018	52
2019	50
2020	49
2021	61
Thereafter	236

(1) Excludes any payments associated with the ultimate settlement of the terminated plan discussed above.

Multiemployer Pension Plans

The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following aspects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. Total Company contributions to multiemployer pension plans were $15 million in 2016 and $14 million in 2015 and 2014.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2016 and 2015, the Company's other postretirement benefits have an accumulated postretirement benefit obligation of $24 million and $33 million , respectively. Net periodic benefit costs related to these other postretirement benefits were $1 million , $2 million and $1 million in 2016, 2015 and 2014, respectively.

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. Total Company contributions to multiemployer health and welfare plans were $52 million , $60 million and $58 million in 2016, 2015 and 2014, respectively.

9 Stock Incentive Plans

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for each of the respective periods:

In millions	**2016**	**2015**	**2014**
Stock options [1]	$ 79	$ 90	$ 103
Restricted stock awards [2]	143	140	62
Total stock-based compensation	$ 222	$ 230	$ 165

(1) Includes the Employee Stock Purchase Plan (the "ESPP")
(2) Stock-based compensation for the year ended December 31, 2015 includes $38 million associated with accelerated vesting of restricted stock replacement awards issued to Omnicare executives who were terminated subsequent to the acquisition.

The recognized tax benefit was $22 million , $26 million and $33 million for 2016, 2015 and 2014, respectively.

The ESPP provides for the purchase of up to 30 million shares of common stock. Under the ESPP in 2016, eligible employees could purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. Prior to 2016, the purchase price was equal to 85% of the lower of the fair market value on the first day or the last day of the offering period. During 2016, approximately 1 million shares of common stock were purchased under the provisions of the ESPP at an average price of $84.68 per share. As of December 31, 2016, approximately 12 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for each of the respective periods:

	2016	**2015**	**2014**
Dividend yield [1]	0.88%	0.71%	0.75%
Expected volatility [2]	20.64%	13.92%	14.87%
Risk-free interest rate [3]	0.45%	0.11%	0.08%
Expected life *(in years)* [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 14.98	$ 18.72	$ 13.74

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is based on the historical volatility of the Company's daily stock market prices over the previous six month period.
(3) The risk-free interest rate is based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP options (i.e., six months).
(4) The expected life is based on the semi-annual purchase period.

The terms of the Company's Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at

the discretion of the Management Planning and Development Committee of the Company's Board of Directors. The ICP allows for a maximum of 74 million shares to be reserved and available for grants. The ICP is the only compensation plan under which the Company grants stock options, restricted stock and other stock-based awards to its employees, with the exception of the Company's ESPP. As of December 31, 2016, there were approximately 18 million shares available for future grants under the ICP.

The Company's restricted awards are considered nonvested share awards and require no payment from the employee. Compensation cost is recorded based on the market price of the Company's common stock on the grant date and is recognized on a straight-line basis over the requisite service period. The Company granted 1,992,000 , 2,695,000 and 2,708,000 restricted stock units with a weighted average fair value of $103.26 , $100.81 and $73.60 in 2016, 2015 and 2014, respectively. As of December 31, 2016, there was $327 million of total unrecognized compensation cost related to the restricted stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.29 years. The total fair value of restricted shares vested during 2016, 2015 and 2014 was $218 million , $164 million and $57 million , respectively.

The following table is a summary of the restricted stock unit and restricted share award activity for the year ended December 31, 2016.

Units in thousands	**Units**	**Weighted Average Grant Date Fair Value**
Nonvested at beginning of year	5,418	$ 59.22
Granted	1,992	$ 103.26
Vested	(2,219)	$ 102.47
Forfeited	(316)	$ 89.71
Nonvested at end of year	4,875	$ 55.56

All grants under the ICP are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model and stock-based compensation is recognized on a straight-line basis over the requisite service period. Stock options granted generally become exercisable over a four -year period from the grant date. Stock options generally expire seven years after the grant date.

Excess tax benefits of $72 million , $127 million and $106 million were included in financing activities in the accompanying consolidated statements of cash flow during 2016, 2015 and 2014, respectively. Cash received from stock options exercised, which includes the ESPP, totaled $224 million , $299 million and $421 million during 2016, 2015 and 2014, respectively. The total intrinsic value of stock options exercised was $244 million , $394 million and $372 million in 2016, 2015 and 2014, respectively. The total fair value of stock options vested during 2016, 2015 and 2014 was $298 million , $334 million and $292 million , respectively.

The fair value of each stock option is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2016	**2015**	**2014**
Dividend yield [1]	1.62%	1.37%	1.47%
Expected volatility [2]	17.22%	18.07%	19.92%
Risk-free interest rate [3]	1.24%	1.24%	1.35%
Expected life *(in years)* [4]	4.2	4.2	4.0
Weighted-average grant date fair value	$ 13.00	$ 14.01	$ 11.04

(1) The dividend yield is based on annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is estimated using the Company's historical volatility over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.
(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.
(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option holder exercise experience.

As of December 31, 2016, unrecognized compensation expense related to unvested options totaled $79 million , which the Company expects to be recognized over a weighted-average period of 1.79 years. After considering anticipated forfeitures, the Company expects approximately 11 million of the unvested stock options to vest over the requisite service period.

The following table is a summary of the Company's stock option activity for the year ended December 31, 2016:

Shares in thousands	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at December 31, 2015	24,341	$ 42.17		
Granted	4,343	$ 104.62		
Exercised	(4,328)	$ 42.07		
Forfeited	(768)	$ 85.34		
Expired	(313)	$ 39.73		
Outstanding at December 31, 2016	23,275	$ 68.60	3.69	$ 427,311,414
Exercisable at December 31, 2016	12,196	$ 49.22	2.35	$ 375,563,490
Vested at December 31, 2016 and expected to vest in the future	22,734	$ 67.86	3.64	$ 426,628,851

10 Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31:

In millions	2016	2015	2014
Current:			
Federal	$ 2,803	$ 3,065	$ 2,581
State	511	555	495
	3,314	3,620	3,076
Deferred:			
Federal	5	(180)	(43)
State	(2)	(54)	—
	3	(234)	(43)
Total	$ 3,317	$ 3,386	$ 3,033

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31:

	2016	2015	2014
Statutory income tax rate	35.0%	35.0%	35.0%
State income taxes, net of federal tax benefit	4.1	4.0	4.3
Other	(0.7)	0.3	0.2
Effective income tax rate	38.4%	39.3%	39.5%

The Company has $4.2 billion of net deferred tax liabilities as of December 31, 2016 and 2015. The following table is a summary of the components of the Company's deferred tax assets and liabilities as of December 31:

In millions	**2016**	**2015**
Deferred tax assets:		
Lease and rents	$ 375	$ 378
Inventory	57	99
Employee benefits	400	359
Allowance for doubtful accounts	301	279
Retirement benefits	65	105
Net operating loss and capital loss carryforwards	125	115
Deferred income	144	83
Other	336	498
Valuation allowance	(135)	(115)
Total deferred tax assets	1,668	1,801
Deferred tax liabilities:		
Depreciation and amortization	(5,882)	(6,018)
Total deferred tax liabilities	(5,882)	(6,018)
Net deferred tax liabilities	$ (4,214)	$ (4,217)

The Company assesses positive and negative evidence to determine whether it is more likely than not some portion of a deferred tax asset would not be realized. When it would not, a valuation allowance is established for such portion of a deferred tax asset.

A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows:

In millions	**2016**	**2015**	**2014**
Beginning balance	$ 338	$ 188	$ 117
Additions based on tax positions related to the current year	68	57	32
Additions based on tax positions related to prior years	70	122	70
Reductions for tax positions of prior years	(100)	(11)	(15)
Expiration of statutes of limitation	(22)	(13)	(15)
Settlements	(47)	(5)	(1)
Ending balance	$ 307	$ 338	$ 188

The Company and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. The Company is a participant in the Compliance Assurance Process ("CAP"), which is a voluntary program offered by the Internal Revenue Service ("IRS") under which participating taxpayers work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the filing of their federal income tax. The IRS is currently examining the Company's 2015 and 2016 consolidated U.S. federal income tax returns.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2016, no examination has resulted in any proposed adjustments that would result in a material change to the Company's results of operations, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2010. Certain state exams will be concluded and certain state statutes will lapse in 2017, and the change in the balance of our uncertain tax positions will be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company recognizes interest accrued related to unrecognized tax benefits and penalties in income tax expense. The Company recognized interest of approximately $10 million in 2016, $5 million in 2015 and $6 million in 2014. The Company

had approximately $30 million and $16 million accrued for interest and penalties as of December 31, 2016 and 2015, respectively.

There are no material uncertain tax positions as of December 31, 2016 the ultimate deductibility of which is highly certain but for which there is uncertainty about the timing. If there were, any such items would impact deferred tax accounting only, not the annual effective income tax rate, and would accelerate the payment of cash to the taxing authority to a period earlier than expected.

As of December 31, 2016, the total amount of unrecognized tax benefits that, if recognized, would affect the effective income tax rate is approximately $276 million , after considering the federal benefit of state income taxes.

11 Commitments and Contingencies

Lease Guarantees

Between 1991 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, Marshalls, Kay-Bee Toys, Wilsons, This End Up and Footstar. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser has agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations. As of December 31, 2016, the Company guaranteed approximately 87 such store leases (excluding the lease guarantees related to Linens 'n Things, which are discussed in Note 1 "Significant Accounting Policies"), with the maximum remaining lease term extending through 2047 .

In April 2016, the parent entity of Bob's Stores filed for Chapter 11 bankruptcy protection. As described above, the Company, through one or more of its affiliates, is alleged to have guaranteed certain of the Bob's Stores' leases (the "Bob's Leases"). On June 20, 2016, the bankruptcy court approved the sale of substantially all of the assets of Bob's Stores and certain other assets to a new entity ("Buyer"), which designated Buyer's affiliate Bob's Stores, LLC, a Delaware limited liability company ("New Bob's"), to acquire substantially all of the assets of Bob's Stores.

The Company, through its subsidiary, CVS Pharmacy, Inc., and New Bob's entered into an agreement in October 2016, pursuant to which, in exchange for an immaterial payment to be made by CVS Pharmacy, Inc., New Bob's agreed to accept the assignment of the Bob's Leases and to be bound by certain restrictions regarding renewals, extensions and modifications to the Bob's Leases. The Company believed these restrictions would potentially reduce the Company's exposure to liability under guarantees of the Bob's Leases in the future. The bankruptcy court approved the assignment of the Bob's Leases to New Bob's on November 7, 2016, and all of the Bob's Leases were assigned to New Bob's.

On February 5, 2017, New Bob's and certain of its affiliates (collectively, the "Debtors") filed for Chapter 11 bankruptcy protection. Certain documents filed in connection with the Debtors' bankruptcy case suggest that the Debtors may enter into an asset purchase agreement with Sports Direct Retail Ltd. ("Sports Direct"), for Sports Direct to serve as an initial bidder in an asset sale process to be conducted pursuant to Section 363 of the Bankruptcy Code. The Company will monitor the Debtors' bankruptcy proceedings.

Legal Matters

The Company is a party to legal proceedings, investigations and claims in the ordinary course of its business, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial position.

The Company's contingencies are subject to significant uncertainties, including, among other factors: (i) the procedural status of pending matters; (ii) whether class action status is sought and certified; (iii) whether asserted claims or allegations will survive dispositive motion practice; (iv) the extent of potential damages, fines or penalties, which are often unspecified or indeterminate; (v) the impact of discovery on the legal process; (vi) whether novel or unsettled legal theories are at issue; (vii) the settlement posture of the parties, and/or (viii) in the case of certain government agency investigations, whether a sealed

qui tam lawsuit ("whistleblower" action) has been filed and whether the government agency makes a decision to intervene in the lawsuit following investigation.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters.

- *In re Pharmacy Benefit Managers Antitrust Litigation* (U.S. District Court for the Eastern District of Pennsylvania) (consolidating *North Jackson Pharmacy, Inc.* et al *v. Caremark Rx Inc.* et al. (U.S. District Court for the Northern District of Alabama)). Beginning in August 2003, various lawsuits were filed by pharmacies alleging that various PBMs were violating certain antitrust laws. In October 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. filed three putative class action complaints seeking treble damages and injunctive relief against Caremark (the term "Caremark" as used herein refers to one or more PBM subsidiaries of the Company, as applicable). In August 2006, the Judicial Panel on Multidistrict Litigation issued an order transferring all related PBM antitrust cases, including the North Jackson Pharmacy cases, to the United States District Court for the Eastern District of Pennsylvania for coordinated and consolidated proceedings with the cases originally filed in that court. The consolidated action is now known as *In re Pharmacy Benefit Managers Antitrust Litigation* . On January 18, 2017, the court denied the plaintiffs' motion for class certification filed against Caremark, denied a similar motion filed against another PBM, and decertified classes that had been previously certified against other PBMs.

- *Indiana State District Council of Laborers and HOD Carriers Pension and Welfare Fund v. Omnicare, Inc.* et al. (U.S. District Court for the Eastern District of Kentucky). In February 2006, two substantially similar putative class action lawsuits were filed and subsequently consolidated. The consolidated complaint was filed against Omnicare, three of its officers and two of its directors and purported to be brought on behalf of all open-market purchasers of Omnicare common stock from August 3, 2005 through July 27, 2006, as well as all purchasers who bought shares of Omnicare common stock in Omnicare's public offering in December 2005. The complaint alleged violations of the Securities Exchange Act of 1934 and Section 11 of the Securities Act of 1933 and sought, among other things, compensatory damages and injunctive relief. After dismissals and appeals to the United States Court of Appeals for the Sixth Circuit, the United States Supreme Court remanded the case to the district court. In October 2016, Omnicare filed an answer to plaintiffs' third amended complaint, and discovery commenced.

- *Claims Processing Matter.* In December 2007, the Company received a document subpoena from the Office of Inspector General ("OIG") within the U.S. Department of Health and Human Services, requesting information relating to the processing of Medicaid and certain other government agency claims on behalf of its clients (which allegedly resulted in underpayments from our pharmacy benefit management clients to the applicable government agencies) on one of the Company's adjudication platforms. In September 2014, the Company settled the OIG's claims, as well as related claims by the Department of Justice and private plaintiffs, without any admission of liability. The Company concluded its discussions with the OIG concerning other claim processing issues and resolved those additional matters on December 22, 2016 for the payment of an immaterial amount.

- *FTC and Multi-State Investigation.* In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the U.S. Federal Trade Commission ("FTC"). Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company has cooperated with the multi-state investigation.

- *United States* ex rel. *Jack Chin v. Walgreen Company* et al. (U.S. District Court for the Central District of California). In March 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to the Company's pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. In October 2016, the U.S. District Court for the Central District of California unsealed a *qui tam* complaint, filed in April 2009 against CVS Pharmacy and other retail pharmacies, alleging that the Company violated the federal False Claims Act, and the false claims acts of several states, by offering such programs. The federal government has declined intervention in the case.

- *United States* ex rel. *James Banigan and Richard Templin v. Organon USA Inc.* et al. (U.S. District Court for the District of Massachusetts). On October 29, 2010, the court unsealed a *qui tam* complaint, which had been under seal

since 2007, against Organon, Omnicare, Inc. and PharMerica Corporation. The suit was brought by two former employees of Organon, as relators on behalf of the federal government and several state and local governments. The action alleges civil violations of the federal False Claims Act based on allegations that Organon and its affiliates paid Omnicare and several other long-term care pharmacies rebates, post-purchase discounts and other forms of remuneration in return for purchasing pharmaceuticals from Organon and taking steps to increase the purchase of Organon's drugs in violation of the Anti-Kickback Statute. The U.S. Department of Justice declined to intervene in this action. The Company has tentatively agreed with the Department of Justice to resolve this matter for $23 million plus interest. These financial terms are contingent on approval by authorized officials at the Department of Justice, negotiation of terms of a settlement agreement, approval and releases from the OIG, the National Association of Medicaid Fraud Control Units, and the Department of Justice. While the Company believes that a final settlement will be reached, there can be no assurance that any final settlement agreement will be reached or as to the final terms of such settlement.

- *United States* ex rel. *Anthony R. Spay v. CVS Caremark Corporation* et al. (U.S. District Court for the Eastern District of Pennsylvania). In January 2012, the court unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, Anthony Spay, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that Caremark's processing of Medicare claims on behalf of one of its clients violated the federal False Claims Act. The United States declined to intervene in the lawsuit. In September 2015, the Court granted Caremark's motion for summary judgment in its entirety, and entered judgment in favor of Caremark and against Spay. In October 2015, Spay filed a notice of appeal in the United States Court of Appeals for the Third Circuit; that court heard oral arguments on the appeal in November 2016.

- *State of Texas* ex rel. *Myron Winkelman and Stephani Martinson* et al. *v. CVS Health Corporation* (Travis County District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands and has issued a series of subsequent requests for documents and information in connection with its investigation concerning the Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the court unsealed a first amended petition. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to Texas Medicaid by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the usual and customary price. The amended petition was unsealed following the Company's filing of *CVS Pharmacy, Inc. v. Charles Smith* et al. (Travis County District Court), a declaratory judgment action against the State of Texas in December 2016 seeking a declaration that the prices charged to members of the Health Savings Pass program do not constitute usual and customary prices under the Medicaid regulation.

- *California ReadyFill Subpoena.* In November 2012, the Company received a subpoena for documents from the OIG requesting information concerning automatic refill programs used by pharmacies to refill prescriptions for customers. The subpoena was issued in connection with an investigation conducted out of the U.S. Attorney's Office for the Central District of California. The Company produced documents and data.

- *Pure Services Subpoena.* In 2013, Omnicare received a subpoena seeking information regarding Omnicare's May 2008 acquisition of Pure Service Pharmacy. In 2016, Omnicare reached an agreement regarding financial terms to resolve, for $1.5 million plus interest, the subpoena regarding the acquisition of Pure Service Pharmacy. These financial terms are contingent on approval by authorized officials at the Department of Justice, negotiation of terms of a settlement agreement, approval and releases from the OIG, the National Association of Medicaid Fraud Control Units, and the Department of Justice. While the Company believes that a final settlement will be reached, there can be no assurance that any final settlement agreement will be reached or as to the final terms of such settlement.

- *Auto Label Subpoena.* In 2014, Omnicare received a subpoena seeking information regarding Omnicare's Auto Label Verification system. In 2016, Omnicare reached an agreement regarding financial terms to resolve, for $8 million plus interest, the subpoena regarding Omnicare's Auto Label Verification system. These financial terms are contingent on approval by authorized officials at the Department of Justice, negotiation of terms of a settlement agreement, approval and releases from the OIG, the National Association of Medicaid Fraud Control Units, and the Department of Justice. While the Company believes that a final settlement will be reached, there can be no assurance that any final settlement agreement will be reached or as to the final terms of such settlement.

- *Subpoena Concerning PBM Administrative Fees.* In March 2014, the Company received a subpoena from the United States Attorney's Office for the District of Rhode Island, requesting documents and information concerning bona fide service fees and rebates received from pharmaceutical manufacturers in connection with certain drugs utilized under

Part D of the Medicare Program, as well as the reporting of those fees and rebates to Part D plan sponsors. The Company has been cooperating with the government and providing documents and information in response to the subpoena.

- *ReadyFill Subpoena (Minnesota).* In May 2015, the Company received a subpoena from the OIG requesting information and documents concerning the Company's automatic refill programs, adherence outreach programs, and pharmacy customer incentives, particularly in connection with claims for reimbursement made to the Minnesota Medicaid program. The Company has been cooperating with the investigation and providing information in response to the subpoena.

- *Corcoran* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in United States District Court in the Northern District of California. Plaintiffs seek damages and injunctive relief on behalf of a class of consumers who purchased certain prescription drugs under the consumer protection statutes and common laws of certain states. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* (U.S. District Court for the District of Rhode Island) and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting as the pharmacy's usual and customary price the price available to members of the CVS Health Savings Pass program. The Company is defending these actions.

- *Omnicare DEA Subpoena.* In September 2015, Omnicare was served with an administrative subpoena by the U.S. Drug Enforcement Agency ("DEA"). The subpoena seeks documents related to controlled substance policies, procedures, and practices at eight pharmacy locations from May 2012 to the present. The Company has been cooperating and providing documents in response to this administrative subpoena.

- *Omnicare Cycle Fill CID.* In October 2015, Omnicare received a Civil Investigative Demand from the United States Attorney's Office for the Southern District of New York requesting information and documents concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *PBM Pricing CID.* In October 2015, the Company received from the U.S. Department of Justice a Civil Investigative Demand requesting documents and information in connection with a False Claims Act investigation concerning allegations that the Company submitted, or caused to be submitted, to the Medicare Part D program prescription drug event data that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *United States* ex rel. *Sally Schimelpfenig and John Segura v. Dr. Reddy's Laboratories Limited and Dr. Reddy's Laboratories, Inc.* (U.S. District Court for the Eastern District of Pennsylvania). In November 2015, the court unsealed a second amended *qui tam* complaint filed in September 2015. The U.S. Department of Justice declined to intervene in this action. The relators allege that the Company, Walgreens, Wal-Mart, and Dr. Reddy's Laboratories violated the federal and various state False Claims Acts by dispensing prescriptions in unit dose packaging supplied by Dr. Reddy's that was not compliant with the Consumer Product Safety Improvement Act and the Poison Preventive Packaging Act and thereby allegedly rendering the drugs misbranded under the Food, Drug & Cosmetic Act. The Company's motion to dismiss remains pending.

- *Barchock* et al. *v. CVS Health Corporation* et al. (U.S. District Court for the District of Rhode Island). In February 2016, an ERISA class action lawsuit was filed against the Company, the Benefit Plans Committee of the Company, and Galliard Capital Management, Inc., by Mary Barchock, Thomas Wasecko, and Stacy Weller, purportedly on behalf of the 401(k) Plan and the Employee Stock Ownership Plan of the Company (the "Plan"), and participants in the Plan. The complaint alleges that the defendants breached fiduciary duties owed to the plaintiffs and the Plan by investing too much of the Plan's Stable Value Fund in short-term money market funds and cash management accounts. The Company has moved to dismiss the plaintiffs' amended complaint.

- *State of California* ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined intervention in this case. The relator alleges that the Company submitted false

claims for payment to California Medicaid in connection with reimbursement for drugs available through the Health Savings Pass program as well as certain other generic drugs. The Company's motion to dismiss the complaint was denied.

- *DEA Matters.* In October 2016, the Company reached an agreement in principle with the U.S. Attorney's Office for the Eastern District of California to resolve alleged violations of the Controlled Substances Act ("CSA") for $5 million . The settlement is contingent on the negotiation of terms of a settlement agreement. The Company is also undergoing several audits by the DEA Administrator and is in discussions with the DEA and the U.S. Attorney's Office in several locations concerning allegations that the Company has violated certain requirements of the CSA.

- *State of Mississippi v. CVS Health Corporation* et al. (Chancery Court of Desoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to Mississippi Medicaid by not submitting as the pharmacy's usual and customary price the price available to members of the CVS Health Savings Pass program. The Company has responded to the complaint, filed a counterclaim, and moved to transfer the case to circuit court.

The Company is also a party to other legal proceedings, government investigations, inquiries and audits, and has received and is cooperating with subpoenas or similar process from various governmental agencies requesting information, all arising in the normal course of its business, none of which is expected to be material to the Company. The Company can give no assurance, however, that its business, financial condition and results of operations will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to the Company's business, the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industries or to the health care industry generally; (iii) pending or future federal or state governmental investigations of the Company's business or the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or of the health care industry generally; (iv) pending or future government enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or the health care industry generally.

12 Segment Reporting

The Company currently has three reportable segments: Pharmacy Services, Retail/LTC and Corporate. The Retail/LTC Segment includes the operating results of the Company's Retail Pharmacy and LTC/RxCrossroads operating segments as the operations and economics characteristics are similar. The Company's segments maintain separate financial information for which operating results are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services and Retail/LTC segments' performance based on net revenue, gross profit and operating profit before the effect of nonrecurring charges and gains and certain intersegment activities. The Company evaluates the performance of its Corporate Segment based on operating expenses before the effect of nonrecurring charges and gains and certain intersegment activities. The chief operating decision maker does not use total assets by segment to make decisions regarding resources, therefore the total asset disclosure by segment has not been included. See Note 1 "Significant Accounting Policies" for a description of the Pharmacy Services, Retail/LTC and Corporate segments and related significant accounting policies.

In 2016, approximately 11.2% of the Company's consolidated net revenues were from Aetna, a Pharmacy Services Segment client. In 2015 and 2014, no single customer accounted for 10% or more of the Company's consolidated net revenues. More than 99% of the Company's consolidated net revenues are earned and long-lived assets are located in the United States.

The following table is a reconciliation of the Company's business segments to the consolidated financial statements:

In millions	Pharmacy Services Segment [1][2]	Retail/LTC Segment [2]	Corporate Segment	Intersegment Eliminations [2]	Consolidated Totals
2016:					
Net revenues	$ 119,963	$ 81,100	$ —	$ (23,537)	$ 177,526
Gross profit [3]	5,901	23,738	—	(782)	28,857
Operating profit [4][5][6]	4,672	7,281	(894)	(721)	10,338
Depreciation and amortization	714	1,642	119	—	2,475
Additions to property and equipment	295	1,732	252	—	2,279
2015:					
Net revenues	$ 100,363	$ 72,007	$ —	$ (19,080)	$ 153,290
Gross profit	5,227	21,992	—	(691)	26,528
Operating profit [5][6]	3,989	7,130	(1,037)	(628)	9,454
Depreciation and amortization	654	1,336	102	—	2,092
Additions to property and equipment	359	1,883	125	—	2,367
2014:					
Net revenues	$ 88,440	$ 67,798	$ —	$ (16,871)	$ 139,367
Gross profit	4,771	21,277	—	(681)	25,367
Operating profit	3,514	6,762	(796)	(681)	8,799
Depreciation and amortization	630	1,205	96	—	1,931
Additions to property and equipment	308	1,745	83	—	2,136

(1) Net revenues of the Pharmacy Services Segment include approximately $10.5 billion , $8.9 billion and $8.1 billion of Retail Co-Payments for 2016, 2015 and 2014, respectively. See Note 1 "Significant Accounting Policies" to the consolidated financial statements for additional information about Retail Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services Segment and the Retail/LTC Segment. These occur in the following ways: when members of Pharmacy Services Segment clients ("members") fill prescriptions at the Company's retail pharmacies to purchase covered products, when members enrolled in programs such as Maintenance Choice ® elect to pick up maintenance prescriptions at one of the Company's retail pharmacies instead of receiving them through the mail, or when members have prescriptions filled at the Company's long-term care pharmacies. When these occur, both the Pharmacy Services and Retail/LTC segments record the revenues, gross profit and operating profit on a standalone basis.

(3) The Retail/LTC Segment gross profit for the year ended December 31, 2016 includes $46 million of acquisition-related integration costs. The integration costs are related to the acquisitions of Omnicare and the pharmacies and clinics of Target.

(4) The Pharmacy Services Segment operating profit for the year ended December 31, 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

(5) The Retail/LTC Segment operating profit for the three months and year ended December 31, 2016 includes a $34 million asset impairment charge in connection with planned store closures in 2017 related to the Company's enterprise streamlining initiative. The Retail/LTC Segment operating profit for the 2016 and 2015 include $281 million and $64 million , respectively, of acquisition-related integration costs. The integration costs are related to the acquisitions of Omnicare and the pharmacies and clinics of Target.

(6) The Corporate Segment operating loss for the year ended December 31, 2016 includes $10 million of integration costs. For the year ended December 31, 2015, the Corporate Segment operating loss includes $156 million of acquisition-related transaction and integration costs and a $90 million charge related to a legacy lawsuit challenging the 1999 legal settlement by MedPartners of various securities class actions and a related derivative claim.

13 Earnings Per Share

The following is a reconciliation of basic and diluted earnings per share from continuing operations for the respective years:

In millions, except per share amounts	2016	2015	2014
Numerator for earnings per share calculation:			
Income from continuing operations	$ 5,320	$ 5,230	$ 4,645
Income allocated to participating securities	(27)	(26)	(19)
Net income attributable to noncontrolling interest	(2)	(2)	—
Income from continuing operations attributable to CVS Health	$ 5,291	$ 5,202	$ 4,626
Denominator for earnings per share calculation:			
Weighted average shares, basic	1,073	1,118	1,161
Effect of dilutive securities	6	8	8
Weighted average shares, diluted	1,079	1,126	1,169
Earnings per share from continuing operations:			
Basic	$ 4.93	$ 4.65	$ 3.98
Diluted	$ 4.91	$ 4.62	$ 3.96

14 Quarterly Financial Information (Unaudited)

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2016:					
Net revenues	$ 43,215	$ 43,725	$ 44,615	$ 45,971	$ 177,526
Gross profit	6,744	7,015	7,492	7,606	28,857
Operating profit	2,176	2,350	2,817	2,995	10,338
Income from continuing operations	1,147	924	1,542	1,707	5,320
Income (loss) from discontinued operations, net of tax	—	—	(1)	—	(1)
Net income attributable to CVS Health	1,146	924	1,540	1,707	5,317
Basic earnings per share:					
Income from continuing operations attributable to CVS Health	$ 1.04	$ 0.86	$ 1.44	$ 1.60	$ 4.93
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income attributable to CVS Health	$ 1.04	$ 0.86	$ 1.44	$ 1.60	$ 4.93
Diluted earnings per share:					
Income from continuing operations attributable to CVS Health	$ 1.04	$ 0.86	$ 1.43	$ 1.59	$ 4.91
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income attributable to CVS Health	$ 1.04	$ 0.86	$ 1.43	$ 1.59	$ 4.90
Dividends per share	$ 0.425	$ 0.425	$ 0.425	$ 0.425	$ 1.70
Stock price: (New York Stock Exchange)					
High	$ 104.05	$ 106.10	$ 98.06	$ 88.80	$ 106.10
Low	$ 89.65	$ 93.21	$ 88.99	$ 73.53	$ 73.53

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2015:					
Net revenues	$ 36,332	$ 37,169	$ 38,644	$ 41,145	$ 153,290
Gross profit	6,164	6,402	6,661	7,301	26,528
Operating profit	2,132	2,262	2,331	2,729	9,454
Income from continuing operations	1,221	1,272	1,237	1,500	5,230
Income (loss) from discontinued operations, net of tax	—	—	10	(1)	9
Net income attributable to CVS Health	1,221	1,272	1,246	1,498	5,237
Basic earnings per share:					
Income from continuing operations attributable to CVS Health	$ 1.08	$ 1.13	$ 1.10	$ 1.35	$ 4.65
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ 0.01	$ —	$ 0.01
Net income attributable to CVS Health	$ 1.08	$ 1.13	$ 1.11	$ 1.35	$ 4.66
Diluted earnings per share:					
Income from continuing operations attributable to CVS Health	$ 1.07	$ 1.12	$ 1.10	$ 1.34	$ 4.62
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ 0.01	$ —	$ 0.01
Net income attributable to CVS Health	$ 1.07	$ 1.12	$ 1.11	$ 1.34	$ 4.63
Dividends per share	$ 0.35	$ 0.35	$ 0.35	$ 0.35	$ 1.40
Stock price: (New York Stock Exchange)					
High	$ 104.56	$ 106.47	$ 113.45	$ 105.29	$ 113.45
Low	$ 94.16	$ 98.74	$ 95.12	$ 91.56	$ 91.56

Five-Year Financial Summary

In millions, except per share amounts	2016	2015	2014	2013	2012
Statement of operations data:					
Net revenues	$ 177,526	$ 153,290	$ 139,367	$ 126,761	$ 123,120
Gross profit	28,857	26,528	25,367	23,783	22,488
Operating expenses	18,519	17,074	16,568	15,746	15,278
Operating profit	10,338	9,454	8,799	8,037	7,210
Interest expense, net	1,058	838	600	509	557
Loss on early extinguishment of debt	643	—	521	—	348
Income tax provision [1]	3,317	3,386	3,033	2,928	2,436
Income from continuing operations	5,320	5,230	4,645	4,600	3,869
Income (loss) from discontinued operations, net of tax	(1)	9	(1)	(8)	(7)
Net income	5,319	5,239	4,644	4,592	3,862
Net (income) loss attributable to noncontrolling interest	(2)	(2)	—	—	2
Net income attributable to CVS Health	$ 5,317	$ 5,237	$ 4,644	$ 4,592	$ 3,864
Per share data:					
Basic earnings per share:					
Income from continuing operations attributable to CVS Health	$ 4.93	$ 4.65	$ 3.98	$ 3.78	$ 3.05
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ 0.01	$ —	$ (0.01)	$ (0.01)
Net income attributable to CVS Health	$ 4.93	$ 4.66	$ 3.98	$ 3.77	$ 3.04
Diluted earnings per share:					
Income from continuing operations attributable to CVS Health	$ 4.91	$ 4.62	$ 3.96	$ 3.75	$ 3.02
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ 0.01	$ —	$ (0.01)	$ (0.01)
Net income attributable to CVS Health	$ 4.90	$ 4.63	$ 3.96	$ 3.74	$ 3.02
Cash dividends per share	$ 1.70	$ 1.40	$ 1.10	$ 0.90	$ 0.65
Balance sheet and other data:					
Total assets [1]	$ 94,462	$ 92,437	$ 73,202	$ 70,550	$ 65,474
Long-term debt	$ 25,615	$ 26,267	$ 11,630	$ 12,767	$ 9,079
Total shareholders' equity	$ 36,834	$ 37,203	$ 37,963	$ 37,938	$ 37,653
Number of stores (at end of year)	9,750	9,681	7,866	7,702	7,508

(1) As of January 1, 2016, the Company early adopted Accounting Standard Update No. 2015-17, *Income Taxes* (Topic 740) issued by the Financial Accounting Standards Board in November 2015. The effect of the retrospective adoption on the Company's historical consolidated balance sheets is a reduction in current assets and deferred income taxes of $1.2 billion , $985 million , $902 million and $693 million as of December 31, 2015, 2014, 2013 and 2012, respectively.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders of CVS Health Corporation

We have audited the accompanying consolidated balance sheets of CVS Health Corporation as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2016. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of CVS Health Corporation at December 31, 2016 and 2015, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), CVS Health Corporation's internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 9, 2017 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 9, 2017

Exhibit 21

SUBSIDIARIES OF THE REGISTRANT

As of December 31, 2016, CVS Health Corporation had the following significant subsidiaries:

Caremark, L.L.C. (a California limited liability company)
CaremarkPCS Health, L.L.C. (a Delaware limited liability company)
Caremark Rx, L.L.C. (a Delaware limited liability company) (1)
CVS Caremark Part D Services, L.L.C. (a Delaware limited liability company)
CVS Pharmacy, Inc. (a Rhode Island corporation) (2)
Omnicare, Inc. (a Delaware corporation) (3)
SilverScript Insurance Company (a Tennessee corporation)

(1) Caremark Rx, L.L.C., the parent of the Registrant's pharmacy services subsidiaries, is the immediate or indirect parent of many mail order, pharmacy benefit management, infusion, Medicare Part D, insurance, specialty mail and retail specialty pharmacy subsidiaries, all of which operate in the United States and its territories.

(2) CVS Pharmacy, Inc. is the immediate or indirect parent of approximately 57 entities that operate drugstores, all of which drugstores are in the United States and its territories except approximately 37 drugstores that are operated by Drogaria Onofre Ltda., a Brazil limited liability company that is an indirect subsidiary of CVS Pharmacy, Inc.

(3) Omnicare, Inc., the parent of the Registrant's long-term care subsidiaries, is the immediate or indirect parent of many long-term care and specialty subsidiaries, all of which operate in the United States and its territories.

Exhibit 23

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statements (Form S-3ASR Nos. 333-187440 and 333-200217, and Form S-3 Nos. 333-205156 and 333-210872) of CVS Health Corporation,
(2) Registration Statement (Form S-4 No. 333-210873) of CVS Health Corporation, and
(3) Registration Statements (Form S-8 Nos. 333-49407, 333-34927, 333-28043, 333-91253, 333-63664, 333-139470, 333-141481, 333-167746 and 333-208805) of CVS Health Corporation;

of our reports dated February 9, 2017, with respect to the consolidated financial statements of CVS Health Corporation and the effectiveness of internal control over financial reporting of CVS Health Corporation, incorporated by reference in this Annual Report (Form 10-K) of CVS Health Corporation for the year ended December 31, 2016.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 9, 2017

Exhibit 31.1

Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, Larry J. Merlo, President and Chief Executive Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   (a) Designed such disclosure controls and procedures or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors:
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 9, 2017

By: /s/ Larry J. Merlo

Larry J. Merlo
President and
Chief Executive Officer

Exhibit 31.2

Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, David M. Denton, Executive Vice President and Chief Financial Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   (a) Designed such disclosure controls and procedures or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors:
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 9, 2017

By: /s/ David M. Denton

David M. Denton
Executive Vice President and Chief Financial Officer

Exhibit 32.1

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

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2016 (the "Report"), for the purpose of complying with Rule 13(a)-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Larry J. Merlo, President and Chief Executive Officer of the Company, certify that, to the best of my knowledge:

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

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

February 9, 2017

/s/ Larry J. Merlo

Larry J. Merlo
President and
Chief Executive Officer

Exhibit 32.2

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

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2016 (the "Report"), for the purpose of complying with Rule 13(a)-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, David M. Denton, Executive Vice President and Chief Financial Officer of the Company, certify that, to the best of my knowledge:

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

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

February 9, 2017

/s/ David M. Denton

David M. Denton
Executive Vice President and Chief Financial Officer

CVS Form 10-K 2017

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

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the fiscal year ended December 31, 2017

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the transition period from to

Commission file number 001-01011

CVS HEALTH CORPORATION
(Exact name of Registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Exchange Act:

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Exchange Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $81,440,458,676 as of June 30, 2017, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 9, 2018, the registrant had 1,014,532,157 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2017 are incorporated by reference in our response to Items 7, 8 and 9 of Part II.

Information contained in our Proxy Statement for the 2018 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

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PART I

Item 1. Business

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a pharmacy innovation company helping people on their path to better health. At the forefront of a changing health care landscape, the Company has an unmatched suite of capabilities and the expertise needed to drive innovations that will help shape the future of health care.

We are currently the only integrated pharmacy health care company with the ability to impact consumers, payors, and providers with innovative, channel-agnostic solutions. We have a deep understanding of their diverse needs through our unique integrated model, and we are bringing them innovative solutions that help increase access to quality care, deliver better health outcomes and lower overall health care costs.

Through more than 9,800 retail locations, more than 1,100 walk-in health care clinics, a leading pharmacy benefits manager with more than 94 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services and a leading stand-alone Medicare Part D prescription drug plan, we enable people, businesses, and communities to manage health in more affordable, effective ways. We are delivering break-through products and services, from advising patients on their medications at our CVS Pharmacy ® locations, to introducing unique programs to help control costs for our clients at CVS Caremark ®, to innovating how care is delivered to our patients with complex conditions through CVS Specialty ®, to improving pharmacy care for the senior community through Omnicare ®, or by expanding access to high-quality, low-cost care at CVS MinuteClinic ®.

We have three reportable segments: Pharmacy Services, Retail/LTC and Corporate.

Proposed Acquisition of Aetna

On December 3, 2017, we entered into a definitive merger agreement to acquire all of the outstanding shares of Aetna Inc. ("Aetna") for a combination of cash and stock (the "Aetna Acquisition"). Under the terms of the merger agreement, Aetna shareholders will receive $145.00 per share in cash and 0.8378 CVS Health shares for each Aetna share. The transaction values Aetna at approximately $207 per share or approximately $69 billion based on the Company's 5-day volume weighted average price ending December 1, 2017 of $74.21 per share. Including the assumption of Aetna's debt, the total value of the transaction is approximately $77 billion. The final purchase price will be determined based on the Company's stock price on the date of closing of the transaction.

The proposed acquisition is currently projected to close in the second half of 2018 and remains subject to approval by CVS Health and Aetna shareholders and customary closing conditions, including the expiration of the waiting period under the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR Act") and approvals of state departments of insurance and U.S. and international regulators.

Pharmacy Services Segment

The Pharmacy Services Segment provides a full range of pharmacy benefit management ("PBM") solutions, as described more fully below, to clients consisting primarily of employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans, plans offered on the public and private exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, through our SilverScript Insurance Company ("SilverScript") subsidiary, we are a national provider of drug benefits to eligible beneficiaries under the federal government's Medicare Part D program. The Pharmacy Services Segment operates under the CVS Caremark Pharmacy Services, Caremark ®, CVS Specialty ®, AccordantCare ™, SilverScript ®, Wellpartner ®, NovoLogix ®, Coram ®, Navarro ® Health Services and ACS Pharmacy names. As of December 31, 2017, the Pharmacy Services Segment operated 23 retail specialty pharmacy stores, 18 specialty mail order pharmacies and four mail order dispensing pharmacies, and 83 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence, located in 42 states, Puerto Rico and the District of Columbia. During the year ended December 31, 2017, our PBM filled or managed approximately 1.8 billion prescriptions on a 30-day equivalent basis.

Pharmacy Services Business Strategy - Our pharmacy services business strategy centers on providing innovative tools and strategies, as well as quality client service, in order to help improve clinical outcomes for our clients' plan members while assisting them with better managing pharmacy and overall health care costs. Our goal is to produce superior results for our clients and their plan members by leveraging our expertise in core PBM services, including: plan design offerings and administration, formulary management, Medicare Part D services, mail order, specialty pharmacy and infusion services, retail pharmacy network management services, prescription management systems, clinical services, disease management services and medical spend management.

In addition, as a fully integrated pharmacy services company that helps clients improve quality and lower their pharmacy costs, we offer our clients and their plan members a variety of programs and tools, including plan design offerings, that benefit from our integrated systems and the ability of our almost 36,000 pharmacists, nurses, nurse practitioners and physician assistants to interact personally with the many plan members we serve. Through our multiple member touch points (retail stores, mail order, infusion, long-term care and specialty pharmacies, retail clinics, digital resources and cost management tools), we seek to engage plan members in behaviors that help lower cost and improve health care outcomes. Examples of these programs and services include: Maintenance Choice ®, a program where eligible client plan members can elect to fill their maintenance prescriptions through delivery to their home or business or at our CVS Pharmacy retail stores for the same price as mail order; Pharmacy Advisor ®, a program that facilitates face-to-face and telephone counseling by our pharmacists to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions; enhanced disease management programs, such as our TransformCare ™ offerings, that are targeted at managing chronic disease states; Specialty Connect ®, our specialty pharmacy offering that integrates specialty mail and retail capabilities, providing members with disease-state specific counseling from our experienced specialty pharmacists and the convenience of picking up their prescriptions at their local CVS Pharmacy or having them delivered to their home or office and an ExtraCare ® Health Card program that offers discounts to eligible plan members on certain over-the-counter health care products sold in our CVS Pharmacy stores. In addition, CVS MinuteClinic ("MinuteClinic") is an important and differentiated part of the enterprise that offers certain capabilities to PBM clients and their members. For example, we offer plan-sponsored co-pay reductions to encourage use of MinuteClinic, thereby helping to reduce emergency room visits and to lower overall health care costs. We also partner with our health plan clients sponsoring patient-centered medical homes, biometric screenings for plan members, closing gaps in care, and onsite clinics at client corporate headquarters.

PBM Services - Our PBM solutions are described more fully below.

Plan Design Offerings and Administration - We administer pharmacy benefit plans for clients who contract with us to facilitate prescription coverage and claims processing for their eligible plan members. We assist our clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. We also assist clients in monitoring the effectiveness of their plans through frequent, informal communications, their use of our proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

We make recommendations to help clients design benefit plans that promote the use of the lower cost, clinically appropriate drugs. We help our clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Our clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management - We utilize an independent panel of doctors, pharmacists and other medical experts, referred to as our CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet our high standards of safety and efficacy for inclusion on one of our template formularies. Our formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for our clients that select one of our formularies. To help improve clinical outcomes for members and clients, we conduct ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products. Many of our clients choose to adopt one of our template formulary offerings as part of their plan design. Beginning in 2018, clients will have new capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Medicare Part D Services - We participate in the administration of the drug benefit added to the Medicare program under Part D of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) through the provision of PBM services to those of our health plan clients and other clients that have qualified as a Medicare Part D prescription drug plans (“PDP”) or as a Medicare Advantage prescription drug plan (“MA-PD”) and by offering Medicare Part D pharmacy benefits through SilverScript, a PDP that has contracted with the United States Centers for Medicare and Medicaid Services (“CMS”). We also assist employer, union and other health plan clients that qualify for the retiree drug subsidy made available under the MMA by collecting and submitting eligibility and/or drug cost data to CMS in order for them to obtain the subsidy and offer Medicare Part D pharmacy benefits to such clients' retirees through SilverScript-sponsored Employer Group Waiver Plans (“EGWPs”).

Mail Order Pharmacy - As of December 31, 2017, we operated four mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies via mail, telephone, fax, e-prescribing or the Internet. We also operate a network of smaller mail order specialty pharmacies described below. Our staff pharmacists review mail order prescriptions and refill requests with the assistance of our prescription management systems. This review may involve communications with the prescriber and, with the prescriber’s approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. These pharmacies have been awarded Mail Order Pharmacy accreditation from Utilization Review Accreditation Commission (“URAC”), a Washington DC-based health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy - Our specialty pharmacies support individuals who require complex and expensive drug therapies. As of December 31, 2017, our specialty pharmacy operations included 18 specialty mail order pharmacies located throughout the United States, including Puerto Rico, that are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. These pharmacies have also been awarded Specialty Pharmacy accreditation from URAC. As of December 31, 2017, the Company operated a network of 23 retail specialty pharmacy stores, which operate under the CVS Pharmacy specialty services and Navarro ®Health Services names. These stores average 1,100 square feet in size and sell prescription drugs and a limited assortment of front store items such as alternative medications, homeopathic remedies and vitamins. Our care management program, AccordantCare, is a differentiated clinical model that focuses on whole patient care, including comorbidity management. It embeds specially trained nurses into the CVS Specialty CareTeam for members who fill their specialty medications through CVS Specialty helping deliver better care and improved outcomes. Through our affiliate Coram LLC and its subsidiaries (collectively, “Coram”), one of the nation’s largest providers of comprehensive infusion services, we care for approximately 165,000 patients annually, providing specialty infusion and enteral nutrition services. Our Specialty Connect ®offering integrates our specialty pharmacy mail and retail capabilities, providing members with disease-state specific counseling from our experienced specialty pharmacists and the convenience of picking-up their prescriptions at their local CVS Pharmacy, or having them delivered to their preferred address. Whether submitted through our specialty mail order pharmacy or at a CVS Pharmacy, all prescriptions are filled through our specialty mail order pharmacies, so all revenue from this specialty prescription services program is recorded within the Pharmacy Services Segment. Members then can choose to pick up their medication at their local CVS Pharmacy, or have it sent to their home through the mail. Specialty Connect is available where allowed by law. Innovative digital tools for specialty pharmacy provide a more accessible, connected, and personal health experience. Members can manage all their specialty medications in real-time using the CVS Specialty app and more than 60 percent have opted in to receive email and text messages including refill reminders and order status. Patients can also use secure messaging to contact their Specialty CareTeam with any questions. Additionally, with the acquisition of Omnicare, Inc. (“Omnicare”), we expanded our specialty pharmacy to include the specialty pharmacy operations of Omnicare which operates under the name ACS Pharmacy.

Retail Pharmacy Network Management - We maintain a national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes our CVS Pharmacy locations) and 27,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the U.S. Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to us from the point-of-sale. This data interfaces with our proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. We are also able to build client-specific networks and managed network solutions to further drive savings for our clients. These include a performance-based pharmacy network with approximately 30,000 stores that will be anchored by CVS Pharmacy and Walgreens, along with up to 10,000 community-based, independently owned pharmacies across the United States. The network is designed to deliver unit cost savings and to improve clinical outcomes that will help to lower overall health

care costs for participating payors and their members. This network will be available beginning March 2018 to eligible commercial and Medicaid clients.

Prescription Management Systems - We dispense prescription drugs both directly, through one of our mail order or specialty pharmacies, or through a network of retail pharmacies, described above. All prescriptions processed through our systems, whether they are filled through one of our mail order or specialty dispensing pharmacies or through a pharmacy in our retail network, are analyzed, processed and documented by our proprietary prescription management systems. These systems provide essential features and functionality to allow a plan member to use their prescription drug benefit. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists, by enhancing review of various items through automation, including, but not limited to, plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Clinical Services - We offer multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. Our programs are primarily designed to promote good health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that negatively impact member health and client pharmacy and medical spend. In this regard, we offer various utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address the opioid epidemic, we introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy; limits the daily dosage of opioids dispensed based on the strength of the opioid; and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. To support improved adherence, our Pharmacy Advisor program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. We also have digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs - Our clinical services utilize advanced protocols and offer clients convenience in working with health care providers and other third parties. Our AccordantCare programs include integrated rare disease management programs, which cover diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis. The majority of these integrated programs are accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations. They have also been awarded Case Management accreditation from URAC.

Medical Benefit Management - We offer a technology platform, NovoLogix ®, an online preauthorization tool that helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of these drugs.

Pharmacy Services Information Systems - We currently operate and support a small number of claim adjudication platforms to support our Pharmacy Services Segment. However, the majority of our clients have migrated to one platform. These information systems incorporate architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to our PBM clients. Our Health Engagement Engine ® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serves an essential role in cost management and health improvement. This capability responsibly transforms pharmacy data into actionable interventions at key points of care such as our mail and specialty pharmacists to help provide quality care, and our enterprise digital strategy and integrated digital offerings help patients seamlessly manage mail, specialty and retail prescriptions.

Pharmacy Services Clients - Our clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on public and private exchanges, other sponsors of health benefit plans and individuals located throughout the United States. We provide pharmaceuticals to eligible members in benefit plans maintained by our clients and utilize our information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. We generate substantially all of our Pharmacy Services Segment net revenue from dispensing and managing prescription drugs to eligible members in benefit plans maintained by our clients. In 2017, 2016 and 2015, net revenues from Aetna accounted for approximately 12.3%, 11.7% and 10.0%, respectively, of our consolidated net revenues.

Pharmacy Services Seasonality - The majority of our Pharmacy Services Segment revenues are not seasonal in nature. However, our quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in plan sponsors sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating profit generally increases as the year progresses.

Pharmacy Services Competition - We believe the primary competitive factors in the industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members including satisfaction of experience; and (vi) operational excellence in delivering services. The Pharmacy Services Segment has a significant number of competitors (e.g., Express Scripts, OptumRx, Prime Therapeutics, MedImpact, and Humana) offering PBM services including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs.

Retail/LTC Segment

As of December 31, 2017, the Retail/LTC Segment included 9,803 retail locations (of which 8,060 were our stores that operated a pharmacy and 1,695 were our pharmacies located within Target Corporation ("Target") stores), our online retail pharmacy websites, CVS.com ®, Navarro.com ™and Onofre.com.br ™, 37 onsite pharmacy stores, our long-term care pharmacy operations and our retail health care clinics. The retail locations are in 49 states, the District of Columbia, Puerto Rico and Brazil, operating primarily under the CVS Pharmacy ®, CVS ®, CVS Pharmacy y más ®, Longs Drugs ®, Navarro Discount Pharmacy ®and Drogaria Onofre ™names. Including the pharmacies within Target, we currently operate in all of the top 100 United States drugstore markets. Existing retail stores range in size from approximately 5,000 to 30,000 square feet, although most new stores range in size from approximately 11,000 to 15,000 square feet and typically include a drive-thru pharmacy. The pharmacies within Target stores range in size from approximately 450 to 1,100 square feet. During 2017, our Retail/LTC Segment filled approximately 1.2 billion prescriptions (counting 90-day prescriptions as three prescriptions), and we held approximately 23.6% of the United States retail pharmacy market.

Our acquisition of Omnicare broadened our base of pharmacy care to an additional dispensing channel, long-term care pharmacy. Omnicare's LTC operations include the distribution of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Omnicare also provided commercialization services under the name RxCrossroads until January 2, 2018, when we completed the sale of RxCrossroads. LTC is comprised of 145 spoke pharmacies that primarily handle new prescription orders, of which 30 are also hub pharmacies that use automation to support spoke pharmacies with refill prescriptions. LTC primarily operates under the Omnicare ®and NeighborCare ®names. With the addition of the LTC operations, we are continuing to enhance our service offerings to further address the needs of an aging population throughout the continuum of senior care.

Retail Pharmacy Business Strategy - Our integrated pharmacy services model has enhanced the ability of our retail pharmacy stores to expand customer access to care while helping to lower overall health care costs and improve health outcomes. In that regard, the role of our retail pharmacist is shifting from primarily dispensing prescriptions to also providing services, including flu vaccinations as well as face-to-face patient counseling with respect to adherence to drug therapies, closing gaps in care and recommending more cost effective drug therapies. We also provide a broad assortment of quality merchandise at competitive prices using a retail format that emphasizes service, innovation and convenience. One of the keys to our strategy is technology, which allows us to focus on constantly improving service and exploring ways to provide more personalized product offerings and services. We are continuing to leverage digital to empower our customers and patients by making the full breadth of health care and pharmacy services available to them anytime, anywhere. We are continuing to introduce digital tools to make it easier for people to save time and money and to live healthier lives. In 2017, we rolled out CVS Pay ® nationwide, an end-to-end mobile payment solution that integrates payment, prescription pick-up and our ExtraCare ®loyalty program into one spot at checkout. We believe that continuing to innovate with new and unique products and services, using innovative marketing and adjusting our mix of merchandise to match our customers' needs and preferences is very important to our ability to continue to improve customer satisfaction.

Retail/LTC Products and Services - A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, beauty products and cosmetics, personal care products, convenience foods, photo finishing services, seasonal merchandise and greeting cards. The pharmacies within Target stores sell prescription drugs and over-the-counter drugs that are required to be held behind the counter. The LTC operations include distribution of pharmaceuticals and related consulting and ancillary services. We purchase our merchandise from numerous manufacturers and distributors. We believe that competitive sources are readily available for substantially all of the products we carry and the loss of any one supplier would not likely have a material effect on the business. Our clinics offer a variety of health care services by nurse practitioners and physician assistants.

Retail/LTC net revenues by major product group are as follows:

	Percentage of Net Revenues		
	2017	2016	2015
Pharmacy [1]	75.0 %	75.0 %	72.9 %
Front store and other [2]	25.0	25.0	27.1
	100.0 %	100.0 %	100.0 %

(1) Pharmacy includes LTC sales and sales in pharmacies within Target stores.
(2) "Other" represents less than 5% of the "Front store and other" net revenue category.

Pharmacy - Pharmacy revenues represented approximately three-fourths of the Retail Pharmacy Segment revenues in each of 2017, 2016 and 2015. We believe that our retail pharmacy operations will continue to represent a critical part of our business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, pharmaceuticals being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, and Medicare Part D. We believe our retail pharmacy business benefits from our investment in both people and technology, as well as our innovative partnerships with health plans, PBMs and providers. Given the nature of prescriptions, people want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers need medication management programs and better information to help them get the most out of their health care dollars. To assist our customers with these needs, we have introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging them in behaviors that can help lower costs, improve health, and save lives. Examples include: our Patient Care Initiative, an enhanced medication adherence program; Maintenance Choice ®, a program where eligible client plan members can elect to fill their maintenance prescriptions through delivery to their home or business or at our CVS Pharmacy retail stores for the same price as mail order; Pharmacy Advisor ®, our program that facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions; Specialty Connect ®, which integrates our specialty pharmacy mail and retail capabilities, providing members with disease-state specific counseling from our experienced specialty pharmacists and the convenience of picking-up their prescriptions at their local CVS Pharmacy, or having them delivered to their preferred address; ScriptSync ®, a service that enables patients with multiple medications to pick up their eligible maintenance prescriptions in a single monthly CVS Pharmacy visit; S criptPath ™ Prescription Schedule, a new capability for CVS Pharmacy patients, who manage multiple prescription medications, which features all of a patient's current CVS Pharmacy prescription information in one place – including which medications the patient takes, when the patient should take them and how much of each medication should be taken in each dose; and HealthTag ®, an integrated communications platform that can be leveraged to communicate healthcare opportunities to members that provides unmatched ability to reach and connect with members as well as industry-leading data integration to improve coordination of member care. Each of these are programs that demonstrate our ability to enhance the customer experience through our integrated enterprise products and services. Further evidencing our belief in the importance of pharmacy service is our continuing investment in technology, such as our Drug Utilization Review system that helps check for harmful interactions between prescription drugs and patient identified over-the-counter products, vitamins and herbal remedies; RxConnect, our proprietary pharmacy system that integrates our product delivery and clinical workflows as well as advanced patient safety functionality such as drug utilization review; our prescription refill program, ReadyFill ®; and our online retail businesses, CVS.com, Navarro.com and Onofre.com.br. Our Health Engagement Engine enables patient-specific opportunities to be prioritized and delivered at each key moment of care relevant to that specific patient. In December 2015, we expanded our pharmacy offering with the acquisition of the

pharmacies within Target stores. We offer all the same pharmacy services available in our retail drugstores and online at our pharmacies within Target stores.

Front Store - Front store revenues benefited from our strategy to innovate with new and unique products and services, using innovative personalized marketing and adjusting our mix of merchandise to match our customers' needs and preferences. A key component of our front store strategy is our ExtraCare ® card program, which is helping us continue to build our loyal customer base. The ExtraCare program is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows us to balance our marketing efforts so we can reward our best customers by providing them automatic sale prices, customized coupons, ExtraBucks ® rewards and other benefits. We continue to launch and enhance new and exclusive brands to create unmatched offerings in beauty. Another component of our front store strategy is our unique product offerings, which include a full range of high-quality CVS Pharmacy ® and proprietary brand products that are only available through CVS Pharmacy stores. We currently carry approximately 7,000 CVS Pharmacy and proprietary brand products, which accounted for approximately 23% of our front store revenues during 2017. These products include expanded offerings of healthy foods and vitamins. Furthermore, we are tailoring certain groups of stores, such as suburban area stores, to better meet the needs of our customers.

MinuteClinic - As of December 31, 2017, we operated 1,134 MinuteClinic ® locations in 33 states and the District of Columbia, of which 1,050 were located in our retail pharmacy stores, and 79 were located in Target stores. We opened 15 new clinics during 2017. Our clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions, provide wellness services and deliver vaccinations. Payors value our clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. As a result, visits paid for by employers, health insurers or other third parties accounted for approximately 91% of MinuteClinic's total revenues in 2017. MinuteClinic is collaborating with our Pharmacy Services Segment to help meet the needs of CVS Caremark's client plan members by offering programs that can improve member health and lower costs. MinuteClinic is now affiliated with more than 75 major health systems and continues to build a platform that supports primary care.

Long-term Care - Through our Omnicare business, we provide the distribution of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. We provide pharmacy consulting, including monthly patient drug therapy evaluations, assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. We also provide pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Onsite Pharmacies - We also operate a limited number of small pharmacies located at client sites, typically under the CarePlus ®, CarePlus CVS Pharmacy ® or CVS Pharmacy ® name, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Retail Pharmacy Drugstore Development - The addition of new stores has played, and will continue to play, a key role in our continued growth and success. Our store development program focuses on three areas: entering new markets, adding stores within existing markets and relocating stores to more convenient sites. During 2017, we opened 175 new retail locations, relocated 30 stores and closed 81 locations. During the last five years, we opened approximately 1,000 new and relocated locations, and acquired 1,880 locations including the pharmacies acquired from Target. We believe that continuing to grow our store base and locating stores in more accessible markets are essential components to compete effectively in the current health care environment. As a result, we believe that our store development program is an integral part of our ability to maintain our leadership position given the changing health care landscape and to meet the increasing needs of our customers.

Retail/LTC Information Systems - We have continued to invest in information systems to enable us to deliver exceptional customer service, enhance safety and quality, and expand our patient care services while lowering operating costs. Our proprietary WeCARE Workflow supports our pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating our clinical programs. This solution delivers improved efficiency and enhances the customer experience, as well as providing a framework to accommodate the evolution of pharmacy practice and the expansion of our clinical programs. Our Health Engagement Engine technology and proprietary clinical algorithms enable us to help identify opportunities for our pharmacists to deliver face-to-face

counseling regarding patient health and safety matters, including adherence issues, gaps in care and management of certain chronic health conditions. Our digital strategy empowers the consumer to navigate their pharmacy experience and manage their condition through our on-line and mobile tools that offer utility and convenience. This includes the ability to schedule an appointment at MinuteClinic, get next-in line alerts or health reminders and appointment updates via text messages. Our integrated digital offerings help patients seamlessly manage retail, mail and specialty prescriptions dispensed by a CVS Pharmacy or LTC location and enhance front store personalization to drive value for customers. We continue to experience strong adoption of our digital solutions with our mobile app receiving critical acclaim for ease of use and our text message program experiencing significant growth. LTC's digital technology suite, Omniview ®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers - The success of our retail drugstore and LTC businesses is dependent upon our ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Pharmacy benefit managers, managed care organizations, government-funded health care programs, commercial employers and other third party payors accounted for 99.2% of our 2017 pharmacy revenues. No single Retail/LTC payor accounts for 10% or more of our annual consolidated net revenues.

Retail/LTC Seasonality - The majority of our revenues, particularly pharmacy revenues, are generally not seasonal in nature. However, retail front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and retail front store revenues are affected by the timing and severity of the cough, cold and flu season. For additional information, we refer you to "Risks related to the seasonality of our business" in Item 1A. Risk Factors.

Retail/LTC Competition - The retail drugstore business is highly competitive. We believe that we compete principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the markets we serve, we compete with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Wal-Mart), independent pharmacies, restrictive pharmacy networks, membership clubs, Internet companies, and retail health clinics (including urgent care centers), as well as other mail order pharmacies.

LTC pharmaceutical services are highly regional or local in nature and within a given geographic area of operation, highly competitive. Our largest competitor nationally is PharMerica. We also compete with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that we face in providing services to long-term care facility residents in these states.

Corporate Segment

Our Corporate Segment provides management and administrative services to support the overall operations of the Company. The Corporate Segment consists of certain aspects of our executive management, corporate relations, legal, compliance, human resources, information technology and finance departments.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

We fund the growth of our business through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on our working capital practices, we refer you to the caption "Management's Discussion and Analysis - Liquidity and Capital Resources" in our Annual Report to Stockholders for the year ended December 31, 2017, which section is

incorporated by reference herein. The majority of our non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government-funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of our consolidated pharmacy revenues, typically settle in less than 30 days. With the exception of our Medicare Part D services, the remainder of our consolidated pharmacy revenues are paid in cash, or with debit or credit cards. As a provider of Medicare Part D services, we contract annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters which impacts our working capital from year to year.

Colleague Development

As of December 31, 2017, we employed approximately 246,000 colleagues in 50 states, the District of Columbia, Puerto Rico and Brazil, which included approximately 36,000 pharmacists, nurses, nurse practitioners and physician assistants. The total included approximately 86,000 part-time colleagues who work less than 30 hours per week. To deliver the highest levels of service to our customers, we devote considerable time and attention to our people and service standards. We emphasize attracting and training knowledgeable, friendly and helpful associates to work in our organization.

Intellectual Property

We have registered and/or applied to register a variety of our trademarks and service marks used throughout our business, as well as domain names, and rely on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect our proprietary rights. We regard our intellectual property as having significant value in our Pharmacy Services and Retail/LTC segments. We are not aware of any facts that could materially impact our continuing use of any of our intellectual property.

Government Regulation

Overview - Much of our business is subject to federal and state laws and regulations. In addition, many of our PBM clients and our payors in the Retail/LTC Segment, including insurers, Medicare Part D plans, Managed Medicaid plans and managed care organizations ("MCOs"), are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, our LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which we are subject. The application of these complex legal and regulatory requirements to the detailed operation of our business creates areas of uncertainty. Further, there are numerous proposed health care laws and regulations at the federal and state levels, some of which could adversely affect our business if they are enacted. We are unable to predict what federal or state legislation or regulatory initiatives may be enacted in the future relating to our business or the health care industry in general, or what effect any such legislation or regulations might have on our business. Any failure or alleged failure to comply with applicable laws and regulations as summarized below, or any adverse applications of, or changes in, the laws and regulations affecting our business, could have a material adverse effect on our operating results and/or financial condition. See Item 3, "Legal Proceedings" for further information.

Although we believe that we are in material compliance with existing laws and regulations applicable to our various business lines, we cannot give any assurances that our business, financial condition and results of operations will not be materially adversely affected, or that we will not be required to materially change our business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to our business, the pharmacy services, retail pharmacy, long-term care or retail clinic industry or to the health care industry generally; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services, retail pharmacy, long-term care or retail clinic industry or of the health care industry generally; (iv) institution of government enforcement actions against us; (v) adverse developments in any pending *qui tam* lawsuit against us, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against us; or (vi) adverse developments in other pending or future legal proceedings against us or affecting the pharmacy services, retail pharmacy, long-term care or retail clinic industry or the health care industry generally.

Laws and Regulations Related to Each Operating Segment of Our Business

Laws Related to Reimbursement by Government Programs - We are subject to various state and federal laws concerning our submission of claims for reimbursement by Medicare, Medicaid and other government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, multiples damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act ("FCA"), the federal Anti-Kickback statute, various state false claims acts and anti-kickback statutes, the federal "Stark Law" and related state laws. In particular, the FCA prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. As part of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "ACA"), the federal Anti-Kickback Statute was amended in 2010 to provide that any claim for government reimbursement violates the FCA where it results from a violation of the Anti-Kickback Statute. Most states have enacted false claims laws analogous to the FCA, and both federal and state false claims laws permit private individuals to file *qui tam* or "whistleblower" lawsuits on behalf of the federal or state government. Further, the federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other government-sponsored health care programs.

Antitrust and Unfair Competition - The Federal Trade Commission ("FTC") has authority under Section 5 of the Federal Trade Commission Act ("FTCA") to investigate and prosecute practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various state and federal antitrust and unfair competition laws challenging, among other things: (i) brand drug pricing practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that we appear to have actual or potential market power in a relevant market or CVS Pharmacy or CVS Specialty plays a unique or expanded role in a PBM product offering, our business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties.

Privacy and Confidentiality Requirements - Many of our activities involve the receipt, use and disclosure by us of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, we use and disclose de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have recently incorporated these requirements into state laws.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA") impose extensive requirements on the way in which health plans, health care providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of the American Recovery and Reinvestment Act of 2009, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. It also extended HIPAA privacy and security requirements and penalties directly to business associates. In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA.

Finally, the Health Insurance Marketplaces (formerly known as the "exchanges") are required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Health Insurance Marketplace has implemented for itself or non-Health Insurance Marketplace entities, which include insurers offering plans through the Health Insurance Marketplaces and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the FTCA, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws. These laws have been the basis for investigations, lawsuits and multi-state settlements relating to, among other matters, the marketing of loyalty programs and health care services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs and disclosures related to how personal data is used and protected.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, Medicare Part D prescription drug plans, expired products, environmental and safety matters, marketing and advertising practices, PBM, long term care and pharmacy operations and various other business practices. These agreements may contain certain ongoing reporting, monitoring or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - Our business is subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in our stores, distribution centers and other facilities. Governmental agencies on the federal, state and local levels have, in recent years, increasingly focused on the retail and health care sectors' compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

Health Reform Legislation - Passed in 2010, ACA affects virtually every aspect of health care in the country. In addition to establishing the framework for every individual to have health coverage, ACA enacted a number of significant health care reforms. Many of these reforms affect the coverage and plan designs that are provided by our health plan clients. As a result, these reforms impact a number of our services and business practices. Some significant ACA provisions are still being finalized (e.g., implementation of the excise tax on high-cost employer-sponsored health coverage has been delayed by Congress) and parts of ACA may still face potential Congressional changes, so the full impact of ACA on our Company is still uncertain.

Pharmacy and Professional Licensure and Regulation - We are subject to a variety of intersecting state and federal statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians and nurses; registration of facilities with the United States Drug Enforcement Administration ("DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the United States Food and Drug Administration ("FDA"), the Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of local, state and federal agencies, with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the United States Department of Justice, the United States Department of Health and Human Services ("HHS") and others. Many of these agencies have broad enforcement powers, conduct audits on a regular basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Laws and Regulations Related to Our Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect our business as a whole, we are subject to federal, state and local statutes and regulations governing the operation of our Pharmacy Services Segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation seeking to regulate PBM activities in a comprehensive manner has been introduced or enacted in a number of states. This legislation could adversely impact our ability to conduct business on commercially reasonable terms in states where the legislation is in effect.

In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM or specialty pharmacy services. Moreover, any standards established by these organizations could also impact our health plan clients and/or the services we provide to them.

Medicare Part D - The Medicare Part D program, which makes prescription drug coverage available to eligible Medicare beneficiaries through private insurers, regulates all aspects of the provision of Medicare drug coverage, including enrollment, formularies, pharmacy networks, marketing, and claims processing. The Medicare Part D program has undergone significant legislative and regulatory changes since its inception, and continues to attract a high degree of legislative and regulatory scrutiny. The applicable government rules and regulations continue to evolve. CMS has imposed restrictions and issued new requirements to protect Medicare Part D beneficiaries and has used its authority to sanction and impose civil monetary penalties on plans for non-compliance.

Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the ability to limit access to a pharmacy provider network or remove network providers. For example, certain "any willing provider" legislation may require us or our clients to admit a non-participating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively impact the services and economic benefits achievable through a limited pharmacy provider network.

Also, a majority of states now have some form of legislation affecting our ability (and the health plans' ability) to conduct audits of network pharmacies regarding claims submitted to us for payment. These laws could negatively impact our ability to recover overpayments in health care payments stemming from pharmacy audits. Lastly, several states have passed legislation regulating our ability to manage and establish maximum allowable costs ("MAC") for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively impact our ability to establish MAC prices for generic drugs.

Contract Audits - We are subject to audits of many of our contracts, including our PBM client contracts, our PBM rebate contracts, our PBM network contracts, our contracts relating to Medicare Part D and the agreements our pharmacies enter into with other payors. Because some of our contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these agreements are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - We have a contractual arrangement with carriers for the Federal Employee Health Benefits ("FEHB") Program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB Program. These arrangements subjects us to certain aspects of FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise are not applicable to us.

State Insurance Laws - PDPs and our PBM service contracts, including those in which we assume certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in several states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a few states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code. Additionally, some states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

As a PDP, SilverScript is subject to state insurance laws limited to licensure and solvency. In addition, PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

ERISA Regulation - The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, we assist plan sponsors in the administration of the prescription drug portion of their health benefit plans in accordance with the plan designs adopted by the plan sponsors. We do not believe that the conduct of our business subjects us to the fiduciary obligations of ERISA, except when we have specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan, and with respect to the Contraceptive Coverage Mandate, one of the health reforms presently included in ACA.

In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state exchanges. Additionally, NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect our ability to develop and administer formularies, networks and other plan design features on behalf of our insurer, MCO and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Managed Care Reform - In addition to health reforms enacted by ACA, proposed legislation has been considered at the state level, and legislation has been enacted in several states, aimed primarily at providing additional rights and access to drugs to individuals enrolled in managed care plans. This legislation may impact the design and implementation of prescription drug benefit plans sponsored by our PBM health plan clients and/or the services we provide to them. Both the scope of the managed care reform proposals considered by state legislatures and reforms enacted by states to date vary greatly, and the scope of future legislation that may be enacted is uncertain.

Disease Management Services Regulation - We provide disease management programs to PBM plan members for rare medical conditions and arrange for them to receive disease management programs for common medical conditions. State laws regulate the practice of medicine, the practice of pharmacy and the practice of nursing. Clinicians engaged in a professional practice in connection with the provision of disease management services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as preferred provider organizations, third party administrators and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

Laws and Regulations Related to Our Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect our business as a whole, we are subject to federal, state and local statutes and regulations governing the operation of our Retail/LTC Segment specifically. Among these are the following:

Specific FDA Regulation - The FDA generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, medical devices (including mobile medical devices), cosmetics, dietary supplements and certain food items.

Retail Clinics - States regulate retail clinics operated by nurse practitioners or physician assistants through physician oversight, lab licensing and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of our owned and managed retail clinics.

Available Information

CVS Health Corporation is a Delaware corporation. Our corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. Our common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about CVS Health is available through the Company's Web site at *http://www.cvshealth.com* . Our financial press releases and filings with the United States Securities and Exchange Commission ("SEC") are available free of charge within the Investors section of our Web site at *http://www.cvshealth.com/investors* . In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that Web site is *http://www.sec.gov.*

Item 1A. Risk Factors

Our business is subject to various industry, economic, regulatory and other risks and uncertainties. Our business, financial condition, results of operations, cash flows and prospects could be materially adversely affected by any one or more of the following risk factors and by additional risks and uncertainties not presently known to us or that we currently deem to be immaterial:

Risks of declining gross margins in the PBM, retail pharmacy and LTC pharmacy industries.

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, enhanced service offerings and/or higher service levels. In that regard, we maintain contractual relationships with generic pharmaceutical manufacturers and brand name pharmaceutical manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one

or more pharmaceutical manufacturers, or if the discounts or rebates provided by pharmaceutical manufacturers decline, our business and financial results could be adversely affected. Further, competitive pressures in the PBM industry have resulted in our clients sharing in a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. Market dynamics and regulatory changes have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could negatively impact our future profitability. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to patent term extensions, purchase discount and rebate arrangements with pharmaceutical manufacturers, or to formulary management or other PBM services could also reduce the discounts or rebates we receive. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, could adversely impact our profitability.

Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have also been affected by the margin pressures described above, including client demands for lower prices, generic pricing and network reimbursement pressure. In addition, as competition increases in the markets in which we operate, a significant increase in general pricing pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive. A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates could adversely affect our margins, including the shift in pharmacy mix towards 90-day prescriptions at retail and the shift in pharmacy mix towards Medicare Part D prescriptions. Finally, the margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements. These actions could also adversely affect the margins of our LTC business.

Efforts to reduce reimbursement levels and alter health care financing practices.

The continued efforts of health maintenance organizations, managed care organizations, PBMs, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, as well as litigation and other legal proceedings relating to how drugs are priced, may impact our profitability. In particular, increased utilization of generic pharmaceuticals (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail, specialty, LTC and mail order pharmacies for generic drugs, causing a reduction in the generic profit rate. Historically, the effect of this trend on generic profitability has been mitigated by our efforts to negotiate reduced acquisition costs of generic pharmaceuticals with manufacturers. However, in recent years, there has been significant consolidation within the generic manufacturing industry, and it is possible that this and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic pharmaceuticals and diminish our ability to negotiate reduced acquisition costs. Any inability to offset increased costs or to modify our activities to lessen the impact could have a significant adverse effect on our results of operations.

In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and audits at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are continuing at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices. For example, we anticipate that federal and state governments will continue to review and assess alternative health care delivery systems, payment methodologies and operational requirements for health care providers, including LTC facilities and pharmacies. A change in the composition of pharmacy prescription volume toward programs offering lower reimbursement rates could negatively impact our profitability. Any action taken to repeal or replace all or significant parts of ACA could also impact our profitability, though it is unclear at this time what the full effects will be.

ACA made several significant changes to Medicaid rebates and to reimbursement. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for multi-source (i.e., generic) drugs. This change has negatively affected our reimbursement. In addition, ACA made other changes that affect the coverage and plan designs that are or will be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum medical loss ratio to avoid having to pay rebates to enrollees. These ACA changes may not affect our business directly, but they could indirectly impact our services and/or business practices.

A highly competitive business environment.

Each of our retail pharmacy, LTC pharmacy, retail health clinic and pharmacy services operations currently operates in a highly competitive and evolving health care environment.

The competitive success of our retail pharmacy business, as well as our specialty pharmacy operations with non-Caremark payors, is derived by their ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. As a pharmacy retail business, we compete with other drugstore chains, supermarkets, on-line and other discount retailers, independent pharmacies, membership clubs, convenience stores and mass merchants, some of which are aggressively expanding into markets we serve. We also face competition from other retail health clinics, as well as other mail order pharmacies and PBMs. Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such changes and make timely and effective changes to our strategies and business model to compete effectively. Competition may also come from other sources in the future. Changes in market dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and the exclusion from new narrow or restricted networks, could materially and adversely impact us.

We could also be adversely affected if we fail to identify or effectively respond to changes in market dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the United States, a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy operations focuses on complex and high-cost medications that serve a relatively limited universe of patients, the future growth of this business depends to a significant extent upon expanding our ability to access key drugs and successfully penetrate key treatment categories.

The competitive success of our LTC pharmacy operations is dependent upon our ability to compete in each geographic region where we have operations. In the geographic regions we serve, we compete with PharMerica, our largest competitor, as well as with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Our long-term care customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. We believe that the assisted living segment, where residents can choose which pharmacy will provide them with pharmaceuticals, is projected to grow the most as a percentage of the total LTC sector over the near term. The ability of a resident of an assisted living facility to select the pharmacy that supplies him or her with pharmaceuticals could adversely affect our business, financial condition and results of operations because there can be no assurance that such resident will select us.

The competitive success of our pharmacy services business is impacted by its ability to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. Competitors in the PBM industry (e.g., Express Scripts, OptumRx, Prime Therapeutics, MedImpact and Humana), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Competition may also come from other sources in the future. In addition, changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could adversely affect our claims volume and/or our competitiveness generally.

Competitors in each of our business areas may offer services and pricing terms that we may not be willing or able to offer. Strong competition in the PBM marketplace has generated greater client demand for lower pricing, increased revenue sharing and enhanced product and service offerings. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings, particularly in a rapidly changing health care industry, we may be unable to remain competitive.

Changes in U.S. policy, laws and regulations, including reform of the United States health care system.

The results of the November 2016 elections continue to generate some uncertainty with respect to, and could result in, significant changes in legislation, regulation and government policy that could significantly impact our business and the health care and retail industries. While it is not possible to predict whether and when any such changes will occur or what form any such changes may take (including through the use of Executive Orders), specific proposals discussed by the Presidential Administration could have a material adverse effect on our business, liquidity and results of operations include, but are not limited to, immigration policies, the modification of ACA. Other significant changes to health care system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries are also possible.

Potential modification to ACA, significant changes to Medicaid funding or even significant destabilization of the Health Insurance Marketplaces could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to ACA are possible and we cannot predict the effect, if any, on future changes to ACA, the implementation or failure to implement the outstanding provisions of ACA, or the enactment of new health care system legislation to replace current legislation may have on our retail pharmacy, LTC pharmacy, specialty pharmacy and pharmacy services operations.

In addition, much of the branded and generic drug product that we sell in our retail, mail and specialty pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material impact on our business, liquidity and results of operations. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our business.

Risks related to compliance with a broad and complex regulatory framework.

Our business is subject to numerous federal, state and local laws and regulations. See “Business - Government Regulation.” In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and enforcement activity at both the federal and state levels. Further, uncertainties exist regarding the application of many of these legal requirements to our business. In addition, it is possible that certain provisions of the current health care reform legislation may be modified, repealed or otherwise invalidated. Changes in these laws and regulations and the related interpretations and enforcement practices may require extensive system and operating changes that may be difficult to implement. Untimely compliance or noncompliance with applicable laws and regulations could adversely affect the continued operation of our business, including, but not limited to: imposition of civil or criminal penalties; significant fines or monetary penalties; suspension or disgorgement of payments from government programs; loss of required government certifications or approvals; loss of authorizations to participate in or exclusion from government reimbursement programs, such as the Medicare and Medicaid programs; or loss of registrations or licensure. The regulations to which we are subject include, but are not limited to: the laws and regulations described in the Government Regulation section; accounting standards; financial disclosure; securities laws and regulations; federal anti-trust laws; tax laws and regulations and their possible reform; laws and regulations relating to the protection of the environment and health and safety matters, including those governing exposure to, and the management and disposal of, hazardous materials and wastes; and laws and regulations of the FTC, the FCC, and the Consumer Product Safety Commission, as well as state regulatory authorities, governing the sale, advertisement and promotion of products that we sell, such as Boards of Pharmacy. The FDA, DEA and various states regulate the distribution of pharmaceuticals and controlled substances. We are required to hold valid DEA and state-level registrations and licenses, meet various security and operating standards and comply with the federal and various states’ controlled substances acts and their accompanying regulations governing the sale, marketing, packaging, holding and distribution of controlled substances. The DEA, FDA and state regulatory authorities have broad enforcement powers, including the ability to suspend our registrations and licenses, seize or recall products and impose significant criminal, civil and administrative sanctions for violations of these laws and regulations. In addition, our business interests outside of the United States are subject to the Foreign Corrupt Practices Act and other applicable domestic and international laws and regulations. We are also subject to the terms of various government agreements and mandates, including those described in the Government Regulation section. In that regard, our business, financial position and results of operations could be adversely affected by existing and new government legislative, regulatory action and enforcement activity, including, without limitation, any one or more of the following:

- federal and state laws and regulations concerning the submission of claims for reimbursement by Medicare, Medicaid and other government programs, whether at retail, mail, specialty or LTC;
- federal and state laws and regulations governing the purchase, distribution, tracking, management, compounding, dispensing and reimbursement of prescription drugs and related services, whether at retail, mail, specialty or LTC, and applicable registration or licensing requirements;
- heighted enforcement of controlled substances regulations;
- the effect of the expiration of patents covering brand name drugs and the introduction of generic products;

- the frequency and rate of approvals by the FDA of new brand name and generic drugs, or of over-the-counter status for brand name drugs;
- rules and regulations issued pursuant to HIPAA and the HITECH Act; and other federal and state laws affecting the collection, use, disclosure and transmission of health or other personal information, such as federal laws on information privacy precipitated by concerns about information collection through the Internet, state security breach laws and state laws limiting the use and disclosure of prescriber information;
- health care fraud and abuse laws regulations;
- consumer protection laws affecting our health care services, our loyalty programs, our drug discount card programs, the products we sell, the informational calls we make and/or the marketing of our goods and services;
- federal, state and local environmental, health and safety laws and regulations applicable to our business, including the management of hazardous substances, storage and transportation of hazardous materials, and various recordkeeping disclosure and procedure requirements promulgated by the Occupational Safety and Health Administration that may apply to our operations;
- health care reform, managed care reform and plan design legislation;
- laws against the corporate practice of medicine;
- FDA regulation affecting the retail, LTC, specialty or PBM industry;
- government regulation of the development, administration, review and updating of formularies and drug lists including requirements and/or limitations around formulary tiering and patient cost sharing;
- state laws and regulations related to increased oversight of PBM activities by state departments of insurance pharmacy reimbursement for generics and pharmacy audits;
- drug pricing legislation, including "most favored nation" pricing;
- federal and state laws and regulations establishing or changing prompt payment requirements for payments to retail pharmacies;
- impact of network access legislation or regulations, including "any willing provider" laws, on our ability to manage pharmacy networks;
- ERISA and related regulations;
- administration of Medicare Part D, including legislative changes and/or CMS rulemaking and interpretation;
- Medicare and Medicaid regulations applicable to our business, in particular our LTC pharmacies and those of our client's facilities;
- ongoing compliance with consent decrees, corporate integrity agreements, corrective action plans and other agreements with government agencies;
- insurance licensing and other insurance regulatory requirements applicable to offering Medicare Part D programs and services or other health care services; and
- direct regulation of pharmacies or PBMs by regulatory and quasi-regulatory bodies.

The possibility of client losses and/or the failure to win new business.

Our PBM business generates net revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM's client base typically is subject to renewal each year. In some cases, however, PBM clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Our clients are generally well informed and organized, can move between our competitors and often seek competing bids prior to expiration of their contracts. In addition, the reputational impact of a service-related incident could negatively affect our business. These factors, together with the impact of competitive pressures, could make it difficult for us to attract new clients, retain existing clients and cross-sell additional services. Further, the PBM industry has been affected by consolidation activity that may continue in the future. In the event one or more of our PBM clients is acquired by an entity that is not also our client, we may be unable to retain all or a portion of the acquired business. These circumstances, either individually or in the aggregate, could result in an adverse effect on our business and financial results. Therefore, we continually face challenges in competing for new PBM business and retaining or renewing our existing PBM business. With respect to our LTC business, reimbursement from skilled nursing facilities for prescriptions we dispense is determined pursuant to our agreements with those skilled nursing facilities. The termination of these agreements generally causes our ability to provide services to any of the residents of that facility to cease, resulting in the loss of revenue from any source for those residents. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to us as the present terms.

Additionally, with respect to our retail and LTC pharmacy businesses, reimbursement under Medicare Part D, as well as reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their pharmacy benefit manager representatives. The loss of those agreements, or a material change in the terms of those agreements, could negatively impact the Company. In addition, restricted networks that exclude our retail or specialty pharmacies negatively impact those businesses.

Risks relating to the market availability, suppliers and safety profiles of prescription drugs that we purchase and sell.

We dispense significant volumes of brand-name and generic drugs from our retail, LTC, specialty and mail-order pharmacies and through our PBM's network of retail pharmacies. When increased safety risk profiles or manufacturing or other supply issues of specific drugs or classes of drugs occur, or drugs become subject to greater restrictions as controlled substances, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced.

Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can result in lower prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our volumes, net revenues, profitability and cash flows may decline as a result of such regulatory rulings or market changes.

Further, we acquire a substantial amount of our mail and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers are often short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the agreement and may allow the supplier to distribute through channels other than ours. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could have a material adverse effect on our business, financial condition and results of operations. Moreover, many products distributed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply.

In addition, our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

A disruption in our business operations could occur as a result of contamination of drugs, a failure to maintain necessary shipment and storage conditions, errors in mail order processing, the unavailability of prescription drugs provided by suppliers, labor disruptions or other unanticipated disruptions at our mail order facilities, call centers, data centers or corporate facilities, among other factors. Such disruption could reduce our ability to process and dispense prescriptions and provide products and services to our customers.

In the event any products we distribute are in limited supply for significant periods of time, our financial condition and results of operations could be materially and adversely affected.

Risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription products.

The profitability of our business is dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription pharmaceuticals as well as lower-priced generic alternatives to existing brand name products, as the sale of generic alternatives normally yield higher gross margins than brand name equivalents. In addition, inflation in the price of the brand name drugs can affect utilization, particularly given the increase in high deductible health plans. Accordingly, our business could be impacted by a slowdown or delay in the number or magnitude of new and successful prescription pharmaceuticals and/or generic alternatives, as well as the pricing of brand name drugs.

The health of the economy in general and in the markets we serve.

Our business is affected by the economy and consumer confidence in general, including various economic factors, inflation and changes in consumer purchasing power, preferences and/or spending patterns. It is possible that an unfavorable, uncertain or volatile economic environment will cause a decline in drug and health care services utilization and dampen demand for pharmacy benefit management services as well as consumer demand for products sold in our retail stores. Further economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms and our ability to execute sale-leaseback transactions under acceptable terms. These changes in conditions could result in an adverse effect on our business and financial results. This could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments.

The failure or disruption of our information technology systems, our information security systems and our infrastructure to support our business and to protect the privacy and security of sensitive customer and business information.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, ExtraCare customer loyalty program, finance, human resource and other processes. Throughout our operations, we receive, retain and transmit certain confidential information, including PII that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks. Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches including credit card or personally identifiable information breaches, coordinated cyber attacks, vandalism, catastrophic events and human error. Although we deploy a layered approach to address information security threats and vulnerabilities, including ones from a cyber security standpoint, designed to protect confidential information against data security breaches, a compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our business, financial position, and results of operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

Failure to adequately protect receipt and use of confidential health information concerning individuals.

Many aspects of our business involve the collection, transmission and use of an individual's protected health information or other sensitive personal information. In some cases, we also use aggregated and de-identified data as defined by HIPAA for analytical and research purposes, particularly data related to improving the quality of the care we provide. In other cases, we may provide de-identified data to pharmaceutical manufacturers and to third-party data aggregators where permitted by our contracts. These activities are subject to federal and state privacy and security laws and regulations and, in the future, may be subject to international regulatory requirements such as the General Data Protection Regulation, a new European Union privacy regulation that takes effect on May 25, 2018. At the federal level, HIPAA imposes extensive privacy and security requirements governing the transmission, use and disclosure of health

information by all participants in the health care industry, whether directly as a covered entity or as a business associate. Our business encompasses both situations and includes our pharmacists, nurse practitioners and PBM operations. In addition, industry requirements, such as Generally Accepted Privacy Principles may be imposed on us by our contracts with our PBM clients or other customers. Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a security standard mandated by the credit card industry for the purpose of protecting credit card account data. These increasingly complex laws, regulations and industry requirements are subject to change and compliance with them may result in significant expenses associated with increased operational and compliance costs, particularly as we continue to collect and retain large amounts of information. To the extent that either we or our vendors with whom we share information are found to be out of compliance with applicable laws and regulations or experience a data security breach, we could be subject to additional litigation, regulatory risks and reputational harm. For example, the privacy and security of the information we maintain may be compromised by the actions of outside parties, by employee errors or by malfeasance. Such risks may result in an unauthorized party obtaining access to our data systems thereby threatening the privacy of protected health information or other sensitive personal information we use and maintain. Failure to comply with federal or state statutes or regulations may result in criminal penalties and civil sanctions. In addition, failure to comply with our own privacy or security policies may result in sanctions by the FTC or other federal oversight agencies. Future regulations and legislation that severely restrict or prohibit our use of patient, member or customer identifiable or other information could limit our ability to use information critical to the operation of our business. Furthermore, if we violate a patient's privacy or are found to have violated any federal or state statute or regulation with regard to confidentiality or dissemination or use of PHI, we could be liable for significant damages, fines or penalties and suffer reputational harm, any one of which could have a material adverse effect on our business and results of operations.

Regulatory and business changes relating to our participation in Medicare Part D.

Medicare Part D has resulted in increased utilization and puts pressure on pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of ACA and changes to the retiree drug subsidy rules, our PBM clients could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that impacts the profitability of our Medicare Part D business; if changes to the regulations impact our ability to retain fees from third parties including network pharmacies; if the government alters Medicare program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if the government mandates the use of point-of-sale manufacturer rebates or makes changes to how pharmacy pay-for-performance is calculated; if Congress acts to reduce reinsurance thresholds from 80% to 20%; if we fail to design and maintain programs that are attractive to Medicare participants; if CMS imposes restrictions on our Medicare Part D business as a result of audits or other regulatory actions; if we fail to successfully implement corrective action or other remedial measures sufficient to prevent or remove any applicable restrictions that may be imposed by CMS; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare Part D's competitive bidding process, our Medicare Part D services and the ability to expand our Medicare Part D services could be negatively impacted.

Possible changes in industry pricing benchmarks and drug pricing generally.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace Average Wholesale Price ("AWP") or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, pharmaceutical purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs ("FFS Medicaid") have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact in reimbursement practices in other commercial and government segments. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish pharmaceutical pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with pharmaceutical manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have an adverse effect on our results of operations.

Additionally, any future changes in drug prices could be significantly different than our projections. The effect of these possible changes on our business cannot be predicted at this time.

Product liability, product recall or personal injury issues could damage our reputation; failure to maintain adequate liability insurance coverage.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of pharmaceuticals could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the products or pharmaceuticals we sell or services we provide. Our business involves the provision of professional services including by pharmacists, nurses and nurse practitioners that exposes us to professional liability claims. Should a product or other liability issue arise, the coverage limits under our insurance programs and the indemnification amounts available to us may not be adequate to protect us against claims. We also may not be able to maintain this insurance on acceptable terms in the future. Damage to our reputation in the event of a product liability or personal injury issue or judgment against us or a product recall could have a significant adverse effect on our business, financial condition and results of operations.

Relationship with our retail and specialty pharmacy customers and the demand for our products and services, including propriety brands.

The success of our business depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in our markets, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could negatively affect our relationship with our clients and customers and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks and mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. Any failure to adequately address some or all of these risks could have an adverse effect on our business, results of operations and financial condition. Additionally, an increase in the sales of our proprietary brands may negatively affect our sales of products owned by our suppliers which, consequently, could adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our financial performance and erode customer loyalty.

Finally, our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs), that serve a relatively limited universe of patients. As a result, the future growth of our specialty pharmacy business is dependent largely upon expanding our base of drugs or penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our business, financial condition and results of operations.

Risks related to developing and maintaining a relevant omni-channel experience for our customers.

Our business has evolved from a retail store experience to interaction with customers across numerous channels, including in-store, online, mobile and social media, among others. Omni-channel retailing is rapidly evolving and we must keep pace with changing customer expectations and new developments by our competitors. Our customers are increasingly using computers, tablets, mobile phones, and other devices to comparison shop, determine product availability and complete purchases through mobile commerce applications. As a result, the portion of total consumer expenditures with all retailers occurring online and through mobile commerce applications is increasing and the pace of this increase could accelerate. We must compete by offering a consistent and convenient shopping experience for our customers regardless of the ultimate sales channel and by investing in, providing and maintaining mobile commerce

applications for our customers that have the right features and are reliable and easy to use. If we are unable to make, improve, or develop relevant customer-facing technology in a timely manner that keeps pace with technological developments and dynamic customer expectations, our ability to compete and our results of operations could be materially and adversely affected. In addition, if our online activities or our other customer-facing technology systems do not function as designed, we may experience a loss of customer confidence, data security breaches, lost sales, or be exposed to fraudulent purchases, any of which could materially and adversely affect our business operations, reputation and results of operations.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these companies are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our results of operations.

Solvency of our customers.

In the event that our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our business, financial condition and results of operations. In addition, both state and federal government sponsored payers, as a result of budget deficits or reductions, may suspend payments or seek to reduce their healthcare expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us. Any delay or reduction in payments by such government sponsored payers may adversely affect our business, financial condition and results of operations.

Our outstanding debt and associated payment obligations could significantly increase in the future if we incur additional debt and do not retire existing debt.

Our current debt service costs associated with our increased debt levels may negatively impact our ability to make important investments in our business and limit our flexibility to respond to industry changes and market conditions. In addition, our debt levels and related debt service obligations could make it more difficult or expensive for us to obtain financing for working capital, capital expenditures, acquisitions or other purposes in the future. These circumstances could have a material adverse effect on our business operations and financial condition.

Further, we may incur and assume significantly more debt in the future, including in connection with the Aetna Acquisition or other acquisitions, strategic investments or joint ventures. For example, in connection with the Aetna Acquisition, if it is completed, we expect to incur approximately, $45.0 billion of new indebtedness and assume approximately $8.2 billion of existing indebtedness of Aetna. If we do not retire our existing debt or debt we assume in acquisitions or other strategic transactions, the risks described above could increase. We also could be adversely impacted by any failure to renew or replace, on terms acceptable to us or at all, existing indebtedness when it expires, and by any failure to satisfy applicable covenants.

We may be unable to refinance existing indebtedness or otherwise access the capital markets for any reason, whether due to market conditions or otherwise. Our continued access to the capital markets, and the terms of such access, depend on multiple factors including the condition of debt capital markets, our operating performance, the amount of our

indebtedness and debt service obligations and our credit ratings. Any disruptions or turmoil in the capital markets or any downgrade of our credit ratings could have a material adverse effect on our cost of funds, liquidity, competitive position and access to capital markets, which could materially and adversely affect our business operations, financial condition, and results of operations.

Our long-term debt obligations include covenants that limit our ability and the ability of our subsidiaries to secure indebtedness with a security interest on certain property or stock or engage in certain sale and leaseback transactions with respect to certain properties. In addition, our existing credit agreements require us to maintain a ratio of consolidated debt to total capitalization not to exceed specified levels. Our ability to comply with these restrictions and covenants may be affected by events beyond our control, and if we fail to comply with such restrictions or covenants, our outstanding indebtedness could be declared immediately due and payable. This could have a material adverse effect on our business operations and financial condition.

We may be unable to successfully integrate companies acquired by us.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company may also be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems, while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disruption of management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays encountered in the integration process, could have a material adverse effect on our business and results of operation. Furthermore, these acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or geographic markets, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

Risks related to the seasonality of our business.

Although the majority of our revenues, particularly pharmacy revenues, are generally not seasonal in nature, front store revenues tend to be higher during the December holiday season. Uncharacteristic or extreme weather conditions can adversely impact consumer shopping patterns as well. This could lead to lost sales, as well as increased snow removal and other costs, thereby negatively affecting our short-term results of operations. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season, which is susceptible to large fluctuations from year to year, and our quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. See "Business - Pharmacy Services Seasonality."

Our operations are subject to a variety of business continuity hazards and risks, any of which could interrupt operations or otherwise adversely affect our performance and results.

We are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events might disrupt or shut down operations, or otherwise adversely impact our operations. We may also be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we have developed business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and

industry, our insurance policies include limits and, as such, our coverage may be insufficient to protect against all potential hazards and risks incident to our business. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our business financial condition and results of operations could be adversely affected.

Risks related to litigation and other legal proceedings.

Pharmacy services, retail pharmacy and LTC pharmacy are highly regulated and litigious industries. We are currently subject to various litigation matters, investigations, audits, inspections, government inquiries, and regulatory and legal proceedings. Litigation, and particularly securities and collective or class action litigation, is often expensive and disruptive. Further, under the *qui tam* or "whistleblower" provisions of the federal and various state false claims acts, private citizens may bring lawsuits alleging that a violation of the federal anti-kickback statute or similar laws has resulted in the submission of "false" claims to federal and/or state health care programs, including Medicare and Medicaid. Litigation related to our provision of professional services in our pharmacies, specialty pharmacies, clinics and LTC facilities has also increased as we expand our services along the continuum of health care. We cannot predict the outcome of any of these matters, and the costs incurred may be substantial regardless of outcome. Our business, financial condition and results of operations may be adversely affected, or we may be required to materially change our business practices, as a result of such proceedings. We refer you to Item 3, "Legal Proceedings" for additional information.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could have an adverse impact on our future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet current and future goals and objectives and there is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased salaries or other benefits. An inability to retain existing employees or attract additional employees, or an unexpected loss of leadership, could have a material adverse effect on our business and results of operations.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our business and results of operations. While we have succession plans in place and employment arrangements with certain key executives, these do not guarantee the services of these executives will continue to be available to us.

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2017, we had $52.1 billion of goodwill and other intangible assets. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we first compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow model and a comparable market multiple model. If the estimated fair value of the reporting unit is less than its carrying amount, an impairment loss calculation is prepared. The impairment loss calculation compares the fair value of a reporting unit to its carrying amount. If the carrying amount of the reporting unit exceeds the fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows, or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our results of operations, which could have a material adverse effect on our financial condition and results of operations.

The foregoing is not a comprehensive listing of all possible risks and there can be no assurance that we have correctly identified and appropriately assessed all factors affecting the business. As such, we refer you to "Management's Discussion and Analysis of Financial Condition and Results of Operations," which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section, of our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

Aetna-Related Risk Factors In addition to the risk factors described above that could materially adversely affect our business, financial condition, results of operations, cash flows and prospects, the following risk factors, and additional risks not presently known to us or that we currently deem to be immaterial, could also materially adversely affect us and the Aetna Acquisition.

In order to complete the merger, we and Aetna must obtain certain governmental authorizations, and if such authorizations are not granted or are granted with conditions that become applicable to the parties, completion of the merger may be jeopardized or prevented or the anticipated benefits of the merger could be reduced.

Completion of the merger is conditioned upon the expiration or early termination of the waiting period relating to the merger under the HSR Act and certain other applicable laws or regulations and the required governmental authorizations having been obtained and being in full force and effect. Although we and Aetna have agreed in the merger agreement to use our reasonable best efforts, subject to certain limitations, to make certain governmental filings or obtain the governmental authorizations required to complete the merger (the "required governmental authorizations"), as the case may be, there can be no assurance that the relevant waiting periods will expire or authorizations will be obtained and no assurance that the merger will be completed.

In addition, the governmental authorities from which these authorizations are required have broad discretion in administering the governing laws and regulations, and may take into account various facts and circumstances in their consideration of the merger, including other potential transactions in the health care industry or other industries. These governmental authorities may initiate proceedings seeking to prevent, or otherwise seek to prevent, the merger. As a condition to authorization of the merger or related transactions, these governmental authorities also may impose requirements, limitations or costs, require divestitures or place restrictions on the conduct of our business after completion of the merger. Under the terms of the merger agreement, we are not required, and Aetna is not permitted without our consent, to take any actions or agree to any terms or conditions in connection with (i) the expiration or early termination of the waiting period relating to the merger under the HSR Act, (ii) any other antitrust law or (iii) the required governmental authorizations, in each case if such action, term or condition would have, or would reasonably be expected to have, individually or in the aggregate, a regulatory material adverse effect on us or Aetna.

However, notwithstanding the provisions of the merger agreement, either we or Aetna could become subject to terms or conditions in connection with such waiting periods, laws or other authorizations (whether because such term or condition does not rise to the specified level of materiality or we otherwise consent to its imposition) the imposition of which could adversely affect our ability to integrate Aetna's operations with our operations, reduce the anticipated benefits of the merger or otherwise materially and adversely affect our business and results of operations after completion of the merger.

In addition to receipt of certain governmental authorizations, completion of the merger is subject to a number of other conditions, and if these conditions are not satisfied or waived, the merger will not be completed.

Our obligations and the obligations of Aetna to complete the merger are subject to satisfaction or waiver of a number of conditions in addition to receipt of certain governmental authorizations, including, among other conditions: (i) approval and adoption of the merger agreement by Aetna shareholders at an Aetna special meeting, (ii) approval of the stock issuance by our stockholders at the CVS Health special meeting, (iii) approval for the listing on the New York Stock Exchange of the shares of CVS Health common stock to be issued in the merger, (iv) absence of any applicable law or order that prohibits completion of the transaction, (v) accuracy of the representations and warranties made in the merger agreement by the other party, subject to certain materiality qualifications, (vi) performance in all material respects by the other party of the material obligations required to be performed by it at or prior to completion of the transaction, and (vii) the absence of a material adverse effect on the other party. There can be no assurance that the conditions to completion of the merger will be satisfied or waived or that the merger will be completed.

In addition, the CVS Health special meeting and the Aetna special meeting may take place before certain governmental authorizations have been obtained and, therefore, before the terms on which such governmental authorizations may be obtained, or the conditions to obtaining such governmental authorizations that may be imposed, are known. As a result, if CVS Health stockholders approve the stock issuance at the CVS Health special meeting, or Aetna shareholders approve and adopt the merger agreement at the Aetna special meeting, we and Aetna may make decisions after the respective meetings to waive a condition as to the receipt of certain governmental authorizations or to take certain

actions required to obtain such governmental authorizations without seeking further stockholder or shareholder approval, as applicable, and such actions could have an adverse effect on the combined company.

After completion of the merger, we may fail to realize the anticipated benefits and cost savings of the merger, which could adversely affect the value of shares of our common stock.

The success of the merger will depend, in part, on our ability to realize the anticipated benefits and cost savings from combining the businesses of CVS Health and Aetna. Our ability to realize these anticipated benefits and cost savings is subject to certain risks, including:

- Our ability to successfully combine the businesses of CVS Health and Aetna;
- whether the combined businesses will perform as expected;
- the possibility that we paid more for Aetna than the value we will derive from the acquisition;
- the reduction of our cash available for operations and other uses and the incurrence of indebtedness to finance the acquisition; and
- the assumption of known and unknown liabilities of Aetna.

If we are not able to successfully combine the businesses of CVS Health and Aetna within the anticipated time frame, or at all, the anticipated cost savings and other benefits of the merger may not be realized fully or may take longer to realize than expected, the combined businesses may not perform as expected and the value of the shares of our common stock may be adversely affected.

We and Aetna have operated and, until completion of the merger will continue to operate, independently, and there can be no assurances that our respective businesses can be integrated successfully. It is possible that the integration process could result in the loss of key CVS Health or Aetna employees, the disruption of either company's or both companies' ongoing businesses or in unexpected integration issues, higher than expected integration costs and an overall post-completion integration process that takes longer than originally anticipated. Specifically, issues that must be addressed in integrating the operations of Aetna and CVS Health in order to realize the anticipated benefits of the merger so the combined business performs as expected include, among other things:

- combining the companies' separate operational, financial, reporting and corporate functions;
- integrating the companies' technologies, products and services;
- identifying and eliminating redundant and underperforming operations and assets;
- harmonizing the companies' operating practices, employee development, compensation and benefit programs, internal controls and other policies, procedures and processes;
- addressing possible differences in business backgrounds, corporate cultures and management philosophies;
- consolidating the companies' corporate, administrative and information technology infrastructure;
- coordinating sales, distribution and marketing efforts;
- managing the movement of certain businesses and positions to different locations;
- maintaining existing agreements with customers, providers and vendors and avoiding delays in entering into new agreements with prospective customers, providers and vendors;
- operating in industry sectors in which we and our current management may have little or no experience;
- coordinating geographically dispersed organizations;
- consolidating offices of Aetna and CVS Health that are currently in or near the same location; and
- effecting potential actions that may be required in connection with obtaining regulatory approvals.

In addition, at times, the attention of certain members of each company's management and each company's resources may be focused on completion of the merger and the integration of the businesses of the two companies and diverted from day-to-day business operations, which may disrupt each company's ongoing business and the business of the combined company.

We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve the combined company's objectives.

We have limited experience operating an insurance and managed health care business, and will rely in large part on the existing management of Aetna to continue to manage the Aetna business following the merger. However, there is no

assurance that we will be able to retain the services of such management. If we fail to retain the existing management of Aetna, our ability to realize the anticipated benefits of the transaction may be adversely affected.

We and Aetna may have difficulty attracting, motivating and retaining executives and other key employees in light of the merger.

As we will be operating in industry sectors for which our existing management team has little or no experience, our success after the transaction will depend in part on our ability to retain key executives and other employees of Aetna. Uncertainty about the effect of the merger on CVS Health and Aetna employees may have an adverse effect on each of us and Aetna separately and consequently the combined business. This uncertainty may impair our and/or Aetna's ability to attract, retain and motivate key personnel. Employee retention may be particularly challenging during the pendency of the merger, as employees of CVS Health and Aetna may experience uncertainty about their future roles in the combined business.

Additionally, Aetna's officers and employees may hold Aetna common shares, as well as Aetna stock appreciation rights, Aetna restricted stock units ("Aetna RSUs") and Aetna performance stock units ("Aetna PSUs") that are subject to accelerated vesting on a change in control, and, if the merger is completed, these officers and employees may be entitled to cash and/or the consideration payable under the merger agreement in respect of such Aetna common shares, stock appreciation rights, Aetna RSUs and Aetna PSUs. These payouts could also make retention of these officers and employees more difficult. Additionally, pursuant to employment agreements and/or other agreements or arrangements with Aetna, certain key employees of Aetna are entitled to receive severance payments upon a termination without cause and/or a resignation for "good reason" following completion of the merger. Under these agreements, certain key employees of Aetna potentially could resign from his or her employment following specified circumstances set forth in his or her applicable agreement, including an adverse change in his or her title, authority or responsibilities, compensation and benefits or primary office location.

Furthermore, if key employees of CVS Health or Aetna depart or are at risk of departing, including because of issues relating to the uncertainty and difficulty of integration, financial security or a desire not to become employees of the combined business, we may have to incur significant costs in retaining such individuals or in identifying, hiring and retaining replacements for departing employees and may lose significant expertise and talent relating to the business of Aetna, and our ability to realize the anticipated benefits of the merger may be materially and adversely affected. Accordingly, no assurance can be given that we will be able to attract or retain key employees of Aetna to the same extent that Aetna has been able to attract or retain employees in the past.

Our and Aetna's business relationships may be subject to disruption due to uncertainty associated with the merger.

Parties with which we or Aetna do business may experience uncertainty associated with the merger, including with respect to current or future business relationships with us, Aetna or the combined business. Our and Aetna's business relationships may be subject to disruption as customers, providers, vendors and others may attempt to negotiate changes in existing business relationships or consider entering into business relationships with parties other than us, Aetna or the combined business. These disruptions could have a material adverse effect on the businesses, financial condition, results of operations or prospects of CVS Health, Aetna and/or the combined business, including a material adverse effect on our ability to realize the anticipated benefits of the merger. The risk and adverse effect of such disruptions could be exacerbated by a delay in completion of the merger or termination of the merger agreement.

The merger agreement contains provisions that may make it more difficult for us and Aetna to pursue alternatives to the merger.

The merger agreement contains provisions that make it more difficult for Aetna to sell its business to a party other than us, or for us to sell its business. These provisions include a general prohibition on each party soliciting any acquisition proposal. Further, there are only limited exceptions to each party's agreement that its board of directors will not withdraw or modify in a manner adverse to the other party the recommendation of its board of directors in favor of the approval and adoption of the merger agreement, in the case of Aetna, or the approval of the stock issuance, in our case, and the other party generally has a right to match any acquisition proposal that may be made. However, at any time prior to the approval and adoption of the merger agreement by Aetna shareholders, in the case of Aetna, or the approval of the stock issuance by CVS Health stockholders, in our case, such party's board of directors is permitted to take certain of

these actions if it determines in good faith that the failure to take such action would be reasonably likely to be inconsistent with its fiduciary duties under applicable law.

While we believe these provisions are reasonable and not preclusive of other offers, these restrictions might discourage a third party that has an interest in acquiring all or a significant part of either Aetna or CVS Health from considering or proposing that acquisition, even if that party were prepared to pay consideration with a higher per-share value than the currently proposed merger consideration, in the case of Aetna, or that party were prepared to enter into an agreement that may be favorable to us or our stockholders, in our case. Furthermore, the termination fees described below may result in a potential competing acquirer proposing to pay a lower per-share price to acquire the applicable party than it might otherwise have proposed to pay because of the added expense of the termination fee that may become payable by such party in certain circumstances.

Failure to complete the merger could negatively impact our stock price and our future business and financial results.

If the merger is not completed for any reason, including as a result of Aetna shareholders failing to approve and adopt the merger agreement or CVS Health stockholders failing to approve the stock issuance, our ongoing business may be materially and adversely affected and, without realizing any of the benefits of having completed the merger, we would be subject to a number of risks, including the following:

- we may experience negative reactions from the financial markets, including negative impacts on the trading price of our common stock and other securities, and from our customers, providers, vendors, regulators and employees;
- we may be required to pay Aetna a termination fee of $2.1 billion if the merger agreement is terminated under certain circumstances;
- we will be required to pay certain transaction expenses and other costs incurred in connection with the merger, whether or not the merger is completed;
- the merger agreement places certain restrictions on the conduct of our businesses prior to completion of the merger, and such restrictions, the waiver of which is subject to the consent of Aetna, may prevent us from making certain acquisitions, taking certain other specified actions or otherwise pursuing business opportunities during the pendency of the merger that we would have made, taken or pursued if these restrictions were not in place; and
- matters relating to the merger (including arranging permanent financing and integration planning) will require substantial commitments of time and resources by our management and the expenditure of significant funds in the form of fees and expenses, which would otherwise have been devoted to day-to-day operations and other opportunities that may have been beneficial to us as an independent company.

There can be no assurance that the risks described above will not materialize. If any of those risks materialize, they may materially and adversely affect our businesses, financial condition, financial results, ratings, stock prices and/or bond prices.

In addition, we could be subject to litigation related to any failure to complete the merger or related to any proceeding to specifically enforce our obligation to perform our obligations under the merger agreement. If the merger is not completed, these risks may materialize and may materially and adversely affect our businesses, financial condition, financial results, ratings, stock prices and/or bond prices.

We and Aetna may be targets of securities class action and derivative lawsuits which could result in substantial costs and may delay or prevent the merger from being completed.

Securities class action lawsuits and derivative lawsuits are often brought against public companies that have entered into merger agreements. Even if the lawsuits are without merit, defending against these claims can result in substantial costs and divert management time and resources. An adverse judgment could result in monetary damages, which could have a negative impact on our and Aetna's respective liquidity and financial condition. Additionally, if a plaintiff is successful in obtaining an injunction prohibiting completion of the merger, then that injunction may delay or prevent the merger from being completed, which may adversely affect our and Aetna's respective business, financial position and results of operation. Since the filing with the SEC of the preliminary joint proxy statement/prospectus relating to the proposed merger, a number of class action lawsuits in connection with the merger have been filed against us, Aetna and Aetna's

directors and officers. Neither we nor Aetna presently believe that there is any merit to any such lawsuit. We and Aetna intend to defend them vigorously.

Our indebtedness following completion of the merger will be substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility, and increase our borrowing costs. Downgrades in our ratings could adversely affect our business, cash flows, financial condition and operating results.

In order to complete the merger, we expect to incur acquisition-related debt financing of approximately $45.0 billion and assume Aetna's existing indebtedness of approximately $8.2 billion. Our substantially increased indebtedness and higher debt-to-equity ratio following completion of the merger in comparison to that of CVS Health prior to the merger will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and will increase our borrowing costs. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources will be greater than the amount of cash flows required to service the indebtedness of CVS Health or Aetna individually prior to the merger. The increased levels of indebtedness could also reduce funds available to fund our efforts to combine our business with Aetna and realize expected benefits of the merger and/or engage in investments in product development, capital expenditures, dividend payments, share repurchases and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

In addition, our credit ratings impact the cost and availability of future borrowings, and, as a result, our cost of capital. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or, following completion of the merger, obligations to the combined company's insureds. Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Following the announcement of the merger agreement, each of Standard & Poor's and Moody's placed certain of our debt, financial strength and other credit ratings under review for a possible downgrade. Following the announcement of the merger agreement, Standard & Poor's, A.M. Best and Fitch placed Aetna's debt, financial strength and other credit ratings under review with negative implications. Downgrades in our ratings could adversely affect our business, cash flows, financial condition and operating results. In addition, if the merger is completed and, in certain circumstances, Aetna's debt securities are rated below investment grade, this may constitute a change of control triggering event under the indentures governing such debt. Upon the occurrence of a change of control triggering event, Aetna, as the surviving corporation of the merger, would be required to offer to repurchase most of Aetna's outstanding notes at 101% of the principal amount thereof plus accrued and unpaid interest if any, to, but not including, the date of repurchase. However, it is possible that Aetna (or us) would not have sufficient funds at the time of the change of control triggering event to make the required repurchase of notes or that restrictions in other debt instruments would not allow such repurchases. We cannot provide any assurance that there will be sufficient funds available for Aetna (or us) to make any required repurchases of the notes upon a change of control triggering event.

We will incur significant transaction and integration-related costs in connection with the merger.

We expect to incur a number of non-recurring costs associated with the merger and combining the operations of the two companies. We will incur significant transaction costs related to the merger, including with respect to the financing for the cash consideration to be paid to Aetna shareholders. We also will incur significant integration-related fees and costs related to formulating and implementing integration plans, including facilities and systems consolidation costs and employment-related costs. We continue to assess the magnitude of these costs, and additional unanticipated costs may be incurred in the merger and the integration of the two companies' businesses. Although we expect that the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of the businesses, should allow us to offset integration-related costs over time, this net benefit may not be achieved in the near term, or at all.

The merger may not be accretive, and may be dilutive, to our earnings per share, which may negatively affect the market price of shares of our common stock.

We currently project that the merger will result in a number of benefits, including enhanced competitive positioning and a platform from which to accelerate growth, and that it will be accretive to earnings per share in the second full year after the close of the transaction. This projection is based on preliminary estimates that may materially change. In addition, future events and conditions could decrease or delay the accretion that is currently projected or could result in dilution, including adverse changes in market conditions, additional transaction and integration-related costs and other factors such as the failure to realize some or all of the anticipated benefits of the merger. Any dilution of, decrease in or delay of any accretion to, our earnings per share could cause the price of shares of our common stock to decline or grow at a reduced rate.

The future results of the combined company may be adversely impacted if the combined company does not effectively manage its expanded operations following completion of the merger.

Following completion of the merger, the size of the combined company's business will be significantly larger than the current size of either our or Aetna's respective businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to implement an effective integration of the two companies and its ability to manage a combined business with significantly larger size and scope with the associated increased costs and complexity. There can be no assurances that the management of the combined company will be successful or that the combined company will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the merger.

Additional information concerning these risks, uncertainties and assumptions can be found in the section entitled "Risk Factors" beginning on page 62 of our preliminary joint proxy statement/prospectus filed February 9, 2018 with the SEC on Form S-4/A.

Item 1B. Unresolved Staff Comments

There are no unresolved SEC Staff Comments.

Item 2. Properties

We lease most of our stores under long-term leases that vary as to rental amounts, expiration dates, renewal options and other rental provisions. For additional information on the amount of our rental obligations for our leases, we refer you to Note 7 "Leases" in our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

As of December 31, 2017, we owned approximately 4% of our 8,108 retail stores. Net selling space for our retail stores was approximately 79.5 million square feet as of December 31, 2017. Approximately 20% of our store base was opened or significantly remodeled within the last five years.

We lease 1,695 retail pharmacies and 79 clinics in Target stores located in 47 states and the District of Columbia.

We own nine distribution centers located in Alabama, California, Hawaii, New York, Rhode Island, South Carolina, Tennessee and Texas and lease 13 additional distribution facilities located in Arizona, Florida, Indiana, Michigan, Missouri, New Jersey, Pennsylvania, Texas, Virginia and Brazil. The 22 distribution centers total approximately 10.4 million square feet as of December 31, 2017.

As of December 31, 2017, we owned six and leased 139 LTC pharmacies in 44 states and owned one LTC repackaging facility in Kentucky.

As of December 31, 2017, we owned one mail service dispensing pharmacy located in Texas and leased three additional mail order dispensing pharmacies located in Hawaii, Illinois and Pennsylvania; we leased call centers located in California, Missouri, Pennsylvania, Tennessee and Texas; we leased 37 onsite pharmacy stores and 23 specialty pharmacy stores, and leased 18 specialty mail order pharmacies; we leased 83 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence.

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We own our corporate offices located in Woonsocket, Rhode Island, which totals approximately one million square feet. In addition, we lease corporate offices in Scottsdale, Arizona, Northbrook, Illinois, Cincinnati, Ohio, Monroeville, Pennsylvania, Irving, Texas, and Sao Paulo, Brazil.

In connection with certain business dispositions completed between 1991 and 1997, we continue to guarantee lease obligations for approximately 85 former stores. We are indemnified for these guarantee obligations by the respective purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information, we refer you to Note 12 “Commitments and Contingencies” in our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

Management believes that the Company’s owned and leased facilities are suitable and adequate to meet the Company’s anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space.

The following is a breakdown by state, District of Columbia, Puerto Rico and Brazil of our retail stores, pharmacies and clinics in Target stores, LTC hub and spoke pharmacies, onsite pharmacy stores, specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies and branches and centers of excellence for infusion and enteral services as of December 31, 2017:

	Retail Stores [1]	Pharmacies within Target [1]	LTC Hub & Spoke Pharmacies	Onsite Pharmacy Stores	Specialty Pharmacy Stores	Specialty Mail Order Pharmacies	Mail Order Dispensing Pharmacies	Infusion & Enteral Services Locations	Total
United States:									
Alabama	160	22	2	1	1	—	—	1	187
Alaska	3	3	—	—	—	—	—	—	6
Arizona	152	46	2	—	1	1	—	2	204
Arkansas	15	8	1	—	—	—	—	1	25
California	886	260	8	—	3	1	—	8	1,166
Colorado	3	39	3	—	1	—	—	1	47
Connecticut	154	20	1	1	—	—	—	1	177
Delaware	17	3	—	—	—	—	—	—	20
District of Columbia	58	1	—	—	1	—	—	—	60
Florida	754	121	5	1	1	2	—	7	891
Georgia	311	41	1	3	1	—	—	1	358
Hawaii	64	7	—	—	1	—	1	—	73
Idaho	—	2	1	—	—	—	—	1	4
Illinois	282	90	7	2	—	1	1	3	386
Indiana	309	30	4	—	—	—	—	3	346
Iowa	20	18	2	—	—	—	—	1	41
Kansas	39	14	2	—	—	1	—	2	58
Kentucky	70	9	9	—	—	1	—	—	89
Louisiana	119	14	3	—	—	—	—	1	137
Maine	22	5	1	—	—	—	—	1	29
Maryland	185	39	2	5	—	—	—	1	232
Massachusetts	376	40	5	2	2	1	—	1	427
Michigan	248	50	4	1	—	1	—	2	306
Minnesota	61	75	6	1	—	—	—	2	145
Mississippi	52	5	1	1	—	—	—	1	60
Missouri	97	33	5	—	—	—	—	1	136
Montana	14	2	1	—	—	—	—	—	17
Nebraska	19	11	1	—	—	—	—	1	32
Nevada	86	15	2	—	—	—	—	2	105
New Hampshire	40	9	1	—	—	—	—	—	50
New Jersey	291	45	3	4	—	1	—	1	345
New Mexico	19	6	1	—	—	—	—	1	27
New York	489	75	5	—	1	—	—	7	577
North Carolina	314	51	3	1	1	1	—	3	374
North Dakota	6	—	—	—	—	—	—	—	6
Ohio	329	59	7	—	—	—	—	4	399
Oklahoma	62	15	2	—	—	—	—	1	80
Oregon	—	18	2	—	1	1	—	1	23
Pennsylvania	410	66	6	2	1	1	1	2	489
Puerto Rico	25	—	—	—	—	1	—	—	26
Rhode Island	62	4	1	1	1	—	—	1	70
South Carolina	191	19	3	1	1	—	—	2	217
South Dakota	—	3	1	—	—	—	—	—	4
Tennessee	136	27	3	1	1	3	—	3	174
Texas	695	135	10	3	2	1	1	5	852
Utah	12	13	2	—	—	—	—	1	28
Vermont	10	—	—	—	—	—	—	—	10
Virginia	286	58	6	5	1	—	—	2	358
Washington	12	30	3	—	1	—	—	2	48
West Virginia	51	6	2	—	—	—	—	—	59
Wisconsin	50	33	5	1	—	—	—	1	90
Wyoming	—	—	—	—	—	—	—	1	1
Total United States	8,066	1,695	145	37	23	18	4	83	10,071
Brazil	42	—	—	—	—	—	—	—	42
Total	8,108	1,695	145	37	23	18	4	83	10,113

(1) The Retail Stores above include 1,050 in-store MinuteClinic locations and the Target stores with CVS pharmacies also include 79 MinuteClinic locations.

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Item 3. Legal Proceedings

I. Legal Proceedings

We refer you to the Note 12 “Commitments and Contingencies” contained in the “Notes to the Consolidated Financial Statements” of our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of certain environmental legal proceedings if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with long-term care pharmacies in the State of New York. These proceedings are not material to the Company's business or financial position.

Item 4. Mine Safety Disclosures

Not applicable.

Executive Officers of the Registrant

Executive Officers of the Registrant

The following sets forth the name, age and biographical information for each of our executive officers as of February 14, 2018. In each case the officer's term of office extends to the date of the board of directors meeting following the next annual meeting of stockholders of the Company. Previous positions and responsibilities held by each of the executive officers over the past five years are indicated below:

Lisa G. Bisaccia , age 61, Executive Vice President of CVS Health Corporation since March 2016 and Chief Human Resources Officer of CVS Health Corporation since January 2010; Senior Vice President of CVS Health Corporation from January 2010 through February 2016; Vice President, Human Resources of CVS Pharmacy, Inc. from September 2004 through December 2009. Ms. Bisaccia is also a member of the Board of Directors of Aramark, a leading global provider of food, facilities and uniform services.

Eva C. Boratto , age 51, Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since March 2017; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017; Senior Vice President of PBM Finance from July 2010 through June 2013; Vice President, U.S. Market Finance Leader of Merck & Co., Inc. from June 2009 through June 2010.

Troyen A. Brennan, M.D ., age 63, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna, Inc. from February 2006 through November 2008.

David M. Denton , age 52, Executive Vice President and Chief Financial Officer of CVS Health Corporation since January 2010; Senior Vice President and Controller and Chief Accounting Officer of CVS Health Corporation from March 2008 until December 2009; Senior Vice President, Financial Administration of CVS Health Corporation and CVS Pharmacy, Inc. from April 2007 to March 2008. Mr. Denton is also a member of the Board of Directors of Tapestry, Inc. (formerly known as Coach, Inc.), a leading retailer of premium bags and luxury accessories.

Larry J. Merlo, age 62, President and Chief Executive Officer of CVS Health Corporation since March 2011; President and Chief Operating Officer of CVS Health Corporation from May 2010 through March 2011; President of CVS Pharmacy from January 2007 through August 2011; Executive Vice President of CVS Health Corporation from January 2007 through May 2010; also a director of CVS Health Corporation since May 2010.

Thomas M. Moriarty , age 54, Executive Vice President and General Counsel of CVS Health Corporation since October 2012 and Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017; General Counsel of Celgene Corporation, a global biopharmaceutical company, from May 2012 through September 2012; General Counsel and Corporate Secretary of Medco Health Solutions, Inc. ("Medco"), a pharmacy benefit management company, from March 2008 through April 2012; also President of Global Pharmaceutical Strategies of Medco from March 2011 through April 2012.

Jonathan C. Roberts , age 62, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017; Executive Vice President of CVS Health Corporation and Chief Operating Officer of CVS Caremark from October 2010 through August 2011; Executive Vice President, Rx Purchasing, Pricing and Network Relations of CVS Health Corporation from January 2009 through October 2010.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Our common stock is listed on the New York Stock Exchange under the symbol "CVS." The table below sets forth the high and low closing prices of our common stock on the New York Stock Exchange Composite Tape and the quarterly cash dividends declared per share of common stock during the periods indicated.

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2017 High	$ 83.92	$ 82.79	$ 83.31	$ 80.91	$ 83.92
Low	$ 74.80	$ 75.95	$ 75.35	$ 66.80	$ 66.80
Cash dividends per common share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00
2016 High	$ 104.05	$ 106.10	$ 98.06	$ 88.80	$ 106.10
Low	$ 89.65	$ 93.21	$ 88.99	$ 73.53	$ 73.53
Cash dividends per common share	$ 0.425	$ 0.425	$ 0.425	$ 0.425	$ 1.70

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Company's Board of Directors. As of February 9, 2018, there were 21,453 registered shareholders according to the records maintained by our transfer agent.

The following share repurchase programs were authorized by the Company's Board of Directors:

In billions Authorization Date	Authorized	Remaining as of December 31, 2017
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—
December 17, 2013 ("2013 Repurchase Program")	6.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board of Directors at any time.

Pursuant to the authorization under the 2014 Repurchase Program, in August 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion. Upon payment of the $3.6 billion purchase price in January 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares, which were placed into treasury stock in January 2017. The ASRs were accounted for as an initial treasury stock transaction for $2.9 billion and a forward contract for $0.7 billion. In April 2017, the Company received 9.9 million shares of common stock, representing the remaining 20% of the $3.6 billion notional amount of the ASRs, thereby concluding the ASRs. The remaining 9.9 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in April 2017.

In the ASR transactions described above, the initial repurchase of the shares and delivery of the remainder of the shares to conclude the ASR, resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

During the year ended December 31, 2017, the Company repurchased an aggregate of 55.4 million shares of common stock for approximately $4.4 billion under the 2014 and 2016 Repurchase Programs. As of December 31, 2017, there remained an aggregate of approximately $13.9 billion available for future repurchases under the 2016 Repurchase Program and the 2014 Repurchase Program was complete. During the fourth quarter of 2017, the Company suspended share repurchase activity in connection with the Aetna Acquisition.

Fiscal Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs
October 1, 2017 through October 31, 2017	—	$ —	—	$ 13,869,392,446
November 1, 2017 through November 30, 2017	—	$ —	—	$ 13,869,392,446
December 1, 2017 through December 31, 2017	—	$ —	—	$ 13,869,392,446
	—		—	

Item 6. Selected Financial Data

The selected consolidated financial data of CVS Health Corporation as of and for the periods indicated in the five-year period ended December 31, 2017, have been derived from the consolidated financial statements of CVS Health Corporation. The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated elsewhere herein.

In millions, except per share amounts	2017	2016	2015	2014	2013
Statement of operations data:					
Net revenues	$ 184,765	$ 177,526	$ 153,290	$ 139,367	$ 126,761
Gross profit	28,545	28,857	26,528	25,367	23,783
Operating expenses [1]	19,028	18,491	17,053	16,545	15,713
Operating profit	9,517	10,366	9,475	8,822	8,070
Interest expense, net	1,041	1,058	838	600	509
Loss on early extinguishment of debt	—	643	—	521	—
Other expense [1]	208	28	21	23	33
Income tax provision	1,637	3,317	3,386	3,033	2,928
Income from continuing operations	6,631	5,320	5,230	4,645	4,600
Income (loss) from discontinued operations, net of tax	(8)	(1)	9	(1)	(8)
Net income	6,623	5,319	5,239	4,644	4,592
Net income attributable to noncontrolling interest	(1)	(2)	(2)	—	—
Net income attributable to CVS Health	$ 6,622	$ 5,317	$ 5,237	$ 4,644	$ 4,592
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 6.48	$ 4.93	$ 4.65	$ 3.98	$ 3.78
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ 0.01	$ —	$ (0.01)
Net income attributable to CVS Health	$ 6.47	$ 4.93	$ 4.66	$ 3.98	$ 3.77
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 6.45	$ 4.91	$ 4.62	$ 3.96	$ 3.75
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ 0.01	$ —	$ (0.01)
Net income attributable to CVS Health	$ 6.44	$ 4.90	$ 4.63	$ 3.96	$ 3.74
Cash dividends per common share	$ 2.00	$ 1.70	$ 1.40	$ 1.10	$ 0.90
Balance sheet and other data:					
Total assets	$ 95,131	$ 94,462	$ 92,437	$ 73,202	$ 70,550
Long-term debt	$ 22,181	$ 25,615	$ 26,267	$ 11,630	$ 12,767
Total shareholders' equity	$ 37,695	$ 36,834	$ 37,203	$ 37,963	$ 37,938
Number of stores (at end of year)	9,846	9,750	9,681	7,866	7,702

(1) As of January 1, 2017, the Company adopted Accounting Standards Update ("ASU") 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* , which resulted in a retrospective reclassification of $28 million, $21 million, $23 million and $33 million of net benefit costs from operating expenses to other expense in the years ended December 31, 2016, 2015, 2014, and 2013, respectively.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

We refer you to "Management's Discussion and Analysis of Financial Condition and Results of Operations," which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section of our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

As of December 31, 2017, the Company had outstanding interest rate derivative instruments and believes that as of December 31, 2017, its exposure to interest rate risk (inherent in the Company's debt portfolio) is not material. We refer you to Note 1 "Significant Accounting Policies" contained in the "Notes to the Consolidated Financial Statements" of our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

As of December 31, 2017, the Company did not have any foreign currency exchange rate or commodity derivative instruments in place and believes that as of December 31, 2017, its exposure to foreign currency exchange rate risk and commodity price risk is not material

Item 8. Financial Statements and Supplementary Data

We refer you to the "Consolidated Statements of Income," "Consolidated Statements of Comprehensive Income," "Consolidated Balance Sheets," "Consolidated Statements of Shareholders' Equity," "Consolidated Statements of Cash Flows," "Notes to Consolidated Financial Statements," and "Report of Independent Registered Public Accounting Firm" of our Annual Report to Stockholders for the year ended December 31, 2017, which sections are incorporated by reference herein.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of disclosure controls and procedures: The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2017, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its subsidiaries would be made known to such officers on a timely basis.

Internal control over financial reporting: We refer you to "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm" of our Annual Report to Stockholders for the fiscal year ended December 31, 2017, which are incorporated by reference herein, for management's report on the Company's internal control over financial reporting and the Independent Registered Public Accounting Firm's report with respect to the effectiveness of internal control over financial reporting.

Changes in internal control over financial reporting: There have been no changes in our internal controls over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2017 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

No events have occurred during the fourth quarter that would require disclosure under this item.

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PART III

Item 10. Directors, Executive Officers and Corporate Governance

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the captions "Committees of the Board," "Code of Conduct," "Director Nominations," "Audit Committee Report," "Biographies of our Board Nominees," and "Section 16(a) Beneficial Ownership Reporting Compliance," which sections are incorporated by reference herein. Biographical information on our executive officers is contained in Part I of this Annual Report on Form 10-K.

Item 11. Executive Compensation

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the captions "Executive Compensation and Related Matters," including "Compensation Discussion & Analysis" and "Management Planning and Development Committee Report," which sections are incorporated by reference herein.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the captions "Share Ownership of Directors and Certain Executive Officers," and "Share Ownership of Principal Stockholders" which sections are incorporated by reference herein, for information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the Company's common stock that may be issued upon the exercise of options, warrants and rights under all of our equity compensation plans as of December 31, 2017.

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1]	Weighted average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1]
Equity compensation plans approved by stockholders	32,219	$ 75.32	20,530
Equity compensation plans not approved by stockholders	—	—	—
Total	32,219	$ 75.32	20,530

(1) Shares in thousands.

Item 13. Certain Relationships and Related Transactions and Director Independence

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the caption "Independence Determinations for Directors" and "Certain Transactions with Directors and Officers," which sections are incorporated by reference herein.

Item 14. Principal Accountant Fees and Services

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the caption "Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm," which section is incorporated by reference herein.

PART IV

Item 15. Exhibits and Financial Statement Schedules

A. Documents filed as part of this report:

1. Financial Statements:

The following financial statements are incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2017, as provided in Item 8 hereof:

Consolidated Statements of Income for the Years Ended December 31, 2017, 2016 and 2015
Consolidated Statements of Comprehensive Income for the Years Ended December 31, 2017, 2016 and 2015
Consolidated Balance Sheets as of December 31, 2017 and 2016
Consolidated Statements of Cash Flows for the Years Ended December 31, 2017, 2016 and 2015
Consolidated Statements of Shareholders' Equity for the Years Ended December 31, 2017, 2016 and 2015
Notes to Consolidated Financial Statements
Report of Independent Registered Public Accounting Firm

2. Financial Statement Schedules

All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

B. Exhibits

Exhibits marked with an asterisk (*) are hereby incorporated by reference to exhibits or appendices previously filed by the Registrant as indicated in brackets following the description of the exhibit.

Exhibit	Description
2.1*	Agreement and Plan of Merger dated as of November 1, 2006 among, the Registrant, Caremark Rx, Inc. and Twain MergerSub Corp. (incorporated by reference to Exhibit 2.1 to the Registrant's Registration Statement No. 333-139470 on Form S-4 filed December 19, 2006).
2.2*	Amendment No. 1 dated as of January 16, 2007 to the Agreement and Plan of Merger dated as of November 1, 2006 among the Registrant, Caremark Rx, Inc. and Twain Merger Sub Corp. (incorporated by reference to Exhibit 2.2 to the Registrant's Registration Statement No. 333-139470 on Form S-4/A filed January 16, 2007).
2.3*	Waiver Agreement dated as of January 16, 2007 between the Registrant and Caremark Rx, Inc. with respect to the Agreement and Plan Merger dated as of November 1, 2006 by and between Registrant and Caremark Rx, Inc (incorporated by reference to Exhibit 2.3 to the Registrant's Registration Statement No. 333-139470 on Form S-4/A filed January 16, 2007).
2.4*	Amendment to Waiver Agreement, dated as of February 12, 2007, between Registrant and Caremark Rx, Inc. (incorporated by reference to Exhibit 99.2 to the Registrant's Current Report on Form 8-K dated February 13, 2007; Commission File No. 001-01011).
2.5*	Amendment to Waiver Agreement, dated as of March 8, 2007, between Registrant and Caremark Rx, Inc. (incorporated by reference to Exhibit 99.2 to the Registrant's Current Report on Form 8-K dated March 8, 2007; Commission File No. 001-01011).
2.6*	Agreement and Plan of Merger dated as of August 12, 2008, among the Registrant, Longs Drug Stores Corporation and Blue MergerSub Corp. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated August 13, 2008; Commission File No. 001-01011).

2.7*	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated May 21, 2015; Commission File No. 001-01011).
2.8*	Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated December 5, 2017; Commission File No. 001-01011).
2.9*	Bridge Facility Commitment Letter dated December 3, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., and Merrill Lynch, Pierce Fenner & Smith Incorporated (incorporated by reference to Exhibit 2.2 to the Registrant's Current Report on Form 8-K dated December 5, 2017; Commission File No. 001-01011).
2.10*	Joinder to Bridge Facility Commitment Letter dated as of December 15, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and each of the Additional Commitment Parties party thereto (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011) .
3.1*	Amended and Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1 of Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1996; Commission File No. 001-01011).
3.1A*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation, effective May 13, 1998 (incorporated by reference to Exhibit 4.1A to Registrant's Registration Statement No. 333-52055 on Form S-3/A dated May 18, 1998).
3.1B*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K dated March 22, 2007; Commission File No. 001-01011).
3.1C*	Certificate of Merger dated May 9, 2007 (incorporated by reference to Exhibit 3.1C to Registrant's Quarterly Report on Form 10-Q dated November 1, 2007; Commission File No. 001-01011).
3.1D*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K dated May 13, 2010; Commission File No. 001-01011).
3.1E*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report On Form 8-K dated May 10, 2012; Commission File No. 001-01011).
3.1F*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report On Form 8-K dated May 13, 2013; Commission File No. 001-01011).
3.1G*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report on Form 8-K dated September 3, 2014 (Commission File No. 001-01011)).
3.2*	By-laws of the Registrant, as amended and restated (incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K dated January 26, 2016; Commission File No. 001-01011).
4	Pursuant to Regulation S-K, Item 601(b)(4)(iii)(A), no instrument which defines the rights of holders of long-term debt of the Registrant and its subsidiaries is filed with this report. The Registrant hereby agrees to furnish a copy of any such instrument to the Securities and Exchange Commission upon request.

4.1*	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant on Form 8-B dated November 4, 1996; Commission File No. 001-01011).
10.1*	Stock Purchase Agreement dated as of October 14, 1995 between The TJX Companies, Inc. and Melville Corporation, as amended November 17, 1995 (incorporated by reference to Exhibits 2.1 and 2.2 to Melville's Current Report on Form 8-K dated December 4, 1995; Commission File No. 001-01011).
10.2*	Stock Purchase Agreement dated as of March 25, 1996 between Melville Corporation and Consolidated Stores Corporation, as amended May 3, 1996 (incorporated by reference to Exhibits 2.1 and 2.2 to Melville's Current Report on Form 8-K dated May 5, 1996; Commission File No. 001-01011).
10.3*	Distribution Agreement dated as of September 24, 1996 among Melville Corporation, Footstar, Inc. and Footstar Center, Inc. (incorporated by reference to Exhibit 99.1 to Melville's Current Report on Form 8-K dated October 28, 1996; Commission File No. 001-01011).
10.4*	Tax Disaffiliation Agreement dated as of September 24, 1996 among Melville Corporation, Footstar, Inc. and certain subsidiaries named therein (incorporated by reference to Exhibit 99.2 to Melville's Current Report on Form 8-K dated October 28, 1996; Commission File No. 001-01011).
10.5*	Stockholder Agreement dated as of December 2, 1996 between the Registrant, Nashua Hollis CVS, Inc. and Linens 'n Things, Inc. (incorporated by reference to Exhibit 10(i)(6) to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1997; Commission File No. 001-01011).
10.6*	Tax Disaffiliation Agreement dated as of December 2, 1996 between the Registrant and Linens 'n Things, Inc. and certain of their respective affiliates (incorporated by reference to Exhibit 10(i)(7) to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1997; Commission File No. 001-01011).
10.7*	Second Amended and Restated Credit Agreement, dated as of July 24, 2014, by and among the Registrant, the lenders party thereto, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014 (Commission File No. 001-01011).
10.8*	Amendment No. 1 to Second Amended and Restated Credit Agreement, dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.4 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.9*	Five Year Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2015 (Commission File No. 001-01011).
10.10*	Amendment No. 1, dated as of December 15, 2017, to Five Year Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.5 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.11*	364-Day Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).

10.12*	Amendment No. 1, dated as of December 15, 2017, to 364-Day Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.2 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.13*	Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.14*	Amendment No. 1 dated as of December 15, 2017, to Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.15*	Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as administrative agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.16*	The Registrant's Supplemental Retirement Plan for Select Senior Management I as amended and restated in December 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009; Commission File No. 001-01011).
10.17*	The Registrant's 1996 Directors Stock Plan, as amended and restated November 5, 2002 (incorporated by reference to Exhibit 10.18 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 28, 2002; Commission File No. 001-01011).
10.18*	The Registrant's 1997 Incentive Compensation Plan as amended through December 2008 (incorporated by reference to Exhibit 10.8 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009; Commission File No. 001-01011).
10.19*	Caremark Rx, Inc. 2004 Incentive Stock Plan (incorporated by reference to Exhibit 99.2 of the Registrant's Registration Statement No. 333-141481 on Form S-8 filed March 22, 2007; Commission File No. 011-01011).
10.20*	The Registrant's Deferred Stock Compensation Plan, as amended (incorporated by reference to Exhibit 10.17 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.21*	The Registrant's Deferred Compensation Plan, as amended (incorporated by reference to Exhibit 10.19 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.22*	The Registrant's 2010 Incentive Compensation Plan, as amended through January 15, 2013 (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 27, 2015; Commission File No. 001-01011).
10.23*	The Registrant's 2017 Incentive Compensation Plan (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 31, 2017; Commission File No. 001-01011).
10.24*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 10.20 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).

10.25*	The Registrant's Management Incentive Plan (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.26*	The Registrant's Executive Incentive Plan (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.27*	The Registrant's Long-Term Incentive Plan (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.28*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.29*	The Registrant's Severance Plan for Non-Store Employees amended as of January 2016 (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.30*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.31*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the year ended December 31, 2013; Commission File No. 001-01011).
10.32*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.33*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.34*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.35*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.36*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.37*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).

10.38*	Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008; Commission File No. 001-01011).
10.39*	Amendment dated December 21, 2012 to the Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.40*	Form of Non-Qualified Stock Option Agreement between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.41*	Form of Restricted Stock Unit Agreement between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.42*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated January 23, 2015; Commission File No. 001-01011).
10.43*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Financial Officer (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010; Commission File No. 001-01011).
10.44*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Financial Officer (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.45*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Operating Officer (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.46*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Operating Officer (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.47*	Restricted Stock Unit Agreement dated April 1, 2017 between the Registrant and the Registrant's Executive Vice President and Chief Operating Officer (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.48*	Restrictive Covenant Agreement dated May 20, 2017 between the Registrant and the Registrant's Executive Vice President and Chief Operating Officer (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.49*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and President of CVS Pharmacy (incorporated by reference to Exhibit 10.43 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).

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10.50*	Amendment dated as of December 31, 2012 to the Change in Control Agreement between the Registrant and the Registrant's Executive Vice President and President of CVS Pharmacy (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.51*	Change in Control Agreement dated October 1, 2012 between the Registrant and the Registrant's Executive Vice President, Chief Policy and External Affairs Officer and General Counsel (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
10.52*	Restrictive Covenant Agreement dated June 1, 2014 between the Registrant and the Registrant's Executive Vice President, Chief Policy and External Affairs Officer and General Counsel (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
12	Computation of Ratios of Earnings to Fixed Charges.
13	Portions of the 2018 Annual Report to Stockholders of CVS Health Corporation, which are specifically designated in this Form 10-K as being incorporated by reference.
21	Subsidiaries of the Registrant.
23	Consent of Ernst & Young LLP.
31.1	Certification by the Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification by the Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification by the Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification by the Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the year ended December 31, 2017 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Income, (ii) the Consolidated Balance Sheets, (iii) the Consolidated Statements of Cash Flows and (iv) related notes.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Annual Report on Form 10-K to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS HEALTH CORPORATION

Date: February 14, 2018

By: /s/ DAVID M. DENTON
David M. Denton
Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ RICHARD M. BRACKEN **Richard M. Bracken**	Director	February 14, 2018
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 14, 2018
/s/ EVA C. BORATTO **Eva C. Boratto**	Executive Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 14, 2018
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 14, 2018
/s/ DAVID M. DENTON **David M. Denton**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 14, 2018
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 14, 2018
/s/ DAVID W. DORMAN **David W. Dorman**	Chairman of the Board and Director	February 14, 2018
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 14, 2018
/s/ LARRY J. MERLO **Larry J. Merlo**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 14, 2018
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 14, 2018
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 14, 2018
/s/ RICHARD J. SWIFT **Richard J. Swift**	Director	February 14, 2018
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 14, 2018
/s/ TONY L. WHITE **Tony L. White**	Director	February 14, 2018

Exhibit 12

CVS Health Corporation
Computation of Ratios of Earnings to Fixed Charges

	Year Ended December 31,				
In millions	**2017**	**2016**	**2015**	**2014**	**2013**
Earnings:					
Income from continuing operations before income taxes [(a)]	$ 8,267	$ 8,635	$ 8,614	$ 7,678	$ 7,528
Interest portion of net rental expense [(b)]	802	790	764	786	750
Interest expense (net of interest capitalized)	1,062	1,078	859	615	517
Adjusted earnings	$ 10,131	$ 10,503	$ 10,237	$ 9,079	$ 8,795
Fixed Charges:					
Interest portion of net rental expense [(b)]	802	790	764	786	750
Interest expense (net of interest capitalized)	1,062	1,078	859	615	517
Interest capitalized	8	13	12	19	25
Total fixed charges	$ 1,872	$ 1,881	$ 1,635	$ 1,420	$ 1,292
Ratio of earnings to fixed charges	5.41 x	5.58 x	6.26 x	6.39 x	6.81 x

(a) Excludes net (income) loss attributable to noncontrolling interest.
(b) The portion of net rental expense deemed to be representative of the interest factor.

Exhibit 13

Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis should be read in conjunction with our audited consolidated financial statements and Cautionary Statement Concerning Forward-Looking Statements that are included in this Annual Report.

Overview of Our Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a pharmacy innovation company helping people on their path to better health. At the forefront of a changing health care landscape, the Company has an unmatched suite of capabilities and the expertise needed to drive innovations that will help shape the future of health care.

We are currently the only integrated pharmacy health care company with the ability to impact consumers, payors, and providers with innovative, channel-agnostic solutions. We have a deep understanding of their diverse needs through our unique integrated model, and we are bringing them innovative solutions that help increase access to quality care, deliver better health outcomes and lower overall health care costs.

Through more than 9,800 retail locations, more than 1,100 walk-in health care clinics, a leading pharmacy benefits manager with more than 94 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services and a leading stand-alone Medicare Part D prescription drug plan, we enable people, businesses, and communities to manage health in more affordable, effective ways. We are delivering break-through products and services, from advising patients on their medications at our CVS Pharmacy ® locations, to introducing unique programs to help control costs for our clients at CVS Caremark ®, to innovating how care is delivered to our patients with complex conditions through CVS Specialty ®, to improving pharmacy care for the senior community through Omnicare ®, or by expanding access to high-quality, low-cost care at CVS MinuteClinic ®.

We have three reportable segments: Pharmacy Services, Retail/LTC and Corporate.

Overview of Our Pharmacy Services Segment

Our Pharmacy Services business generates revenue from a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, Medicare Part D services, mail order pharmacy, specialty pharmacy and infusion services, retail pharmacy network management services, prescription management systems, clinical services, disease management services and medical spend management.

Our clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans, plans offered on the public and private exchanges, other sponsors of health benefit plans, and individuals throughout the United States. A portion of covered lives primarily within the Managed Medicaid, health plan and employer markets have access to our services through public and private exchanges.

As a pharmacy benefits manager, we manage the dispensing of prescription drugs through our mail order pharmacies, specialty pharmacies, national network of long-term care pharmacies and more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes our CVS Pharmacy ® pharmacies) and 27,000 independent pharmacies, to eligible members in the benefit plans maintained by our clients and utilize our information systems to perform, among other things, safety checks, drug interaction screenings and brand-to-generic substitutions.

Our specialty pharmacies support individuals who require complex and expensive drug therapies. Our specialty pharmacy business includes mail order and retail specialty pharmacies that operate under the CVS Caremark ®, Navarro ® Health Services and Advanced Care Scripts ("ACS Pharmacy") names. Substantially all of our mail service specialty pharmacies have been accredited by The Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States. We also offer specialty infusion services and enteral nutrition services through Coram LLC and its subsidiaries (collectively, "Coram"). With Specialty Connect ®, which integrates our specialty pharmacy mail and retail capabilities, we provide members with disease-state specific counseling from our experienced specialty pharmacists and the choice to bring their specialty prescriptions to

any CVS Pharmacy location. Whether submitted through one of our mail order pharmacy or at a CVS Pharmacy, all prescriptions are filled through the Company's specialty mail order pharmacies, so all revenue from this specialty prescription services program is recorded within the Pharmacy Services Segment. Members then can choose to pick up their medication at their local CVS Pharmacy or have it sent to their home through the mail.

We also provide health management programs, which include integrated disease management for 18 conditions, through our AccordantCare ™ rare disease management offering. The majority of these integrated programs are accredited by the National Committee for Quality Assurance.

In addition, through our SilverScript Insurance Company ("SilverScript") subsidiary, we are a national provider of drug benefits to eligible beneficiaries under the federal government's Medicare Part D program. As of December 31, 2017, we provided Medicare Part D plan benefits to approximately 5.5 million beneficiaries through SilverScript, including our individual and employer group waiver plans.

The Pharmacy Services Segment operates under the CVS Caremark ® Pharmacy Services, Caremark ®, CVS Caremark ®, CVS Specialty ®, AccordantCare ™, SilverScript ®, Wellpartner ®, Coram ®, NovoLogix ®, Navarro ® Health Services and ACS Pharmacy names. As of December 31, 2017, the Pharmacy Services Segment operated 23 retail specialty pharmacy stores, 18 specialty mail order pharmacies, four mail order dispensing pharmacies, and 83 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence, located in 42 states, Puerto Rico and the District of Columbia.

Overview of Our Retail/LTC Segment

Our Retail/LTC Segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products and cosmetics, personal care products, convenience foods, photo finishing, seasonal merchandise and greeting cards. With the acquisition of Omnicare's long-term care ("LTC") operations, the Retail/LTC Segment now also includes the distribution of prescription drugs, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Omnicare operations also included commercialization services which were provided under the name RxCrossroads ® ("RxC"), until the sale of RxC was completed on January 2, 2018. See Note 3 "Goodwill and Other Intangibles" to our consolidated financial statements for more information. Our Retail/LTC Segment derives the majority of its revenues through the sale of prescription drugs, which are dispensed by our more than 32,000 pharmacists. The role of our retail pharmacists is expanding from primarily dispensing prescriptions to also providing services, including flu vaccinations as well as face-to-face patient counseling with respect to adherence to drug therapies, closing gaps in care, and more cost-effective drug therapies. Our integrated pharmacy services model enables us to enhance access to care while helping to lower overall health care costs and improve health outcomes.

Our Retail/LTC Segment also provides health care services through our MinuteClinic ® health care clinics. MinuteClinics are staffed by nurse practitioners and physician assistants who utilize nationally recognized protocols to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions, and deliver vaccinations. We believe our clinics provide high quality services that are affordable and convenient.

Our proprietary loyalty card program, ExtraCare ®, has about 62 million active cardholders, making it one of the largest and most successful retail loyalty card programs in the country.

As of December 31, 2017, our Retail/LTC Segment included 9,803 retail stores (of which 8,060 were our stores that operated a pharmacy and 1,695 were our pharmacies located within Target stores) located in 49 states, the District of Columbia, Puerto Rico and Brazil operating primarily under the CVS Pharmacy ®, CVS ®, CVS Pharmacy y más ®, Longs Drugs ®, Navarro Discount Pharmacy ® and Drogaria Onofre ™ names, 37 onsite pharmacies primarily operating under the CarePlus CVS Pharmacy ™, CarePlus ® and CVS Pharmacy ® names, and 1,134 retail health care clinics operating under the MinuteClinic ® name (of which 1,129 were located in our retail pharmacy stores or Target stores), and our online retail websites, CVS.com ®, Navarro.com ™ and Onofre.com.br ™. LTC operations are comprised of 145 spoke pharmacies that primarily handle new prescription orders, of which 30 are also hub pharmacies that use proprietary automation to support spoke pharmacies with refill prescriptions. LTC operates primarily under the Omnicare ® and NeighborCare ® names.

Overview of Our Corporate Segment

The Corporate Segment provides management and administrative services to support the Company. The Corporate Segment consists of certain aspects of our executive management, corporate relations, legal, compliance, human resources, information technology and finance departments.

Proposed Acquisition of Aetna

On December 3, 2017, we entered into a definitive merger agreement to acquire all of the outstanding shares of Aetna Inc. ("Aetna") for a combination of cash and stock ("Aetna Acquisition"). Under the terms of the merger agreement, Aetna shareholders will receive $145.00 per share in cash and 0.8378 CVS Health shares for each Aetna share. The transaction values Aetna at approximately $207 per share or approximately $69 billion based on the Company's 5-day volume weighted average price ending December 1, 2017 of $74.21 per share. Including the assumption of Aetna's debt, the total value of the transaction is approximately $77 billion. The final purchase price will be determined based on the Company's stock price on the date of closing of the transaction. We expect to finance the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45.0 billion of new debt, including senior notes and term loans (see "Liquidity and Capital Resources" in "Management's Discussion and Analysis of Financial Condition and Results of Operations"). We made customary representations, warranties and covenants in the merger agreement, including, among others, a covenant, subject to certain exceptions, to conduct our business in the ordinary course between the execution of the merger agreement and the closing of the transaction.

The proposed acquisition is currently projected to close in the second half of 2018 and remains subject to approval by CVS Health and Aetna shareholders and customary closing conditions, including the expiration of the waiting period under the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976 and approvals of state departments of insurance and U.S. and international regulators.

If the transaction is not completed, the Company could be liable to Aetna for a termination fee of $2.1 billion in connection with the merger agreement, depending on the reasons leading to such termination.

Results of Operations

Summary of our Consolidated Financial Results

	Year Ended December 31,		
In millions, except per share amounts	**2017**	**2016**	**2015**
Net revenues	$ 184,765	$ 177,526	$ 153,290
Cost of revenues	156,220	148,669	126,762
Gross profit	28,545	28,857	26,528
Operating expenses	19,028	18,491	17,053
Operating profit	9,517	10,366	9,475
Interest expense, net	1,041	1,058	838
Loss on early extinguishment of debt	—	643	—
Other expense	208	28	21
Income before income tax provision	8,268	8,637	8,616
Income tax provision	1,637	3,317	3,386
Income from continuing operations	6,631	5,320	5,230
Income (loss) from discontinued operations, net of tax	(8)	(1)	9
Net income	6,623	5,319	5,239
Net income attributable to noncontrolling interest	(1)	(2)	(2)
Net income attributable to CVS Health	$ 6,622	$ 5,317	$ 5,237

Net revenues increased $7.2 billion in 2017 compared to 2016, and increased $24.2 billion in 2016 compared to 2015. As you review our performance in this area, we believe you should consider the following important information:

- During 2017, net revenues in our Pharmacy Services Segment increased 8.9% and net revenues in our Retail/LTC Segment decreased 2.1% compared to the prior year. The Retail/LTC Segment decrease was primarily due to a decline in same store sales of 2.6% as a result of the previously-announced marketplace changes that restrict CVS Pharmacy from participating in certain networks.

- During 2016, net revenues in our Pharmacy Services Segment increased by 19.5% and net revenues in our Retail/LTC Segment increased 12.6% compared to the prior year. The Retail/LTC Segment benefited from the 2015 acquisitions of Omnicare and the pharmacies and clinics of Target.

- In 2017 and 2016, the Pharmacy Services Segment continued to grow from net new business and specialty. The increase in our generic dispensing rates in both of our operating segments continued to have a negative effect on net revenue in 2017 as compared to 2016, as well as in 2016 as compared to 2015.

Please see the Segment Analysis later in this document for additional information about our net revenues.

Gross profit decreased $312 million, or 1.1% in 2017, to $28.5 billion, as compared to $28.9 billion in 2016. Gross profit increased $2.3 billion, or 8.8% in 2016, to $28.9 billion, as compared to $26.5 billion in 2015. Gross profit as a percentage of net revenues declined to 15.4%, as compared to 16.3% in 2016 and 17.3% in 2015.

- During 2017, gross profit in our Pharmacy Services Segment and Retail/LTC Segment increased by 2.4% and decreased by 1.8%, respectively, compared to the prior year. For the year ended December 31, 2017, gross profit as a percentage of net revenues in our Pharmacy Services Segment and Retail/LTC Segment was 4.6% and 29.4%, respectively.

- During 2016, gross profit in our Pharmacy Services Segment and Retail/LTC Segment increased by 12.9% and 7.9%, respectively, compared to the prior year. For the year ended December 31, 2016, gross profit as a percentage of net revenues in our Pharmacy Services Segment and Retail/LTC Segment was 4.9% and 29.3%, respectively.

- The increased weighting toward the Pharmacy Services Segment, which has a lower gross margin than the Retail/LTC Segment, resulted in a decline in consolidated gross profit as a percent of net revenues in 2017 as compared to 2016. In addition, gross profit for 2017 and 2016 has been negatively impacted by price compression in the Pharmacy Services Segment and reimbursement pressure in the Retail/LTC Segment.

- Our gross profit continued to benefit from the increased utilization of generic drugs, which normally yield a higher gross profit rate than brand name drugs, in both the Pharmacy Services and Retail/LTC segments for 2017 and 2016, partially offsetting the negative impacts described above.

Please see the Segment Analysis later in this document for additional information about our gross profit.

Operating expenses increased $537 million, or 2.9%, in the year ended December 31, 2017, as compared to the prior year. Operating expenses as a percent of net revenues declined to 10.3% in the year ended December 31, 2017 compared to 10.4% in the prior year. The increase in operating expense dollars in the year ended December 31, 2017 was primarily due to an increase in charges of $181 million associated with the closure of 71 retail stores in connection with our enterprise streamlining initiative, goodwill impairment charges of $181 million related to the RxCrossroads reporting unit within the Retail/LTC Segment, $57 million of hurricane related expenses which were predominately in the Retail/LTC Segment, and new store openings. The increase in operating expenses also reflects the lack of a favorable impact for the reversal of an accrual of $85 million, in the Pharmacy Services Segment, in connection with a legal settlement in the year ended December 31, 2016. These matters which led to the increase in operating expenses in 2017 were partially offset by a decrease in acquisition-related transaction and integration costs of $226 million due to the bulk of the Omnicare related integration costs being incurred in 2016. The improvement in operating expenses as a percentage of net revenues in 2017 is primarily due to expense leverage from net revenue growth.

Operating expenses increased $1.4 billion, or 8.4%, in the year ended December 31, 2016, as compared to the prior year. Operating expenses as a percent of net revenues declined to 10.4% in the year ended December 31, 2016 compared to 11.1% in the prior year. The increase in operating expense dollars in the year ended December 31, 2016 was primarily due to the acquisition of the Target pharmacy and clinic businesses in December 2015, the Omnicare acquisition in August 2015 and incremental store operating costs associated with a higher store count, partially offset by lower legal settlement costs, including the reversal of an accrual of $85 million, in the Pharmacy Services Segment, in the year ended December 31, 2016. The improvement in operating expenses as a percentage of net revenues in 2016 was primarily due to expense leverage from net revenue growth.

Please see the Segment Analysis later in this document for additional information about operating expenses.

Interest expense, net for the years ended December 31 consisted of the following:

In millions	2017	2016	2015
Interest expense	$ 1,062	$ 1,078	$ 859
Interest income	(21)	(20)	(21)
Interest expense, net	$ 1,041	$ 1,058	$ 838

Net interest expense decreased $17 million during the year ended December 31, 2017, primarily due to the Company's debt issuance and debt tender offers that occurred in 2016 which resulted in overall more favorable interest rates on the Company's long-term debt. See Note 5 "Borrowings and Credit Agreements" to the consolidated financial statements for additional information. During 2016, net interest expense increased $220 million, primarily due to the $15 billion debt issuance in July 2015, the proceeds of which were used to fund the acquisitions of Omnicare and the pharmacies and clinics of Target, and repay the majority of the debt assumed in the Omnicare acquisition.

Loss on early extinguishment of debt - During the year ended December 31, 2016, the Company purchased approximately $4.2 billion aggregate principal amount of certain of its senior notes pursuant to its tender offer for such senior notes and option to redeem the outstanding senior notes (see Note 5 "Borrowings and Credit Agreements" to the consolidated financial statements). The Company paid a premium of $583 million in excess of the debt principal, wrote off $54 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on the early extinguishment of debt of $643 million.

Income tax provision - On December 22, 2017, the President signed into law the Tax Cuts and Jobs Act (the "TCJA"). Among numerous changes to existing tax laws, the TCJA permanently reduces the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As the result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion for year ended December 31, 2017. The Company has not completed all of its processes to determine the TCJA's final impact. The final impact may differ from this provisional amount due to, among other things, changes in interpretations and assumptions the Company has made thus far and the issuance of additional regulatory or other guidance. The accounting is expected to be completed by the time the 2017 federal corporate income tax return is filed in 2018.

Our effective income tax rate was 19.8%, 38.4% and 39.3% in 2017, 2016 and 2015, respectively. The effective income tax rate was lower in 2017 compared to 2016 primarily due to the provisional impact of the TCJA, including the revaluation of net deferred tax liabilities. The effective income tax rate was lower in 2016 compared to 2015 primarily due to the resolution in 2016 of certain income tax matters in tax years through 2012, as well as other permanent items.

Income (loss) from discontinued operations - In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things, which filed for bankruptcy in 2008, and Bob's stores, which filed for bankruptcy in 2016. The Company's loss from discontinued operations includes lease-related costs required to satisfy its Linens 'n Things and Bob's Stores lease guarantees. We incurred a loss from discontinued operations, net of tax, of $8 million and $1 million in 2017 and 2016, respectively. The Company's income from discontinued operations in 2015 of $9 million, net of tax, was related to the release of certain store lease guarantees due to the settlement of a dispute with a landlord.

See Note 1 “Significant Accounting Policies - Discontinued Operations” to the consolidated financial statements for additional information about discontinued operations and Note 12 “Commitments and Contingencies” for additional information about our lease guarantees.

Segment Analysis

We evaluate the performance of our Pharmacy Services and Retail/LTC segments based on net revenues, gross profit and operating profit before the effect of nonrecurring charges and gains and certain intersegment activities. The Company evaluates the performance of its Corporate Segment based on operating expenses before the effect of nonrecurring charges and gains, and certain intersegment activities. The following is a reconciliation of the Company’s business segments to the consolidated financial statements:

In millions	Pharmacy Services Segment [1][2]	Retail/LTC Segment [2]	Corporate Segment	Intersegment Eliminations [2]	Consolidated Totals
2017:					
Net revenues	$ 130,596	$ 79,398	$ —	$ (25,229)	$ 184,765
Gross profit [3]	6,040	23,317	—	(812)	28,545
Operating profit (loss) [4][5]	4,755	6,469	(966)	(741)	9,517
2016:					
Net revenues	119,963	81,100	—	(23,537)	177,526
Gross profit [3]	5,901	23,738	—	(782)	28,857
Operating profit (loss) [4][5][6][7]	4,676	7,302	(891)	(721)	10,366
2015:					
Net revenues	100,363	72,007	—	(19,080)	153,290
Gross profit	5,227	21,992	—	(691)	26,528
Operating profit (loss) [4][5][6][7]	3,992	7,146	(1,035)	(628)	9,475

(1) Net revenues of the Pharmacy Services Segment include approximately $10.8 billion, $10.5 billion and $8.9 billion of Retail/LTC Co-Payments for 2017, 2016 and 2015, respectively. See Note 1 “Significant Accounting Policies - Revenue Recognition” to the consolidated financial statements for additional information about Retail/LTC Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services Segment and the Retail/LTC Segment. These occur in the following ways: when members of Pharmacy Services Segment clients (“members”) fill prescriptions at our retail pharmacies to purchase covered products, when members enrolled in programs such as Maintenance Choice ® elect to pick up maintenance prescriptions at one of our retail pharmacies instead of receiving them through the mail, or when members have prescriptions filled at our long-term care pharmacies. When these occur, both the Pharmacy Services and Retail/LTC segments record the revenues, gross profit and operating profit on a standalone basis.

(3) The Retail/LTC Segment gross profit for the year ended December 31, 2017 and 2016, includes $2 million and $46 million, respectively, of acquisition-related integration costs. The integration costs in 2017 are related to the acquisition of Omnicare and the integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacies and clinics of Target.

(4) The Retail/LTC Segment operating profit for 2017, 2016 and 2015, include $34 million, $281 million and $64 million, respectively, of acquisition-related integration costs. The integration costs in 2017 are related to the acquisition of Omnicare. The integration costs in 2016 and 2015 are related to the acquisitions of Omnicare and the pharmacies and clinics of Target. Operating profit for the year ended December 31, 2017 also includes $215 million of charges associated with store rationalization and $181 million of goodwill impairment charges related to the RxCrossroads reporting unit. For the year ended December 31, 2016, operating profit includes a $34 million asset impairment charge in connection with planned store closures in 2017 related to our enterprise streamlining initiative.

(5) The Corporate Segment operating loss for the year ended December 31, 2017, includes a reduction of $3 million in integration costs for a change in estimate related to the acquisition of Omnicare, $34 million in acquisition-related transaction costs related to the proposed Aetna acquisition and $9 million of transaction costs related to the divestiture of RxCrossroads. The Corporate Segment operating loss for the year ended December 31, 2016 includes integration costs of $10 million related to the acquisitions of Omnicare and the pharmacies and clinics of Target. For the year ended December 31, 2015, the Corporate Segment operating loss includes $156 million of acquisition-related transaction and integration costs related to the acquisitions of Omnicare and the pharmacies and clinics of Target and a $90 million charge related to a legacy lawsuit challenging the 1999 legal settlement by MedPartners of various securities class actions and a related derivative claim.

(6) The Pharmacy Services Segment operating profit for the year ended December 31, 2016, includes the reversal of an accrual of $88 million in connection with a legal settlement.

(7) Amounts revised to reflect the adoption of ASU 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* , which increased consolidated operating profit by $28 million and $21 million for the years ended December 31, 2016 and 2015, respectively.

Pharmacy Services Segment

The following table summarizes our Pharmacy Services Segment's performance for the respective periods:

In millions	Year Ended December 31, 2017	2016	2015
Net revenues	$ 130,596	$ 119,963	$ 100,363
Gross profit	$ 6,040	$ 5,901	$ 5,227
Gross profit % of net revenues	4.6 %	4.9 %	5.2 %
Operating expenses [1][2]	$ 1,285	$ 1,225	$ 1,235
Operating expenses % of net revenues	1.0 %	1.0 %	1.2 %
Operating profit [1]	$ 4,755	$ 4,676	$ 3,992
Operating profit % of net revenues	3.6 %	3.9 %	4.0 %
Net revenues:			
Mail choice [3]	$ 45,709	$ 42,783	$ 37,828
Pharmacy network [4]	$ 84,555	$ 76,848	$ 62,240
Other	$ 332	$ 332	$ 295
Pharmacy claims processed (90 Day = 3 prescriptions) [5][6]:			
Total	1,781.9	1,639.2	1,325.8
Mail choice [3]	265.2	251.5	241.1
Pharmacy network [4]	1,516.7	1,387.7	1,084.7
Generic dispensing rate [5][6]:			
Total	87.0 %	85.9 %	83.9 %
Mail choice [3]	83.1 %	81.4 %	79.4 %
Pharmacy network [4]	87.7 %	86.7 %	84.9 %
Mail choice penetration rate [5][6]	14.9 %	15.3 %	18.2 %

(1) Amounts revised to reflect the adoption of ASU 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* , which decreased operating expenses and increased operating profit by $4 million and $3 million for the year ended December 31, 2016 and 2015, respectively.

(2) The Pharmacy Services Segment operating expenses for the year ended December 31, 2016, includes the reversal of an accrual of $88 million in connection with a legal settlement.

(3) Mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at retail, as well as prescriptions filled at our retail pharmacies under the Maintenance Choice® program.

(4) Pharmacy network net revenues, claims processed and generic dispensing rates do not include Maintenance Choice activity, which is included within the mail choice category. Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including our retail pharmacies and long-term care pharmacies, but excluding Maintenance Choice activity.

(5) Includes the adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

(6) The pharmacy claims processed, the generic dispensing rate and the mail choice penetration rate for the year ended December 31, 2016, has been revised to reflect 90-day prescriptions to the equivalent of three 30-day prescriptions.

Net revenues in our Pharmacy Services Segment increased $10.6 billion, or 8.9%, to $130.6 billion for the year ended December 31, 2017, as compared to the prior year. The increase is primarily due to growth in pharmacy network and specialty pharmacy volume as well as brand inflation, partially offset by continued price compression and increased generic dispensing.

Net revenues increased $19.6 billion, or 19.5%, to $120.0 billion for the year ended December 31, 2016, as compared to the prior year. The increase is primarily due to increased pharmacy network claims, growth in specialty pharmacy, growth in Medicare Part D, addition of ACS Pharmacy through the acquisition of Omnicare, and inflation, partially offset by increased generic dispensing and price compression.

As you review our Pharmacy Services Segment's revenue performance, we believe you should also consider the following important information about the business:

- Our mail choice claims processed increased 5.5% to 265.2 million claims, on a 30-day equivalent basis, in the year ended December 31, 2017, compared to 251.5 million claims in the prior year. During 2016, our mail choice claims processed increased 4.3% to 251.5 million claims on a 30-day equivalent basis. The increases in mail choice claims

were driven by growth in specialty pharmacy claims, an increase in net new business, and continued adoption of our Maintenance Choice offerings.

- During 2017 and 2016, our average revenue per mail choice claim, on a 30-day equivalent basis, increased by 1.7% and 8.3%, compared to 2016 and 2015, respectively. The increase in both years was primarily due to growth in specialty pharmacy and inflation.

- Our pharmacy network claims processed increased 9.3% to 1,516.7 million claims in the year ended December 31, 2017, compared to 1,387.7 million claims in the prior year on a 30-day equivalent basis. During 2016, our pharmacy network claims processed, on a 30-day equivalent basis, increased 27.9% to 1,387.7 million compared to 1,084.7 million pharmacy network claims processed in 2015. These increases were primarily due to volume from net new business.

- During 2017 and 2016, our average revenue per pharmacy network claim processed remained flat on a 30-day equivalent basis.

- Our mail choice generic dispensing rate was 83.1%, 81.4% and 79.4% in the years ended December 31, 2017, 2016 and 2015, respectively. Our pharmacy network generic dispensing rate was 87.7%, 86.7%, and 84.9% in the years ended December 31, 2017, 2016 and 2015, respectively. These continued increases in mail choice and pharmacy network generic dispensing rates were primarily due to the impact of new generic drug introductions, and our continuous efforts to encourage plan members to use generic drugs when they are available and clinically appropriate. We believe our generic dispensing rates will continue to increase in future periods, albeit at a slower pace. This increase will be affected by, among other things, the number of new brand and generic drug introductions and our success at encouraging plan members to utilize generic drugs when they are available and clinically appropriate.

Gross profit in our Pharmacy Services Segment includes net revenues less cost of revenues. Cost of revenues includes (i) the cost of pharmaceuticals dispensed, either directly through our mail service and specialty retail pharmacies or indirectly through our pharmacy network, (ii) shipping and handling costs and (iii) the operating costs of our mail service dispensing pharmacies, customer service operations and related information technology support.

Gross profit increased $139 million, or 2.4%, to $6.0 billion in the year ended December 31, 2017, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 4.6% for the year ended December 31, 2017, compared to 4.9% in the prior year. The increase in gross profit dollars in the year ended December 31, 2017 was primarily due to growth in specialty pharmacy, higher generic dispensing and favorable purchasing economics, partially offset by price compression. The decrease in gross profit as a percentage of net revenues was primarily due to changes in the mix of our business and continued price compression, partially offset by favorable generic dispensing and purchasing economics.

Gross profit increased $674 million, or 12.9%, to $5.9 billion in the year ended December 31, 2016, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 4.9% for the year ended December 31, 2016, compared to 5.2% in the prior year. The increase in gross profit dollars in the year ended December 31, 2016 was primarily due to growth in specialty pharmacy, growth in Medicare Part D lives, higher generic dispensing and favorable purchasing economics, partially offset by price compression. The decrease in gross profit as a percentage of net revenues was primarily due to changes in the mix of our business and continued price compression, partially offset by favorable generic dispensing and purchasing economics.

As you review our Pharmacy Services Segment's performance in this area, we believe you should consider the following important information about the business:

- Our efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts we received from manufacturers, wholesalers and retail pharmacies continue to have an impact on our gross profit dollars and gross profit as a percentage of net revenues. In particular, competitive pressures in the PBM industry have caused us and other PBMs to continue to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, market dynamics and regulatory changes have limited our

ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and we expect these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Operating expenses in our Pharmacy Services Segment, which include selling, general and administrative expenses, depreciation and amortization related to selling, general and administrative activities and administrative payroll, employee benefits and occupancy costs, were flat at 1.0% of net revenues in 2017 and 2016, compared to 1.2% in 2015.

Operating expenses increased $60 million or 4.9% in the year ended December 31, 2017, compared to the prior year. Operating expenses decreased $10 million or 0.8% in the year ended December 31, 2016, compared to the prior year. These changes in operating expense dollars are primarily due to an $88 million reversal of an accrual in connection with a legal settlement in 2016, partially offset by an increase in costs associated with the growth of our business.

Retail/LTC Segment

The following table summarizes our Retail/LTC Segment's performance for the respective periods:

	Year Ended December 31,		
In millions	**2017**	**2016**	**2015**
Net revenues	$ 79,398	$ 81,100	$ 72,007
Gross profit [1]	$ 23,317	$ 23,738	$ 21,992
Gross profit % of net revenues	29.4 %	29.3 %	30.5 %
Operating expenses [2][3]	$ 16,848	$ 16,436	$ 14,846
Operating expenses % of net revenues	21.2 %	20.3 %	20.6 %
Operating profit [3]	$ 6,469	$ 7,302	$ 7,146
Operating profit % of net revenues	8.1 %	9.0 %	9.9 %
Prescriptions filled (90 Day = 3 prescriptions) [4]	1,230.5	1,223.5	1,031.6
Net revenue increase (decrease):			
Total	(2.1)%	12.6 %	6.2 %
Pharmacy	(2.2)%	15.9 %	9.5 %
Front Store	(1.9)%	0.3 %	(2.5)%
Total prescription volume (90 Day = 3 prescriptions) [4]	0.6 %	18.6 %	10.2 %
Same store sales increase (decrease) [5]:			
Total	(2.6)%	1.9 %	1.7 %
Pharmacy	(2.6)%	3.2 %	4.5 %
Front Store [6]	(2.6)%	(1.5)%	(5.0)%
Prescription volume (90 Day = 3 prescriptions) [4]	0.4 %	3.6 %	4.8 %
Generic dispensing rates	87.3 %	85.7 %	84.5 %
Pharmacy % of net revenues	75.0 %	75.0 %	72.9 %

(1) Gross profit for the years ended December 31, 2017 and 2016, includes $2 million and $46 million, respectively, of acquisition-related integration costs. In 2017, the integration costs related to the acquisition of Omnicare. In 2016, the integration costs related to the acquisitions of Omnicare and the pharmacies and clinics of Target.

(2) Operating expenses for the years ended December 31, 2017, 2016 and 2015, include $32 million, $235 million and $64 million, respectively, of acquisition-related integration costs. In 2017, the integration costs related to the acquisition of Omnicare. In 2016 and 2015, the integration costs related to the acquisitions of Omnicare and the pharmacies and clinics of Target. For the year ended December 31, 2017, operating expenses include $215 million of charges associated with store closures and $181 million of goodwill impairment charges related to the segment's RxCrossroads reporting unit. Operating expenses for the year ended December 31, 2016, also include a $34 million asset impairment charge in connection with planned store closures in 2017 related to our enterprise streamlining initiative.

(3) Amounts revised to reflect the adoption of ASU 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* , which decreased operating expenses and increased operating profit by $21 million and $16 million for the year ended December 31, 2016 and 2015, respectively.

(4) Includes the adjustment to convert 90-day, non-specialty prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

(5) Same store sales and prescriptions exclude revenues from MinuteClinic, and revenue and prescriptions from stores in Brazil, from LTC operations and from commercialization services.

(6) Front store same store sales would have been approximately 520 basis points higher for the year ended December 31, 2015, if tobacco and the estimated associated basket sales were excluded from the year ended December 31, 2014.

Net revenues decreased approximately $1.7 billion, or 2.1%, to $79.4 billion for the year ended December 31, 2017, as compared to the prior year. The decrease was primarily due to a decline in same store sales as a result of the previously-announced marketplace changes that restrict CVS Pharmacy from participating in certain networks.

Net revenues increased approximately $9.1 billion, or 12.6%, to $81.1 billion for the year ended December 31, 2016, as compared to the prior year. This increase was primarily driven by the acquisitions of the pharmacies and clinics of Target and new stores, which accounted for approximately 640 basis points of our total net revenue percentage increase during the year, the acquisition of Omnicare's LTC operations and a same store sales increase of 1.9%. As you review our Retail/LTC Segment's performance in this area, we believe you should consider the following important information about the business:

- Front store same store sales declined 2.6% in the year ended December 31, 2017, as compared to the prior year, and were negatively impacted approximately 30 basis points due to the absence of leap day in the current year. The decrease is primarily driven by softer customer traffic and efforts to rationalize promotional strategies, partially offset by an increase in basket size.

- Pharmacy same store sales declined 2.6% in the year ended December 31, 2017, as compared to the prior year. Pharmacy same store sales were negatively impacted by approximately 390 basis points due to recent generic introductions. Same store prescription volumes increased 0.4%, including the approximately 420 basis point negative impact from previously-discussed marketplace changes that restrict CVS Pharmacy from participating in certain networks that had an.

- Pharmacy revenues continue to be negatively impacted by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 87.3% for the year ended December 31, 2017, compared to 85.7% in the prior year. In addition, our pharmacy revenue growth has also been negatively affected by the mix of drugs sold, continued reimbursement pressure and the lack of significant new brand name drug introductions.

- Pharmacy revenue growth may be impacted by industry changes in the LTC business, such as continuing lower occupancy rates at skilled nursing facilities.

- Pharmacy revenue continued to benefit from our ability to attract and retain managed care customers, the increased use of pharmaceuticals by an aging population and as the first line of defense for health care.

Gross profit in our Retail/LTC Segment includes net revenues less the cost of merchandise sold during the reporting period and the related purchasing costs, warehousing costs, delivery costs and actual and estimated inventory losses.

Gross profit decreased $421 million, or 1.8%, to approximately $23.3 billion in the year ended December 31, 2017, as compared to the prior year. Gross profit as a percentage of net revenues increased slightly to 29.4% in year ended December 31, 2017, from 29.3% in 2016. Gross profit increased $1.7 billion, or 7.9%, to approximately $23.7 billion in the year ended December 31, 2016, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 29.3% in year ended December 31, 2016, from 30.5% in 2015.

The decrease in gross profit dollars in both Retail Pharmacy and LTC in the year ended December 31, 2017, was primarily driven by the continued reimbursement pressure as well as a loss of prescriptions in Retail Pharmacy due to previously discussed network restrictions. In the year ended December 31, 2017, gross profit as a percentage of net revenues was relatively flat driven by increased front store margins which offset the continued reimbursement pressure on pharmacy. Front store margins increased due to changes in the mix of products sold and efforts to rationalize promotional strategies.

As you review our Retail/LTC Segment's performance in this area, we believe you should consider the following important information about the business:

- Front store revenues as a percentage of total Retail/LTC Segment net revenues for both of the years ended December 31, 2017 and 2016 was 23.6% and for the year ended December 31, 2015 was 26.5%. On average, our

gross profit on front store revenues is higher than our gross profit on pharmacy revenues. The mix effect from a higher proportion of pharmacy sales had a negative effect on our overall gross profit as a percentage of net revenues for the years ended December 31, 2016 and 2015. This negative effect was partially offset by an increase in generic drugs dispensed, and an improved front store gross margin rate, which includes efforts to rationalize promotional strategies.

- During 2017 and 2016, our front store gross profit as a percentage of net revenues increased compared to the prior year. In both years, the increase reflects a change in the mix of products sold, including store brand products, as a result of our efforts to rationalize promotional strategies.

- Our pharmacy gross profit rates have been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of our business within the pharmacy portion of the Retail/LTC Segment. In the event the reimbursement pressure accelerates, we may not be able to grow our revenues and gross profit dollars could be adversely impacted. The increased use of generic drugs has positively impacted our gross profit but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which we expect to continue, reduces the benefit we realize from brand to generic product conversions.

Operating expenses in our Retail/LTC Segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.

Operating expenses increased $412 million, or 2.5% to $16.8 billion, or 21.2% as a percentage of net revenues, in the year ended December 31, 2017, as compared to $16.4 billion, or 20.3% as a percentage of net revenues, in the prior year. Operating expenses increased $1.6 billion, or 10.7%, to $16.4 billion, or 20.3% as a percentage of net revenues, in the year ended December 31, 2016, as compared to $14.9 billion, or 20.6% as a percentage of net revenues, in the prior year.

The increase in operating expense dollars for the year ended December 31, 2017, was primarily due to $181 million increase in charges associated with the closure of 71 retail stores in connection with our enterprise streamlining initiative, $181 million of goodwill impairment charges related to the RxCrossroads reporting unit, which was subsequently sold on January 2, 2018, $55 million in hurricane related costs, and new store openings. Operating expenses as a percentage of net revenues for the year ended December 31, 2017 increased due to a decline in expense leverage with the loss of business from restricted network changes.

The increase in operating expense dollars for the year ended December 31, 2016, was primarily due to the 2015 acquisitions of LTC and the pharmacies and clinics within Target stores, including acquisition-related integration costs of $235 million, as well as incremental store operating costs associated with operating more stores. Operating expenses for the year ended December 31, 2016, includes a gain from a legal settlement with certain credit card companies of $32 million and an asset impairment charge of $34 million in connection with planned store closures in 2017 related to our enterprise streamlining initiative. Additionally, in April 2016, the Retail/LTC Segment made a charitable contribution of $32 million to the CVS Foundation to fund future charitable giving. The CVS Foundation is a non-profit entity that focuses on health, education and community involvement programs. The charitable contribution was recorded as an operating expense in the year ended December 31, 2016.

Corporate Segment

Operating expenses increased $75 million, or 8.4%, to $966 million in the year ended December 31, 2017, as compared to the prior year. Operating expenses decreased $144 million, or 13.9%, to $891 million in the year ended December 31, 2016. Operating expenses within the Corporate Segment include executive management, corporate relations, legal, compliance, human resources, information technology and finance related costs. The increase in operating expenses for the year ended December 31, 2017, was partially driven by ongoing investments in strategic initiatives and increased employee benefit costs. Operating expenses for the year ended December 31, 2017, include $34 million in transaction costs associated with the proposed acquisition of Aetna, $9 million of transaction costs associated with the divestiture of RxCrossroads. The decrease in operating expenses for the year ended December 31, 2016 was primarily due to

acquisition-related transaction and integration costs associated with the acquisition of Omnicare that occurred in August 2015, and the acquisition of the pharmacies and clinics of Target that occurred in December 2015.

Liquidity and Capital Resources

We maintain a level of liquidity sufficient to allow us to meet our cash needs in the short-term. Over the long-term, we manage our cash and capital structure to maximize shareholder return, maintain our financial position and maintain flexibility for future strategic initiatives. We continuously assess our working capital needs, debt and leverage levels, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. We believe our operating cash flows, commercial paper program, credit facilities, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives.

The change in cash and cash equivalents is as follows:

	Year Ended December 31,		
In millions	**2017**	**2016**	**2015**
Net cash provided by operating activities	$ 8,007	$ 10,141	$ 8,539
Net cash used in investing activities	(2,932)	(2,470)	(13,420)
Net cash provided by (used in) financing activities	(6,751)	(6,761)	4,879
Effect of exchange rate changes on cash and cash equivalents	1	2	(20)
Net increase (decrease) in cash and cash equivalents	$ (1,675)	$ 912	$ (22)

Net cash provided by operating activities decreased by $2.1 billion in 2017 and increased by $1.6 billion in 2016. These changes are primarily related to the timing of payments for our Medicare Part D operations.

Net cash used in investing activities increased by $462 million in 2017 and decreased $11.0 billion in 2016. The increase in 2017 is largely driven by an increase in acquisition activity as compared to 2016. The decrease in 2016 was primarily due to the $9.6 billion paid for the acquisition of Omnicare and the $1.9 billion paid for the acquisition of the pharmacies and clinics of Target in 2015, compared to the $539 million paid for acquisitions in 2016.

In 2017, gross capital expenditures totaled approximately $1.9 billion, a decrease of approximately $306 million compared to the prior year. The decrease in 2017 capital expenditures is due to the Target integration being completed in 2016. During 2017, approximately 25% of our total capital expenditures were for new store construction, 30% were for store, fulfillment and support facilities expansion and improvements and 45% were for technology and other corporate initiatives. Gross capital expenditures totaled approximately $2.2 billion and $2.4 billion during 2016 and 2015, respectively. During 2016, approximately 31% of our total capital expenditures were for new store construction, 20% were for store, fulfillment and support facilities expansion and improvements and 49% were for technology and other corporate initiatives.

Proceeds from sale-leaseback transactions totaled $265 million in 2017. This compares to $230 million in 2016 and $411 million in 2015. Under the sale-leaseback transactions, the properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The specific timing and amount of future sale-leaseback transactions will vary depending on future market conditions and other factors.

Below is a summary of our store development activity for the respective years:

	2017 (2)	**2016 (2)**	**2015 (2)**
Total stores (beginning of year)	9,750	9,665	7,866
New and acquired stores [(1)]	179	132	1,833
Closed stores [(1)]	(83)	(47)	(34)
Total stores (end of year)	9,846	9,750	9,665
Relocated stores	30	50	58

(1) Relocated stores are not included in new or closed store totals.
(2) Includes retail drugstores, certain onsite pharmacy stores, specialty pharmacy stores and pharmacies within Target stores.

Net cash used in financing activities was $6.8 billion in both 2017 and 2016 as net borrowings and net payments to shareholders were relatively flat in both years. Net cash provided by financing activities was $4.9 billion in 2015 versus net cash used in financing activities of $6.8 billion in 2016. The difference of $11.6 billion was primarily due to higher net borrowings in 2015, including the $14.8 billion in net proceeds received from the July 2015 debt issuance that was used to fund the acquisition of Omnicare and the acquisition of the pharmacies and clinics of Target.

Share repurchase programs — The following share repurchase programs were authorized by the Company's Board of Directors:

In billions Authorization Date	Authorized	Remaining as of December 31, 2017
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—
December 17, 2013 ("2013 Repurchase Program")	6.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board of Directors at any time.

Pursuant to the authorization under the 2014 Repurchase Program, in August 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion. Upon payment of the $3.6 billion purchase price in January 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares, which were placed into treasury stock in January 2017. The ASRs were accounted for as an initial treasury stock transaction for $2.9 billion and a forward contract for $0.7 billion. In April 2017, the Company received 9.9 million shares of common stock, representing the remaining 20% of the $3.6 billion notional amount of the ASRs, thereby concluding the ASRs. The remaining 9.9 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in April 2017.

Pursuant to the authorization under the 2014 Repurchase Program, in December 2015, the Company entered into a $725 million fixed dollar ASR with Barclays. Upon payment of the $725 million purchase price in December 2015, the Company received a number of shares of its common stock equal to 80% of the $725 million notional amount of the ASR or approximately 6.2 million shares. The initial 6.2 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in December 2015. The ASR was accounted for as an initial treasury stock transaction of $580 million and a forward contract of $145 million. The forward contract was classified as an equity instrument and was recorded within capital surplus on the consolidated balance sheet. In January 2016, the Company received 1.4 million shares of common stock, representing the remaining 20% of the $725 million notional amount of the ASR, thereby concluding the ASR. The remaining 1.4 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in January 2016 and the forward contract was reclassified from capital surplus to treasury stock.

Pursuant to the authorization under the 2013 Repurchase Programs, in January 2015, the Company entered into a $2.0 billion fixed dollar ASR agreement with J.P. Morgan Chase Bank ("JP Morgan"). Upon payment of the $2.0 billion purchase price in January 2015, the Company received a number of shares of its common stock equal to 80% of the $2.0 billion notional amount of the ASR agreement or approximately 16.8 million shares, which were placed into treasury stock in January 2015. In May 2015, the Company received approximately 3.1 million shares of common stock, representing the remaining 20% of the $2.0 billion notional amount of the ASR, thereby concluding the ASR. The remaining 3.1 million shares of common stock delivered to the Company by JP Morgan were placed into treasury stock in May 2015. The ASR was accounted for as an initial treasury stock transaction of $1.6 billion and a forward contract of $0.4 billion. The forward contract was classified as an equity instrument and was initially recorded within capital surplus on the consolidated balance sheet and was reclassified to treasury stock upon the settlement of the ASR in May 2015.

In the ASR transactions described above, the initial repurchase of the shares and delivery of the remainder of the shares to conclude the ASR, resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

During the year ended December 31, 2017, the Company repurchased an aggregate of 55.4 million shares of common stock for approximately $4.4 billion under the 2014 and 2016 Repurchase Programs. As of December 31, 2017, there remained an aggregate of approximately $13.9 billion available for future repurchases under the 2016 Repurchase Program and the 2014 Repurchase Program was complete. During the fourth quarter of 2017, the Company suspended share repurchase activity as a result of the Aetna Acquisition.

During the year ended December 31, 2016, the Company repurchased an aggregate of 47.5 million shares of common stock for approximately $4.5 billion under the 2014 Repurchase Program. As of December 31, 2016, there remained an aggregate of approximately $18.2 billion available for future repurchases under the 2016 and 2014 Repurchase Programs.

During the year ended December 31, 2015, the Company repurchased an aggregate of 48.0 million shares of common stock for approximately $5.0 billion under the 2013 and 2014 Repurchase Programs. As of December 31, 2015, there remained an aggregate of approximately $7.7 billion available for future repurchases under the 2014 Repurchase Program and the 2013 Repurchase Program was complete.

Short-term borrowings - The Company had approximately $1.3 billion of commercial paper outstanding at a weighted average interest rate of 2.0% as of December 31, 2017. The Company had approximately $1.9 billion of commercial paper outstanding at a weighted average interest rate of 1.22% as of December 31, 2016. In connection with its commercial paper program, the Company maintains a $1.0 billion 364-day unsecured back-up credit facility, which expires on May 17, 2018, a $1.25 billion, five-year unsecured back-up credit facility, which expires on July 24, 2019, a $1.25 billion, five-year unsecured back-up credit facility, which expires on July 1, 2020, and a $1.0 billion, five-year unsecured back-up credit facility which expires on May 18, 2022. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.02%, regardless of usage. As of December 31, 2016, there were no borrowings outstanding under the back-up credit facilities. During 2018, the Company intends to refinance the 364-day unsecured back-up credit facility, which expires on May 17, 2018.

On December 3, 2017, in connection with the proposed acquisition of Aetna, the Company entered into a $49.0 billion unsecured bridge loan facility. The Company paid approximately $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and will be amortized as interest expense over the period the bridge facility is outstanding. The bridge loan facility was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense. On December 15, 2017, in connection with the proposed acquisition of Aetna, the Company entered into a $5.0 billion unsecured term loan agreement. The term loan facility under the term loan agreement consists of a $3.0 billion three-year tranche and a $2.0 billion five-year tranche. The term loan facility allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings and require the Company to pay a weighted average quarterly commitment fee, regardless of usage.

On January 3, 2017, the Company entered into a $2.5 billion revolving credit facility. The credit facility allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. The Company terminated the credit facility in May 2017.

On May 20, 2015, in connection with the acquisition of Omnicare, the Company entered into a $13 billion unsecured bridge loan facility. The Company paid approximately $52 million in fees in connection with the facility. The fees were capitalized and amortized as interest expense over the period the bridge facility was outstanding. The bridge loan facility expired on July 20, 2015 upon the Company's issuance of unsecured senior notes with an aggregate principal of $15 billion as discussed below. The bridge loan facility fees became fully amortized in July 2015.

Long-term borrowings - On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the "2016 Notes") for total proceeds of approximately $3.5 billion, net of discounts and underwriting fees. The 2016 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

On May 16, 2016, the Company announced tender offers for (1) any and all of its 5.75% Senior Notes due 2017, its 6.60% Senior Notes due 2019 and its 4.75% Senior Notes due 2020 (collectively, the "Any and All Notes") and (2) up to $1.5 billion aggregate principal amount of its 6.25% Senior Notes due 2027, its 6.125% Senior Notes due 2039, its 5.75% Senior Notes due 2041, the 5.00% Senior Notes due 2024 issued by its wholly-owned subsidiary, Omnicare, Inc. ("Omnicare"), the 4.75% Senior Notes due 2022 issued by Omnicare, its 4.875% Senior Notes due 2035 and its 3.875% Senior Notes due 2025 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion. The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. The Company paid a premium of $486 million in excess of the debt principal in connection with the purchase of the Notes, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on the early extinguishment of debt of $542 million which was recorded in income from continuing operations in the consolidated statement of income for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. The Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of debt of $101 million during the year ended December 31, 2016.

The Company recorded a total loss on the early extinguishment of debt of $643 million which was recorded in the income from continuing operations in the consolidated statement of income for the year ended December 31, 2016.

On July 20, 2015, the Company issued an aggregate of $2.25 billion of 1.9% unsecured senior notes due 2018 ("2018 Notes"), an aggregate of $2.75 billion of 2.8% unsecured senior notes due 2020 ("2020 Notes"), an aggregate of $1.5 billion of 3.5% unsecured senior notes due 2022 ("2022 Notes"), an aggregate of $3 billion of 3.875% unsecured senior notes due 2025 ("2025 Notes"), an aggregate of $2 billion of 4.875% unsecured senior notes due 2035 ("2035 Notes"), and an aggregate of $3.5 billion of 5.125% unsecured senior notes due 2045 ("2045 Notes" and, together with the 2018 Notes, 2020 Notes, 2022 Notes, 2025 Notes and 2035 Notes, the "Notes") for total proceeds of approximately $14.8 billion, net of discounts and underwriting fees. The Notes pay interest semi-annually and contain redemption terms which allow or require the Company to redeem the Notes at a defined redemption price plus accrued and unpaid interest at the redemption date. The net proceeds of the Notes were used to fund the Omnicare acquisition and the acquisition of the pharmacies and clinics of Target. The remaining proceeds were used for general corporate purposes.

Upon the closing of the Omnicare acquisition in August 2015, the Company assumed the long-term debt of Omnicare that had a fair value of approximately $3.1 billion, $2.0 billion of which was previously convertible into Omnicare shares that holders were able to redeem subsequent to the acquisition. During the period from August 18, 2015 to December 31, 2015, all but $5 million of the $2.0 billion of previously convertible debt was redeemed and repaid and approximately $0.4 billion in Omnicare term debt assumed was repaid for total repayments of Omnicare debt of approximately $2.4 billion in 2015.

The remaining principal of the Omnicare debt assumed was comprised of senior unsecured notes with an aggregate principal amount of $700 million ($400 million of 4.75% senior notes due 2022 and $300 million of 5% senior notes due 2024). In September 2015, the Company commenced exchange offers for the 4.75% senior notes due 2022 and the 5%

senior notes due 2024 to exchange all validly tendered and accepted notes issued by Omnicare for notes to be issued by the Company. This offer expired on October 20, 2015 and the aggregate principal amounts of $388 million of the 4.75% senior notes due 2022 and $296 million of the 5% senior notes due 2024 were validly tendered and exchanged for notes issued by the Company. The Company recorded this exchange transaction as a modification of the original debt instruments. Consequently, no gain or loss on extinguishment was recognized in the Company's consolidated income statement as a result of this exchange transaction and the issuance costs of the new debt were expensed as incurred.

Our back-up credit facilities and unsecured senior notes (see Note 5 "Borrowings and Credit Agreements" to the consolidated financial statements) contain customary restrictive financial and operating covenants. The covenants do not materially affect the Company's financial or operating flexibility. As of December 31, 2017, the Company is in compliance with all debt covenants.

As of December 31, 2017, we had outstanding derivative financial instruments (see Note 1 "Significant Accounting Policies" to the consolidated financial statements). We had no outstanding derivative financial instruments as of December 31, 2016.

Debt Ratings - As of December 31, 2017, our long-term debt was rated "Baa1" by Moody's and "BBB+" by Standard & Poor's, and our commercial paper program was rated "P-2" by Moody's and "A-2" by Standard & Poor's. In December 2017, subsequent to the announcement of the proposed acquisition of Aetna, Moody's changed the outlook on our long-term debt to "Under Review" from "Stable." Similarly, S&P placed our-long-term debt outlook on "Watch Negative" from "Stable". The outlook for the commercial paper program was unchanged. In assessing our credit strength, we believe that both Moody's and Standard & Poor's considered, among other things, our capital structure and financial policies as well as our consolidated balance sheet, our historical acquisition activity and other financial information. Although we currently believe our long-term debt ratings will remain investment grade, we cannot guarantee the future actions of Moody's and/or Standard & Poor's. Our debt ratings have a direct impact on our future borrowing costs, access to capital markets and new store operating lease costs.

Quarterly Cash Dividend - In December 2016, our Board of Directors authorized an 18% increase in our quarterly common stock cash dividend to $0.50 per share effective in 2017. This increase equated to an annual dividend rate of $2.00 per share. The Company expects to maintain its quarterly dividend of $0.50 per share throughout 2018. In December 2015, our Board of Directors authorized a 21% increase in our quarterly common stock cash dividend to $0.425 per share. This increase equated to an annual dividend rate of $1.70 per share. In December 2014, our Board of directors authorized a 27% increase to our quarterly common stock cash dividend to $0.35 per share. This increase equated to an annual dividend rate of $1.40 per share.

Off-Balance Sheet Arrangements

In connection with executing operating leases, we provide a guarantee of the lease payments. We also finance a portion of our new store development through sale-leaseback transactions, which involve selling stores to unrelated parties and then leasing the stores back under leases that generally qualify and are accounted for as operating leases. We do not have any retained or contingent interests in the stores, and we do not provide any guarantees, other than a guarantee of the lease payments, in connection with the transactions. In accordance with generally accepted accounting principles, our operating leases are not reflected on our consolidated balance sheets.

Between 1995 and 1997, we sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations.

As of December 31, 2017, we guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things), with the maximum remaining lease term extending through 2029. Management believes the ultimate disposition of any of the remaining lease guarantees will not have a material adverse effect on the Company's consolidated financial condition or future cash flows. Please see "Income (loss) from discontinued operations"

previously in this document for further information regarding our guarantee of certain Linens 'n Things' store lease obligations.

Below is a summary of our significant contractual obligations as of December 31, 2017:

	Payments Due by Period				
In millions	**Total**	**2018**	**2019 to 2020**	**2021 to 2022**	**Thereafter**
Operating leases	$27,151	$ 2,493	$ 4,562	$ 4,006	$ 16,090
Lease obligations from discontinued operations	11	3	5	3	—
Capital lease obligations	1,342	74	148	146	974
Contractual lease obligations with Target [(1)]	1,924	—	—	—	1,924
Long-term debt	25,224	3,523	3,600	5,449	12,652
Interest payments on long-term debt [(2)]	10,469	893	1,614	1,343	6,619
Other long-term liabilities in the consolidated balance sheet	468	52	346	33	37
	$66,589	$ 7,038	$10,275	$10,980	$ 38,296

(1) The Company leases pharmacy and clinic space from Target Corporation ("Target"). See Note 7 "Leases" to the consolidated financial statements for additional information regarding the lease arrangements with Target. Amounts related to the operating and capital leases with Target are reflected within the operating leases and capital lease obligations above. Amounts due in excess of the remaining estimated economic lives of the buildings are reflected herein assuming equivalent stores continue to operate through the term of the arrangements.

(2) Interest payments on long-term debt are calculated on outstanding balances and interest rates in effect on December 31, 2017.

Critical Accounting Policies

We prepare our consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. We base our estimates and judgments on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, we review our accounting policies and how they are applied and disclosed in our consolidated financial statements. While we believe the historical experience, current trends and other factors considered, support the preparation of our consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from our estimates, and such differences could be material.

Our significant accounting policies are discussed in Note 1 "Significant Accounting Policies" to our consolidated financial statements. We believe the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. We have discussed the development and selection of our critical accounting policies with the Audit Committee of our Board of Directors and the Audit Committee has reviewed our disclosures relating to them.

Revenue Recognition

Pharmacy Services Segment

Our Pharmacy Services Segment sells prescription drugs directly through our mail service dispensing pharmacies and indirectly through our retail pharmacy network. We recognize revenues in our Pharmacy Services Segment from prescription drugs sold by our mail service dispensing pharmacies and under retail pharmacy network contracts where we are the principal using the gross method at the contract prices negotiated with our clients. Net revenue from our Pharmacy Services Segment includes: (i) the portion of the price the client pays directly to us, net of any volume-related or other discounts paid back to the client, (ii) the price paid to us ("Mail Co-Payments") or a third party pharmacy in our retail pharmacy network ("Retail Co-Payments") by individuals included in our clients' benefit plans, and (iii) administrative fees for retail pharmacy network contracts where we are not the principal. Sales taxes are not included in revenue.

We recognize revenue in the Pharmacy Services Segment when: (i) persuasive evidence of an arrangement exists, (ii) delivery has occurred or services have been rendered, (iii) the seller's price to the buyer is fixed or determinable, and

(iv) collectability is reasonably assured. The following revenue recognition policies have been established for the Pharmacy Services Segment.

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription is delivered. At the time of delivery, the Pharmacy Services Segment has performed substantially all of its obligations under its client contracts and does not experience a significant level of returns or reshipments.

- Revenues generated from prescription drugs sold by third party pharmacies in the Pharmacy Services Segment's retail pharmacy network and associated administrative fees are recognized at the Pharmacy Services Segment's point-of-sale, which is when the claim is adjudicated by the Pharmacy Services Segment's online claims processing system.

We determine whether we are the principal or agent for our retail pharmacy network transactions on a contract by contract basis. In the majority of our contracts, we have determined we are the principal due to us: (i) being the primary obligor in the arrangement, (ii) having latitude in establishing the price, changing the product or performing part of the service, (iii) having discretion in supplier selection, (iv) having involvement in the determination of product or service specifications, and (v) having credit risk. Our obligations under our client contracts for which revenues are reported using the gross method are separate and distinct from our obligations to the third party pharmacies included in our retail pharmacy network contracts. Pursuant to these contracts, we are contractually required to pay the third party pharmacies in our retail pharmacy network for products sold, regardless of whether we are paid by our clients. Our responsibilities under these client contracts typically include validating eligibility and coverage levels, communicating the prescription price and the co-payments due to the third party retail pharmacy, identifying possible adverse drug interactions for the pharmacist to address with the physician prior to dispensing, suggesting clinically appropriate generic alternatives where appropriate and approving the prescription for dispensing. Although we do not have credit risk with respect to Retail Co-Payments or inventory risk related to retail network claims, we believe that all of the other indicators of gross revenue reporting are present. For contracts under which we act as an agent, we record revenues using the net method.

We deduct from our revenues the manufacturers' rebates that are earned by our clients based on their members' utilization of brand-name formulary drugs. We estimate these rebates at period-end based on actual and estimated claims data and our estimates of the manufacturers' rebates earned by our clients. We base our estimates on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. We adjust our rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. We record any cumulative effect of these adjustments against revenues as identified, and adjust our estimates prospectively to consider recurring matters. Adjustments generally result from contract changes with our clients or manufacturers, differences between the estimated and actual product mix subject to rebates or whether the product was included in the applicable formulary. We also deduct from our revenues pricing guarantees and guarantees regarding the level of service we will provide to the client or member as well as other payments made to our clients. Because the inputs to most of these estimates are not subject to a high degree of subjectivity or volatility, the effect of adjustments between estimated and actual amounts have not been material to our results of operations or financial position.

We participate in the federal government's Medicare Part D program as a PDP through our SilverScript subsidiary. Our net revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, but which is subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially deferred as accrued expenses and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

In addition to these premiums, our net revenues include co-payments, coverage gap benefits, deductibles and co-insurance (collectively, the "Member Co-Payments") related to PDP members' actual prescription claims. In certain cases, CMS subsidizes a portion of these Member Co-Payments and we are paid an estimated prospective Member Co-Payment subsidy, each month. The prospective Member Co-Payment subsidy amounts received from CMS are also included in our net revenues. These amounts represent 7.2%, 5.9% and 6.3% of consolidated net revenues in 2017, 2016 and 2015, respectively. If the prospective Member Co-Payment subsidies received differ from the amounts based on actual prescription claims, the difference is recorded in either accounts receivable or accrued expenses. We account for fully insured CMS obligations and Member Co-Payments (including the amounts subsidized by CMS) using the gross

method consistent with our revenue recognition policies for Mail Co-Payments and Retail Co-Payments. We have recorded estimates of various assets and liabilities arising from our participation in the Medicare Part D program based on information in our claims management and enrollment systems. Significant estimates arising from our participation in the Medicare Part D program include: (i) estimates of low-income cost subsidy, reinsurance amounts and coverage gap discount amounts ultimately payable to or receivable from CMS based on a detailed claims reconciliation, (ii) an estimate of amounts payable to CMS under a risk-sharing feature of the Medicare Part D program design, referred to as the risk corridor and (iii) estimates for claims that have been reported and are in the process of being paid or contested and for our estimate of claims that have been incurred but have not yet been reported. Actual amounts of Medicare Part D-related assets and liabilities could differ significantly from amounts recorded. Historically, the effect of these adjustments has not been material to our results of operations or financial position.

Retail/LTC Segment

Retail Pharmacy - We recognize revenue from the sale of front store merchandise at the time the merchandise is purchased by the retail customer and recognize revenue from the sale of prescription drugs when the prescription is picked up by the customer. Customer returns are not material. Sales taxes are not included in revenue.

Long-term Care - We recognize revenue when products are delivered or services are rendered or provided to our customers, prices are fixed and determinable, and collection is reasonably assured. A significant portion of our revenues from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. Payments for services rendered to patients covered by these programs are generally less than billed charges. We monitor our revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and record an estimated contractual allowance for sales and receivable balances at the revenue recognition date, to properly account for anticipated differences between billed and reimbursed amounts. Accordingly, the total net revenues and receivables reported in our consolidated financial statements are recorded at the amount expected to be ultimately received from these payors. Since billing functions for a portion of our revenue systems are largely computerized, enabling on-line adjudication at the time of sale to record net revenues, our exposure in connection with estimating contractual allowance adjustments is limited primarily to unbilled and initially rejected Medicare, Medicaid and third party claims (typically approved for reimbursement once additional information is provided to the payor). For the remaining portion of our revenue systems, the contractual allowance is estimated for all billed, unbilled and initially rejected Medicare, Medicaid and third party claims. We evaluate several criteria in developing the estimated contractual allowances on a monthly basis, including historical trends based on actual claims paid, current contract and reimbursement terms, and changes in customer base and payor/product mix. Contractual allowance estimates are adjusted to actual amounts as cash is received and claims are settled, and the aggregate impact of these resulting adjustments was not significant to our results of operations. Further, we do not expect the impact of changes in estimates related to unsettled contractual allowance amounts from Medicare, Medicaid and third party payors as of December 31, 2017 to be significant to our future consolidated results of operations, financial position and cash flows.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors are typically not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of our normal billing procedures and subject to our normal accounts receivable collections procedures.

Health Care Clinics - for services provided by our health care clinics, revenue recognition occurs for completed services provided to patients, with adjustments made for third party payor contractual obligations and patient direct bill historical collection rates.

Loyalty Program - our customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings coupons redeemed by customers are recorded as a reduction of revenue when redeemed. ExtraBucks Rewards are accrued as a charge to cost of revenues when earned, net of estimated breakage. We determine breakage based on our historical redemption patterns.

Allowances for Doubtful Accounts

Accounts receivable primarily includes amounts due from third party providers (e.g., pharmacy benefit managers, insurance companies, governmental agencies and long-term care facilities), clients, members and private pay customers, as well as vendors and manufacturers. We provide a reserve for accounts receivable considered to be at increased risk of becoming uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. We establish this allowance for doubtful accounts and consider such factors as historical collection experience, (i.e., payment history and credit losses) and creditworthiness, specifically identified credit risks, aging of accounts receivable by payor category, current and expected economic conditions and other relevant factors. We regularly review our allowance for doubtful accounts for appropriateness. Judgment is used to assess the collectability of account balances and the economic ability of a customer to pay.

Our allowance for doubtful accounts as of December 31, 2017 was $307 million, compared with $286 million as of December 31, 2016. Our allowance for doubtful accounts represented 2.3% of gross receivables (net of contractual allowance adjustments) as of both December 31, 2017 and 2016. Unforeseen future developments could lead to changes in our provision for doubtful accounts levels and future allowance for doubtful accounts percentages. For example, a one percentage point increase in the allowance for doubtful accounts as a percentage of gross receivables as of December 31, 2017 would result in an increase to the provision of doubtful accounts of approximately $135 million.

Given our experience, we believe that our aggregate reserves for potential losses are adequate, but if any of our larger customers were to unexpectedly default on their obligations, our overall allowances for doubtful accounts may prove to be inadequate. In particular, if economic conditions worsen, the payor mix shifts significantly or reimbursement rates are adversely affected, we may adjust our allowance for doubtful accounts accordingly, and our accounts receivable collections, cash flows, financial position and results of operations could be adversely affected.

Vendor Allowances and Purchase Discounts

Pharmacy Services Segment

Our Pharmacy Services Segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services Segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the results of operations. We account for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services Segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services Segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of “Cost of revenues”.

Retail/LTC Segment

Vendor allowances received by the Retail/LTC Segment reduce the carrying cost of inventory and are recognized in cost of revenues when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of revenues over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of revenues on a straight-line basis over the life of the related contract.

We have not made any material changes in the way we account for vendor allowances and purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or market using the weighted average cost method.

We reduce the value of our ending inventory for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each store and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. The accounting for inventory contains uncertainty since we must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, we consider a number of factors, which include, but are not limited to, historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

Our total reserve for estimated inventory losses covered by this critical accounting policy was $297 million as of December 31, 2017. Although we believe we have sufficient current and historical information available to us to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help you assess the aggregate risk, if any, associated with the uncertainties discussed above, a ten percent (10%) pre-tax change in our estimated inventory losses, which we believe is a reasonably likely change, would increase or decrease our total reserve for estimated inventory losses by about $30 million as of December 31, 2017.

Although we believe that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from our estimates, and such differences could be material.

Goodwill and Intangible Assets

Identifiable intangible assets consist primarily of trademarks, client contracts and relationships, favorable leases and covenants not to compete. These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition.

Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates. Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired.

We evaluate the recoverability of certain long-lived assets, including intangible assets with finite lives, but excluding goodwill and intangible assets with indefinite lives which are tested for impairment using separate tests, whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. We group and evaluate these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. When evaluating these long-lived assets for potential impairment, we first compare the carrying amount of the asset group to the asset group's estimated future cash flows (undiscounted and without interest charges). If the estimated future cash flows are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges). Our long-lived asset impairment loss calculation contains uncertainty since we must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, we consider historical results and current operating trends and our consolidated sales, profitability and cash flow results and forecasts.

These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable.

Indefinitely-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized and the asset is written down to its estimated fair value.

Our indefinitely-lived intangible asset impairment loss calculation contains uncertainty since we must use judgment to estimate the fair value based on the assumption that in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including, but not limited to, general economic conditions, availability of market information as well as the profitability of the Company.

Goodwill is tested for impairment on a reporting unit basis. The impairment test is calculated by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of our reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the fair value of the reporting unit exceeds its carrying amount, the reporting unit's goodwill is considered to be impaired and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of our reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include, but are not limited to, the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates, terminal growth rates; and forecasts of revenue, operating profit, depreciation and amortization, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, we consider each reporting unit's historical results and current operating trends and our consolidated revenues, profitability and cash flow results, forecasts and industry trends. Our estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, our market capitalization, efforts of customers and payers to reduce costs including their prescription drug costs and/or increase member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

The carrying value of goodwill and other intangible assets covered by this critical accounting policy was $38.5 billion and $13.5 billion as of December 31, 2017, respectively. We recorded $181 million in goodwill impairments in 2017 related to our RxCrossroads reporting unit, see Note 3 "Goodwill and Other Intangibles" to our consolidated financial statements. We did not record any impairment losses related to goodwill or other intangible assets during 2016 or 2015. During the third quarter of 2017, we performed our required annual impairment tests of goodwill and indefinitely-lived trademarks. The goodwill impairment tests resulted in the fair values of our Pharmacy Services and Retail Pharmacy reporting units exceeding their carrying values by significant margins. The fair values of our LTC and RxC reporting units exceeded their carrying values by approximately 1% and 6%, respectively. The balance of goodwill for our LTC and RxCrossroads reporting units at December 31, 2017 was approximately $6.5 billion and $0.4 billion, respectively. On January 2, 2018, we sold our RxCrossroads reporting unit to McKesson Corporation for $725 million.

Although we believe we have sufficient current and historical information available to us to test for impairment, it is possible that actual results could differ from the estimates used in our impairment tests.

As previously discussed, the results of our annual goodwill impairment test resulted in the fair value of our LTC reporting unit exceeding its carrying value by approximately 1%. Our multi-year cash flow projections for our LTC reporting unit have declined from the prior year due to customer reimbursement pressures, industry trends such as lower occupancy rates in skilled nursing facilities, and client retention rates. Our projected discounted cash flow model assumes future script growth from our senior living initiative and the impact of acquisitions. Such projections also include expected cost savings from labor productivity and other initiatives. Our market multiple method is heavily dependent on earnings multiples of market participants in the pharmacy industry, including certain competitors and suppliers. If we do not achieve our forecasts, given the small excess of fair value over the related carrying value, as well as current market conditions in the healthcare industry, it is reasonably possible that the operational performance of the LTC reporting unit could be below our current expectations in the near term and the LTC reporting unit could be deemed to be impaired by a material amount.

We have not made any material changes in the methodologies utilized to test the carrying values of goodwill and intangible assets for impairment during the past three years.

Closed Store Lease Liability

We account for closed store lease termination costs when a leased store is closed. When a leased store is closed, we record a liability for the estimated present value of the remaining obligation under the noncancelable lease, which includes future real estate taxes, common area maintenance and other charges, if applicable. The liability is reduced by estimated future sublease income.

The initial calculation and subsequent evaluations of our closed store lease liability contain uncertainty since we must use judgment to estimate the timing and duration of future vacancy periods, the amount and timing of future lump sum settlement payments and the amount and timing of potential future sublease income. When estimating these potential termination costs and their related timing, we consider a number of factors, which include, but are not limited to, historical settlement experience, the owner of the property, the location and condition of the property, the terms of the underlying lease, the specific marketplace demand and general economic conditions.

Our total closed store lease liability covered by this critical accounting policy was $344 million as of December 31, 2017. This amount is net of $156 million of estimated sublease income that is subject to the uncertainties discussed above. Although we believe we have sufficient current and historical information available to us to record reasonable estimates for sublease income, it is possible that actual results could differ.

In order to help you assess the risk, if any, associated with the uncertainties discussed above, a ten percent (10%) pre-tax change in our estimated sublease income, which we believe is a reasonably likely change, would increase or decrease our total closed store lease liability by about $16 million as of December 31, 2017.

We have not made any material changes in the reserve methodology used to record closed store lease reserves during the past three years.

Self-Insurance Liabilities

We are self-insured for certain losses related to general liability, workers' compensation and auto liability, although we maintain stop loss coverage with third party insurers to limit our total liability exposure. We are also self-insured for certain losses related to health and medical liabilities.

The estimate of our self-insurance liability contains uncertainty since we must use judgment to estimate the ultimate cost that will be incurred to settle reported claims and unreported claims for incidents incurred but not reported as of the balance sheet date. When estimating our self-insurance liability, we consider a number of factors, which include, but are not limited to, historical claim experience, demographic factors, severity factors and other standard insurance industry actuarial assumptions. On a quarterly basis, we review our self-insurance liability to determine if it is adequate as it relates to our general liability, workers' compensation and auto liability. Similar reviews are conducted semi-annually to determine if our self-insurance liability is adequate for our health and medical liability.

Our total self-insurance liability covered by this critical accounting policy was $696 million as of December 31, 2017. Although we believe we have sufficient current and historical information available to us to record reasonable estimates for our self-insurance liability, it is possible that actual results could differ. In order to help you assess the risk, if any, associated with the uncertainties discussed above, a ten percent (10%) pre-tax change in our estimate for our self-insurance liability, which we believe is a reasonably likely change, would increase or decrease our self-insurance liability by about $70 million as of December 31, 2017.

We have not made any material changes in the accounting methodology used to establish our self-insurance liability during the past three years.

Income Taxes

Income taxes are accounted for using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain.

Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, our tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although we believe that our estimates are reasonable and are based on the best available information at the time we prepare the provision, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in our consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement. Interest and/or penalties related to uncertain tax positions are recognized in income tax expense. Significant judgment is required in determining our uncertain tax positions. We have established accruals for uncertain tax positions using our best judgment and adjust these accruals, as warranted, due to changing facts and circumstances.

New Accounting Pronouncements

See Note 1 “Significant Accounting Policies” to the consolidated financial statements for a description of New Accounting Pronouncements applicable to the Company.

Cautionary Statement Concerning Forward-Looking Statements

The Private Securities Litigation Reform Act of 1995 (the “Reform Act”) provides a safe harbor for forward-looking statements made by or on behalf of the Company. In addition, the Company and its representatives may, from time to time, make written or verbal forward-looking statements, including statements contained in the Company’s filings with the U.S. Securities and Exchange Commission (“SEC”) and in its reports to stockholders, press releases, webcasts, conference calls, meetings and other communications. Generally, the inclusion of the words “believe,” “expect,” “intend,” “estimate,” “project,” “anticipate,” “will,” “should” and similar expressions identify statements that constitute forward-looking statements. All statements addressing operating performance of CVS Health Corporation or any subsidiary, events or developments that the Company expects or anticipates will occur in the future, including statements relating to corporate strategy; revenue growth; earnings or earnings per common share growth; adjusted earnings or adjusted earnings per common share growth; free cash flow; debt ratings; inventory levels; inventory turn and loss rates; store development; relocations and new market entries; retail pharmacy business, sales trends and operations; PBM business, sales trends and operations; specialty pharmacy business, sales trends and operations; LTC pharmacy business, sales trends and operations; the Company’s ability to attract or retain customers and clients; Medicare Part D competitive bidding, enrollment and operations; new product development; and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the Reform Act.

The forward-looking statements are and will be based upon management’s then-current views and assumptions regarding future events and operating performance, and are applicable only as of the dates of such statements. The Company undertakes no obligation to update or revise any forward-looking statements, whether as a result of new information, future events, or otherwise.

By their nature, all forward-looking statements involve risks and uncertainties. Actual results may differ materially from those contemplated by the forward-looking statements for a number of reasons as described in our SEC filings, including those set forth in the Risk Factors section within the 2017 Annual Report on Form 10-K, and including, but not limited to:

- *Risks relating to the health of the economy in general and in the markets we serve, which could impact consumer purchasing power, preferences and/or spending patterns, drug utilization trends, the financial health of our PBM and LTC clients, retail and specialty pharmacy payors or other payors doing business with the Company and our ability to secure necessary financing, suitable store locations and sale-leaseback transactions on acceptable terms.*

- *Efforts to reduce reimbursement levels and alter health care financing practices, including pressure to reduce reimbursement levels for generic drugs.*

- *The possibility of PBM and LTC client loss and/or the failure to win new PBM and LTC business, including as a result of failure to win renewal of expiring contracts, contract termination rights that may permit clients to terminate a contract prior to expiration and early or periodic renegotiation of pricing by clients prior to expiration of a contract.*

- *The possibility of loss of Medicare Part D business and/or failure to obtain new Medicare Part D business, whether as a result of the annual Medicare Part D competitive bidding process or otherwise.*

- *Risks related to the frequency and rate of the introduction of generic drugs and brand name prescription products.*

- *Risks of declining gross margins attributable to increased competitive pressures, increased client demand for lower prices, enhanced service offerings and/or higher service levels and market dynamics and, with respect to the PBM industry, regulatory changes that impact our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread" or the use of maximum allowable cost pricing.*

- *Regulatory changes, business changes and compliance requirements and restrictions that may be imposed by Centers for Medicare and Medicaid Services ("CMS"), Office of Inspector General or other government agencies relating to the Company's participation in Medicare, Medicaid and other federal and state government-funded programs, including sanctions and remedial actions that may be imposed by CMS on our Medicare Part D business.*

- *Risks and uncertainties related to the timing and scope of reimbursement from Medicare, Medicaid and other government-funded programs, including the possible impact of sequestration, the impact of other federal budget, debt and deficit negotiations and legislation that could delay or reduce reimbursement from such programs and the impact of any closure, suspension or other changes affecting federal or state government funding or operations.*

- *Possible changes in industry pricing benchmarks used to establish pricing in many of our PBM and LTC client contracts, pharmaceutical purchasing arrangements, retail network contracts, specialty payor agreements and other third party payor contracts.*

- *Efforts to increase reimbursement rates in PBM pharmacy networks and to inhibit the ability of PBMs to audit network pharmacies for fraud, waste and abuse.*

- *Risks related to increasing oversight of PBM activities by state departments of insurance and boards of pharmacy.*

- *A highly competitive business environment, including the uncertain impact of increased consolidation in the PBM industry, the possibility of combinations, joint ventures or other collaboration between PBMs and retailers, uncertainty concerning the ability of our retail pharmacy business to secure and maintain contractual relationships with PBMs and other payors on acceptable terms, uncertainty concerning the ability of our PBM business to secure and maintain competitive access, pricing and other contract terms from retail network pharmacies in an environment where some PBM clients are willing to consider adopting narrow or more restricted retail pharmacy networks, the possibility of our retail stores or specialty pharmacies being excluded from narrow or restricted networks, the potential of disruptive innovation from existing and new competitors and risks related to developing and maintaining a relevant experience for our customers.*

- *The Company's ability to timely identify or effectively respond to changing consumer preferences and spending patterns, an inability to expand the products being purchased by our customers, or the failure or inability to obtain or offer particular categories of products.*

- *Risks relating to our ability to secure timely and sufficient access to the products we sell from our domestic and/or international suppliers, including limited distribution drugs.*

- *Reform of the U.S. health care system, including ongoing implementation of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "ACA") and the possible repeal and replacement of all or parts of ACA, continuing legislative efforts, regulatory changes and judicial interpretations impacting our health care system and the possibility of shifting political and legislative priorities related to reform of the health care system in the future.*

- *Risks related to changes in legislation, regulation and government policy (including through the use of Executive Orders) that could significantly impact our business and the health care and retail industries, including, but not limited to, the possibility of major developments in tax policy or trade relations, such as the imposition of unilateral tariffs on imported products, changes with respect to the approval process for biosimilars, or changes or developments with respect to the regulation of drug pricing, including federal and state drug pricing programs.*

- *Risks relating to any failure to properly maintain our information technology systems, our information security systems and our infrastructure to support our business and to protect the privacy and security of sensitive customer and business information.*

- *Risks related to compliance with a broad and complex regulatory framework, including compliance with new and existing federal, state and local laws and regulations relating to health care, network pharmacy reimbursement and auditing, accounting standards, corporate securities, tax, environmental and other laws and regulations affecting our business.*

- *Risks related to litigation, government investigations and other legal proceedings as they relate to our business, the pharmacy services, retail pharmacy, LTC pharmacy, specialty pharmacy or retail clinic industries, or to the health care industry generally.*

- *The risk that any condition related to the closing of any proposed acquisition, including the Aetna Acquisition, may not be satisfied on a timely basis or at all, including the inability to obtain required regulatory approvals of any proposed acquisition, including the Aetna Acquisition, or on the terms desired or anticipated; the risk that such approvals may result in the imposition of conditions that could adversely affect the resulting combined company or the expected benefits of any proposed transaction, including the Aetna Acquisition; and the risk that the proposed transactions, including the Aetna Acquisition fail to close for any other reason, which could negatively impact our stock price and our future business and financial results.*

- *The possibility that the anticipated synergies and other benefits from any acquisition by us, including the Aetna Acquisition, will not be realized, or will not be realized within the expected time periods.*

- *Other risks related to the Aetna Acquisition including the possibility of failing to retain existing management including key executives of Aetna, the potential for disruption of our business relationships due to uncertainty associated with the Aetna Acquisition, the increased difficulty for us to pursue alternatives to the Aetna Acquisition, and the possibility that the Aetna Acquisition may not be accretive to our earnings per share.*

- *The risks and uncertainties related to our ability to integrate the operations, products, services and employees of any entities acquired by us, including the Aetna Acquisition and the effect of the potential disruption of management's attention from ongoing business operations due to any pending acquisitions, including the Aetna Acquisition.*

- *The accessibility or availability of adequate financing on a timely basis and on reasonable terms and the risks of increased indebtedness incurred to fund the Aetna Acquisition.*

- *Risks related to the outcome of any legal proceedings related to, or involving any entity that is a part of, any proposed acquisition contemplated by us, including the risk that we may be subject to securities class action and derivative lawsuits in connection with the Aetna Acquisition .*

- *The possibility of lower than expected valuations at the Company's reporting units could result in goodwill impairment charges at those reporting units.*

- *Other risks and uncertainties detailed from time to time in our filings with the SEC.*

The foregoing list is not exhaustive. There can be no assurance that the Company has correctly identified and appropriately assessed all factors affecting its business. Additional risks and uncertainties not presently known to the Company or that it currently believes to be immaterial also may adversely impact the Company. Should any risks and uncertainties develop into actual events, these developments could have a material adverse effect on the Company's business, financial condition and results of operations. For these reasons, you are cautioned not to place undue reliance on the Company's forward-looking statements .

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining adequate internal control over financial reporting. Our Company's internal control over financial reporting includes those policies and procedures that pertain to the Company's ability to record, process, summarize and report a system of internal accounting controls and procedures to provide reasonable assurance, at an appropriate cost/benefit relationship, that the unauthorized acquisition, use or disposition of assets are prevented or timely detected and that transactions are authorized, recorded and reported properly to permit the preparation of financial statements in accordance with generally accepted accounting principles (GAAP) and receipts and expenditures are duly authorized. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such controls and did so most recently for its financial reporting as of December 31, 2017.

We conducted an assessment of the effectiveness of our internal controls over financial reporting based on the criteria set forth in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. Our system of internal control over financial reporting is enhanced by periodic reviews by our internal auditors, written policies and procedures and a written Code of Conduct adopted by our Company's Board of Directors, applicable to all employees of our Company. In addition, we have an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of our disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal controls over financial reporting.

Based on our assessment, we conclude our Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2017.

Ernst & Young LLP, independent registered public accounting firm, is appointed by the Board of Directors and ratified by our Company's shareholders. They were engaged to render an opinion regarding the fair presentation of our consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their accompanying reports are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

February 14, 2018

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, CVS Health Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2017 and 2016, the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2017, and the related notes and our report dated February 14, 2018 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 14, 2018

Consolidated Statements of Income

In millions, except per share amounts	Year Ended December 31, 2017	2016	2015
Net revenues	$ 184,765	$ 177,526	$ 153,290
Cost of revenues	156,220	148,669	126,762
Gross profit	28,545	28,857	26,528
Operating expenses	19,028	18,491	17,053
Operating profit	9,517	10,366	9,475
Interest expense, net	1,041	1,058	838
Loss on early extinguishment of debt	—	643	—
Other expense	208	28	21
Income before income tax provision	8,268	8,637	8,616
Income tax provision	1,637	3,317	3,386
Income from continuing operations	6,631	5,320	5,230
Income (loss) from discontinued operations, net of tax	(8)	(1)	9
Net income	6,623	5,319	5,239
Net income attributable to noncontrolling interest	(1)	(2)	(2)
Net income attributable to CVS Health	$ 6,622	$ 5,317	$ 5,237
Basic earnings per share:			
Income from continuing operations attributable to CVS Health	$ 6.48	$ 4.93	$ 4.65
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ 0.01
Net income attributable to CVS Health	$ 6.47	$ 4.93	$ 4.66
Weighted average shares outstanding	1,020	1,073	1,118
Diluted earnings per share:			
Income from continuing operations attributable to CVS Health	$ 6.45	$ 4.91	$ 4.62
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ 0.01
Net income attributable to CVS Health	$ 6.44	$ 4.90	$ 4.63
Weighted average shares outstanding	1,024	1,079	1,126
Dividends declared per share	$ 2.00	$ 1.70	$ 1.40

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income

In millions	Year Ended December 31, 2017	2016	2015
Net income	$ 6,623	$ 5,319	$ 5,239
Other comprehensive income:			
Foreign currency translation adjustments, net of tax	(2)	38	(100)
Net cash flow hedges, net of tax	(10)	2	2
Pension and other postretirement benefits, net of tax	152	13	(43)
Total other comprehensive income (loss)	140	53	(141)
Comprehensive income	6,763	5,372	5,098
Comprehensive income attributable to noncontrolling interest	(1)	(2)	(2)
Comprehensive income attributable to CVS Health	$ 6,762	$ 5,370	$ 5,096

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	December 31, 2017	December 31, 2016
Assets:		
Cash and cash equivalents	$ 1,696	$ 3,371
Short-term investments	111	87
Accounts receivable, net	13,181	12,164
Inventories	15,296	14,760
Other current assets	945	660
Total current assets	31,229	31,042
Property and equipment, net	10,292	10,175
Goodwill	38,451	38,249
Intangible assets, net	13,630	13,511
Other assets	1,529	1,485
Total assets	$ 95,131	$ 94,462
Liabilities:		
Accounts payable	$ 8,863	$ 7,946
Claims and discounts payable	10,355	9,451
Accrued expenses	6,609	6,937
Short-term debt	1,276	1,874
Current portion of long-term debt	3,545	42
Total current liabilities	30,648	26,250
Long-term debt	22,181	25,615
Deferred income taxes	2,996	4,214
Other long-term liabilities	1,611	1,549
Shareholders' equity:		
CVS Health shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,712 shares issued and 1,014 shares outstanding at December 31, 2017 and 1,705 shares issued and 1,061 shares outstanding at December 31, 2016	17	17
Treasury stock, at cost: 697 shares at December 31, 2017 and 643 shares at December 31, 2016	(37,765)	(33,452)
Shares held in trust: 1 share at December 31, 2017 and December 31, 2016	(31)	(31)
Capital surplus	32,079	31,618
Retained earnings	43,556	38,983
Accumulated other comprehensive income (loss)	(165)	(305)
Total CVS Health shareholders' equity	37,691	36,830
Noncontrolling interest	4	4
Total shareholders' equity	37,695	36,834
Total liabilities and shareholders' equity	$ 95,131	$ 94,462

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	Year Ended December 31, 2017	2016	2015
Cash flows from operating activities:			
Cash receipts from customers	$ 176,594	$ 172,310	$ 148,954
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(149,279)	(142,511)	(122,498)
Cash paid to other suppliers and employees	(15,348)	(15,478)	(14,035)
Interest received	21	20	21
Interest paid	(1,072)	(1,140)	(629)
Income taxes paid	(2,909)	(3,060)	(3,274)
Net cash provided by operating activities	8,007	10,141	8,539
Cash flows from investing activities:			
Purchases of property and equipment	(1,918)	(2,224)	(2,367)
Proceeds from sale-leaseback transactions	265	230	411
Proceeds from sale of property and equipment and other assets	33	37	35
Acquisitions (net of cash acquired) and other investments	(1,287)	(539)	(11,475)
Purchase of available-for-sale investments	(86)	(65)	(267)
Maturities of available-for-sale investments	61	91	243
Net cash used in investing activities	(2,932)	(2,470)	(13,420)
Cash flows from financing activities:			
Increase (decrease) in short-term debt	(598)	1,874	(685)
Proceeds from issuance of long-term debt	—	3,455	14,805
Repayments of long-term debt	—	(5,943)	(2,902)
Purchase of noncontrolling interest in subsidiary	—	(39)	—
Payment of contingent consideration	—	(26)	(58)
Dividends paid	(2,049)	(1,840)	(1,576)
Proceeds from exercise of stock options	329	296	362
Payments for taxes related to net share settlement of equity awards	(71)	(72)	(63)
Repurchase of common stock	(4,361)	(4,461)	(5,001)
Other	(1)	(5)	(3)
Net cash provided by (used in) financing activities	(6,751)	(6,761)	4,879
Effect of exchange rate changes on cash and cash equivalents	1	2	(20)
Net increase (decrease) in cash and cash equivalents	(1,675)	912	(22)
Cash and cash equivalents at the beginning of the period	3,371	2,459	2,481
Cash and cash equivalents at the end of the period	$ 1,696	$ 3,371	$ 2,459
Reconciliation of net income to net cash provided by operating activities:			
Net income	$ 6,623	$ 5,319	$ 5,239
Adjustments required to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	2,479	2,475	2,092
Goodwill impairments	181	—	—
Losses on settlements of defined benefit pension plans	187	—	—
Stock-based compensation	234	222	230
Loss on early extinguishment of debt	—	643	—
Deferred income taxes	(1,334)	18	(252)
Other noncash items	53	135	(14)
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(941)	(243)	(1,594)
Inventories	(514)	(742)	(1,141)
Other current assets	(341)	35	355
Other assets	3	(43)	2
Accounts payable and claims and discounts payable	1,710	2,189	2,834
Accrued expenses	(371)	131	892
Other long-term liabilities	38	2	(104)
Net cash provided by operating activities	$ 8,007	$ 10,141	$ 8,539

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

In millions	Shares Year Ended December 31, 2017	2016	2015	Dollars Year Ended December 31, 2017	2016	2015
Common stock:						
Beginning of year	1,705	1,699	1,691	$ 17	$ 17	$ 17
Stock options exercised and issuance of stock awards	7	6	8	—	—	—
End of year	1,712	1,705	1,699	$ 17	$ 17	$ 17
Treasury stock:						
Beginning of year	(643)	(597)	(550)	$ (33,452)	$ (28,886)	$ (24,078)
Purchase of treasury shares	(55)	(47)	(48)	(4,361)	(4,606)	(4,856)
Employee stock purchase plan issuances	1	1	1	48	40	48
End of year	(697)	(643)	(597)	$ (37,765)	$ (33,452)	$ (28,886)
Shares held in trust:						
Balance at beginning and end of year	(1)	(1)	(1)	$ (31)	$ (31)	$ (31)
Capital surplus:						
Beginning of year				$ 31,618	$ 30,948	$ 30,418
Stock option activity, stock awards and other				461	449	533
Excess tax benefit on stock options and stock awards				—	76	142
2015 accelerated share repurchase settled in 2016				—	145	(145)
End of year				$ 32,079	$ 31,618	$ 30,948
Retained earnings:						
Beginning of year				$ 38,983	$ 35,506	$ 31,849
Changes in inventory accounting principles				—	—	(4)
Net income attributable to CVS Health				6,622	5,317	5,237
Common stock dividends				(2,049)	(1,840)	(1,576)
End of year				$ 43,556	$ 38,983	$ 35,506
Accumulated other comprehensive income (loss):						
Beginning of year				$ (305)	$ (358)	$ (217)
Foreign currency translation adjustments, net of tax				(2)	38	(100)
Net cash flow hedges, net of tax				(10)	2	2
Pension and other postretirement benefits, net of tax				152	13	(43)
End of year				(165)	(305)	(358)
Total CVS Health shareholders' equity				$ 37,691	$ 36,830	$ 37,196
Noncontrolling interest:						
Beginning of year				$ 4	$ 7	$ 5
Business combinations				—	—	1
Capital contributions				1	1	2
Net income attributable to noncontrolling interest [1]				1	1	1
Distributions				(2)	(5)	(2)
End of year				4	4	7
Total shareholders' equity				$ 37,695	$ 36,834	$ 37,203

(1) Excludes $1 million attributable to redeemable noncontrolling interest in 2016 and 2015 (See Note 1 "Significant Accounting Policies").

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1 Significant Accounting Policies

Description of business - CVS Health Corporation and its subsidiaries (the "Company") is the largest integrated pharmacy health care provider in the United States based upon revenues and prescriptions filled. The Company currently has three reportable business segments, Pharmacy Services, Retail/LTC and Corporate, which are described below.

Pharmacy Services Segment (the "PSS") - The PSS provides a full range of pharmacy benefit management services including plan design offerings and administration, formulary management, Medicare Part D services, mail order, specialty pharmacy and infusion services, retail pharmacy network management services, prescription management systems, clinical services, disease management services and medical spend management. The Company's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D, Managed Medicaid plans, plans offered on the public and private exchanges, and other sponsors of health benefit plans and individuals throughout the United States.

As a pharmacy benefits manager, the PSS manages the dispensing of pharmaceuticals through the Company's mail order pharmacies and national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies and 27,000 independent pharmacies, to eligible members in the benefits plans maintained by the Company's clients and utilizes its information systems to perform, among other things, safety checks, drug interaction screenings and brand to generic substitutions.

The PSS' specialty pharmacies support individuals that require complex and expensive drug therapies. The specialty pharmacy business includes mail order and retail specialty pharmacies that operate under the CVS Caremark ®, CarePlus CVS Pharmacy ™, Navarro ® Health Services and Advanced Care Scripts ("ACS Pharmacy") names. The Company enhanced its provides specialty infusion services and enteral nutrition services through Coram LLC and its subsidiaries (collectively, "Coram"). In August 2015, the Company further expanded its specialty offerings with the acquisition of ACS Pharmacy which was part of the Omnicare, Inc. ("Omnicare") acquisition. See Note 2 "Acquisitions."

The PSS also provides health management programs, which include integrated disease management for 18 conditions, through the Company's AccordantCare rare disease management offering.

In addition, through the Company's SilverScript Insurance Company ("SilverScript") subsidiary, the PSS is a national provider of drug benefits to eligible beneficiaries under the federal government's Medicare Part D program.

The PSS generates net revenues primarily by contracting with clients to provide prescription drugs to plan members. Prescription drugs are dispensed by the mail order pharmacies, specialty pharmacies and national network of retail pharmacies. Net revenues are also generated by providing additional services to clients, including administrative services such as claims processing and formulary management, as well as health care related services such as disease management.

The PSS operates under the CVS Caremark ® Pharmacy Services, Caremark ®, CVS Caremark ®, CVS Specialty ®, AccordantCare, SilverScript ®, Wellpartner ®, Coram ®, CVS Specialty ®, NovoLogix ®, Navarro ® Health Services and ACS Pharmacy names. As of December 31, 2017, the PSS operates 23 retail specialty pharmacy stores, 18 specialty mail order pharmacies, four mail order dispensing pharmacies, and 83 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence, located in 42 states, Puerto Rico and the District of Columbia.

Retail/LTC Segment (the "RLS") - The RLS sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products and cosmetics, personal care products, convenience foods, photo finishing services, seasonal merchandise, and greeting cards, through the Company's CVS Pharmacy ®, CVS ®, CVS Pharmacy y más ®, Longs Drugs ®, Navarro Discount Pharmacy ® and Drogaria Onofre ™ retail stores and online through CVS.com ®, Navarro.com ™ and Onofre.com.br ™.

The RLS also provides health care services through its MinuteClinic ® health care clinics. MinuteClinics are staffed by nurse practitioners and physician assistants who utilize nationally recognized protocols to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions and deliver vaccinations.

In 2015, the Company made two larger acquisitions which expanded the Retail/LTC Segment's services. With the acquisition of Omnicare, the RLS began providing long-term care ("LTC") operations, which is comprised of providing the distribution of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings, as well as commercialization services which are provided under the name RxCrossroads ® ("RxC"). With the December 2015 acquisition of the pharmacies and clinics of Target Corporation ("Target"), the Company added 1,672 pharmacies and approximately 79 clinics.

As of December 31, 2017, our Retail/LTC Segment included 9,803 retail stores (of which 8,060 were our stores that operated a pharmacy and 1,695 were our pharmacies located within Target stores) located in 49 states, the District of Columbia, Puerto Rico and Brazil operating primarily under the CVS Pharmacy ®, CVS ®, CVS Pharmacy y más ®, Longs Drugs ®, Navarro Discount Pharmacy ® and Drogaria Onofre ™ names, 37 onsite pharmacies primarily operating under the CarePlus CVS Pharmacy ™, CarePlus ® and CVS Pharmacy ® names, and 1,134 retail health care clinics operating under the MinuteClinic ® name (of which 1,129 were located in our retail pharmacy stores or Target stores), and our online retail websites, CVS.com ®, Navarro.com ™ and Onofre.com.br ™. LTC operations are comprised of 145 spoke pharmacies that primarily handle new prescription orders, of which 30 are also hub pharmacies that use proprietary automation to support spoke pharmacies with refill prescriptions. LTC operates primarily under the Omnicare ® and NeighborCare ® names.

Corporate Segment - The Corporate Segment provides management and administrative services to support the Company. The Corporate Segment consists of certain aspects of the Company's executive management, corporate relations, legal, compliance, human resources, information technology and finance departments.

Principles of consolidation - The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

The Company continually evaluates its investments to determine if they represent variable interests in a VIE. If the Company determines that it has a variable interest in a VIE, the Company then evaluates if it is the primary beneficiary of the VIE. The evaluation is a qualitative assessment as to whether the Company has the ability to direct the activities of a VIE that most significantly impact the entity's economic performance. The Company consolidates a VIE if it is considered to be the primary beneficiary.

Assets and liabilities of VIEs for which the Company is the primary beneficiary were not significant to the Company's consolidated financial statements. VIE creditors do not have recourse against the general credit of the Company.

Use of estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Fair value hierarchy - The Company utilizes the three-level valuation hierarchy for the recognition and disclosure of fair value measurements. The categorization of assets and liabilities within this hierarchy is based upon the lowest level of input that is significant to the measurement of fair value. The three levels of the hierarchy consist of the following:

- Level 1 - Inputs to the valuation methodology are unadjusted quoted prices in active markets for identical assets or liabilities that the Company has the ability to access at the measurement date.

- Level 2 - Inputs to the valuation methodology are quoted prices for similar assets and liabilities in active markets, quoted prices in markets that are not active or inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the instrument.

- Level 3 - Inputs to the valuation methodology are unobservable inputs based upon management's best estimate of inputs market participants could use in pricing the asset or liability at the measurement date, including assumptions about risk.

Cash and cash equivalents - Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash. These investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices.

Restricted cash - As of December 31, 2017 and 2016, the Company had $190 million and $149 million, respectively, of restricted cash held in a trust in its insurance captive to satisfy collateral requirements associated with the assignment of certain insurance policies. Such amounts are included in other assets in the consolidated balance sheets. Additionally, as of December 31, 2017, the Company had $14 million of restricted cash held in escrow accounts in connection with certain recent acquisitions. Such amounts are included in other current assets in the consolidated balance sheets. All restricted cash is invested in time deposits which are classified within Level 1 of the fair value hierarchy.

Short-term investments - The Company's short-term investments consist of certificates of deposit with initial maturities of greater than three months when purchased that mature in less than one year from the balance sheet date. These investments, which were classified as available-for-sale within Level 1 of the fair value hierarchy, were carried at fair value, which approximated their historical cost at December 31, 2017 and 2016.

Fair value of financial instruments - As of December 31, 2017, the Company's financial instruments include cash and cash equivalents, short-term and long-term investments, accounts receivable, accounts payable and short-term debt approximate their fair value due to the nature of these financial instruments. The carrying amount and estimated fair value of total long-term debt was $25.7 billion and $26.8 billion, respectively, as of December 31, 2017. The fair value of the Company's long-term debt was estimated based on quoted rates currently offered in active markets for the Company's debt, which is considered Level 1 of the fair value hierarchy.

Derivative financial instruments - The Company is exposed to interest rate risk and management considers it prudent to periodically reduce the Company's exposure to cash flow variability resulting from interest rate fluctuations. In December 2017, the Company entered into several interest rate swap transactions. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of long-term debt in connection with the proposed acquisition of Aetna Inc. ("Aetna"). The interest rate swaps had notional amounts totaling $4.75 billion. At December 31, 2017, the fair value of these agreements were a $5 million asset recorded in other current assets and a $23 million liability recorded in accrued expenses. The fair value of these derivative financial instruments was determined using quoted prices in markets that are not active or inputs that are observable for the asset or liability and therefore they are classified as Level 2 in the fair value hierarchy. The Company has deferred gains and losses in accumulated other comprehensive income which are expected to be reclassified to interest expense over the life of the underlying forecasted debt. The hedges are expected to be highly effective; therefore, no ineffectiveness was recognized in earnings. There were no outstanding derivative financial instruments as of December 31, 2016.

Foreign currency translation and transactions - For local currency functional currency, assets and liabilities are translated at end-of-period rates while revenues and expenses are translated at average rates in effect during the period. Equity is translated at historical rates and the resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts, which are remeasured at historical exchange rates. Revenue and expense are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts, which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in income.

Gains and losses arising from foreign currency transactions and the effects of remeasurements were not material for all periods presented.

Accounts receivable - Accounts receivable are stated net of an allowance for doubtful accounts. The accounts receivable balance primarily includes amounts due from third party providers (e.g., pharmacy benefit managers, insurance companies, governmental agencies and long-term care facilities), clients, members and private pay customers, as well as vendors and manufacturers. Charges to bad debt are based on both historical write-offs and specifically identified receivables.

The activity in the allowance for doubtful accounts receivable for the years ended December 31 is as follows:

In millions	**2017**	**2016**	**2015**
Beginning balance	$ 286	$ 161	$ 256
Additions charged to bad debt expense	177	221	216
Write-offs charged to allowance	(156)	(96)	(311)
Ending balance	$ 307	$ 286	$ 161

Inventories - Inventories are stated at the lower of weighted average cost or market. Physical inventory counts are taken on a regular basis in each retail store and long-term care pharmacy and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current trends.

Property and equipment - Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 10 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

The following are the components of property and equipment at December 31:

In millions	**2017**	**2016**
Land	$ 1,707	$ 1,734
Building and improvements	3,343	3,226
Fixtures and equipment	11,963	10,956
Leasehold improvements	4,793	4,494
Software	2,484	2,392
	24,290	22,802
Accumulated depreciation and amortization	(13,998)	(12,627)
Property and equipment, net	$ 10,292	$ 10,175

The gross amount of property and equipment under capital leases was $588 million and $547 million as of December 31, 2017 and 2016, respectively. Accumulated amortization of property and equipment under capital lease was $140 million

and $119 million as of December 31, 2017 and 2016, respectively. Amortization of property and equipment under capital lease is included within depreciation expense. Depreciation expense totaled $1.7 billion in both 2017 and 2016, and $1.5 billion in 2015.

Goodwill and other indefinitely-lived assets - Goodwill and other indefinitely-lived assets are not amortized, but are subject to impairment reviews annually, or more frequently if necessary. See Note 3 "Goodwill and Other Intangibles" for additional information on goodwill and other indefinitely-lived assets.

Intangible assets - Purchased customer contracts and relationships are amortized on a straight-line basis over their estimated useful lives between 9 and 20 years. Purchased customer lists are amortized on a straight-line basis over their estimated useful lives of up to 10 years. Purchased leases are amortized on a straight-line basis over the remaining life of the lease. See Note 3 "Goodwill and Other Intangibles" for additional information about intangible assets.

Impairment of long-lived assets - The Company groups and evaluates fixed and finite-lived intangible assets for impairment at the lowest level at which individual cash flows can be identified, whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges).

Redeemable noncontrolling interest - As a result of the acquisition of Omnicare in 2015, the Company obtained a 73% ownership interest in a limited liability company ("LLC"). Due to the change in control in Omnicare, the noncontrolling member of the LLC had the contractual right to put its membership interest to the Company at fair value. Consequently, the noncontrolling interest in the LLC was recorded as a redeemable noncontrolling interest at fair value. During 2016, the noncontrolling shareholder of the LLC exercised its option to sell its ownership interest and the Company purchased the noncontrolling interest in the LLC for approximately $39 million.

Below is a summary of the changes in redeemable noncontrolling interest for the years ended December 31:

In millions	**2016**	**2015**
Beginning balance	$ 39	$ —
Acquisition of noncontrolling interest	—	39
Net income attributable to noncontrolling interest	1	1
Distributions	(2)	(1)
Purchase of noncontrolling interest	(39)	—
Reclassification to capital surplus in connection with purchase of noncontrolling interest	1	—
Ending balance	$ —	$ 39

Revenue Recognition

Pharmacy Services Segment

The PSS sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through its retail pharmacy network. The PSS recognizes revenue from prescription drugs sold by its mail service dispensing pharmacies and under retail pharmacy network contracts where it is the principal using the gross method at the contract prices negotiated with its clients. Net revenues include: (i) the portion of the price the client pays directly to the PSS, net of any volume-related or other discounts paid back to the client (see "Drug Discounts" below), (ii) the price paid to the PSS by client plan members for mail order prescriptions ("Mail Co-Payments") and the price paid to retail network pharmacies by client plan members for retail prescriptions ("Retail Co-Payments"), and (iii) administrative fees for retail pharmacy network contracts where the PSS is not the principal as discussed below. Sales taxes are not included in revenue.

Revenue is recognized when: (i) persuasive evidence of an arrangement exists, (ii) delivery has occurred or services have been rendered, (iii) the seller's price to the buyer is fixed or determinable, and (iv) collectability is reasonably assured. The following revenue recognition policies have been established for the PSS:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription is delivered. At the time of delivery, the PSS has performed substantially all of its obligations under its client contracts and does not experience a significant level of returns or reshipments.

- Revenues generated from prescription drugs sold by third party pharmacies in the PSS' retail pharmacy network and associated administrative fees are recognized at the PSS' point-of-sale, which is when the claim is adjudicated by the PSS online claims processing system.

The PSS determines whether it is the principal or agent for its retail pharmacy network transactions on a contract by contract basis. In the majority of its contracts, the PSS has determined it is the principal due to it: (i) being the primary obligor in the arrangement, (ii) having latitude in establishing the price, changing the product or performing part of the service, (iii) having discretion in supplier selection, (iv) having involvement in the determination of product or service specifications, and (v) having credit risk. The PSS' obligations under its client contracts for which revenues are reported using the gross method are separate and distinct from its obligations to the third party pharmacies included in its retail pharmacy network contracts. Pursuant to these contracts, the PSS is contractually required to pay the third party pharmacies in its retail pharmacy network for products sold, regardless of whether the PSS is paid by its clients. The PSS' responsibilities under its client contracts typically include validating eligibility and coverage levels, communicating the prescription price and the co-payments due to the third party retail pharmacy, identifying possible adverse drug interactions for the pharmacist to address with the prescriber prior to dispensing, suggesting generic alternatives where clinically appropriate and approving the prescription for dispensing. Although the PSS does not have credit risk with respect to Retail Co-Payments or inventory risk related to retail network claims, management believes that all of the other applicable indicators of gross revenue reporting are present. For contracts under which the PSS acts as an agent, revenue is recognized using the net method.

Drug Discounts - The PSS deducts from its revenues any rebates, inclusive of discounts and fees, earned by its clients. Rebates are paid to clients in accordance with the terms of client contracts, which are normally based on fixed rebates per prescription for specific products dispensed or a percentage of manufacturer discounts received for specific products dispensed. The liability for rebates due to clients is included in "Claims and discounts payable" in the accompanying consolidated balance sheets.

Medicare Part D - The PSS, through its SilverScript subsidiary, participates in the federal government's Medicare Part D program as a Prescription Drug Plan ("PDP"). Net revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with the Centers for Medicare and Medicaid Services ("CMS"). The insurance premiums include a direct premium paid by CMS and a beneficiary premium, which is the responsibility of the PDP member, but which is subsidized by CMS in the case of low-income members. Premiums collected in advance are initially deferred in accrued expenses and are then recognized in net revenues over the period in which members are entitled to receive benefits.

In addition to these premiums, net revenues include co-payments, coverage gap benefits, deductibles and co-insurance (collectively, the "Member Co-Payments") related to PDP members' actual prescription claims. In certain cases, CMS subsidizes a portion of these Member Co-Payments and pays the PSS an estimated prospective Member Co-Payment subsidy amount each month. The prospective Member Co-Payment subsidy amounts received from CMS are also included in net revenues. SilverScript assumes no risk for these amounts. If the prospective Member Co-Payment subsidies received differ from the amounts based on actual prescription claims, the difference is recorded in either accounts receivable or accrued expenses.

The PSS accounts for CMS obligations and Member Co-Payments (including the amounts subsidized by CMS) using the gross method consistent with its revenue recognition policies for Mail Co-Payments and Retail Co-Payments (discussed previously in this document).

Retail/LTC Segment

Retail Pharmacy - The retail drugstores recognize revenue at the time the customer takes possession of the merchandise. Customer returns are not material. Revenue generated from the performance of services in the RLS' health care clinics is recognized at the time the services are performed. Sales taxes are not included in revenue.

Long-term Care - Revenue is recognized when products are delivered or services are rendered or provided to the customer, prices are fixed and determinable, and collection is reasonably assured. A significant portion of the revenues from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. Payments for services rendered to patients covered by these programs are generally less than billed charges. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and record an estimated contractual allowance for sales and receivable balances at the revenue recognition date, to properly account for anticipated differences between billed and reimbursed amounts. Accordingly, the total net sales and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors. Since billing functions for a portion of the Company's revenue systems are largely computerized, enabling on-line adjudication at the time of sale to record net revenues, the Company's exposure in connection with estimating contractual allowance adjustments is limited primarily to unbilled and initially rejected Medicare, Medicaid and third party claims (typically approved for reimbursement once additional information is provided to the payor). For the remaining portion of the Company's revenue systems, the contractual allowance is estimated for all billed, unbilled and initially rejected Medicare, Medicaid and third party claims. The Company evaluates several criteria in developing the estimated contractual allowances on a monthly basis, including historical trends based on actual claims paid, current contract and reimbursement terms, and changes in customer base and payor/product mix. Contractual allowance estimates are adjusted to actual amounts as cash is received and claims are settled, and the aggregate impact of these resulting adjustments was not significant to our results of operations for any of the periods presented.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors are typically not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of our normal billing procedures and subject to our normal accounts receivable collections procedures.

Health Care Clinics - For services provided by our health care clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Loyalty Program - The Company's customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings coupons redeemed by customers are recorded as a reduction of revenue when redeemed. ExtraBucks Rewards are accrued as a charge to cost of revenues when earned, net of estimated breakage. The Company determines breakage based on historical redemption patterns.

See Note 13 "Segment Reporting" for additional information about the revenues of the Company's business segments.

Cost of revenues

Pharmacy Services Segment - The PSS' cost of revenues includes: (i) the cost of prescription drugs sold during the reporting period directly through its mail service dispensing pharmacies and indirectly through its retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of its mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of revenues includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the PSS' mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor allowances and purchase discounts" below) and (ii) the cost of prescription drugs sold (including Retail Co-Payments) through the PSS' retail pharmacy network under contracts where it is the principal, net of any volume-related or other discounts.

Retail/LTC Segment - The RLS' cost of revenues includes: the cost of merchandise sold during the reporting period and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

See Note 13 "Segment Reporting" for additional information about the cost of revenues of the Company's business segments.

Vendor allowances and purchase discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment - The PSS receives purchase discounts on products purchased. The PSS' contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the PSS to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices, or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the PSS' results of operations. The PSS accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The PSS also receives additional discounts under its wholesaler contracts if it exceeds contractually defined annual purchase volumes. In addition, the PSS receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of "Cost of revenues".

Retail/LTC Segment - Vendor allowances received by the RLS reduce the carrying cost of inventory and are recognized in cost of revenues when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of revenues over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of revenues on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the accompanying consolidated financial statements.

Insurance - The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience.

Facility opening and closing costs - New facility opening costs, other than capital expenditures, are charged directly to expense when incurred. When the Company closes a facility, the present value of estimated unrecoverable costs, including the remaining lease obligation less estimated sublease income and the book value of abandoned property and equipment, are charged to expense. The long-term portion of the lease obligations associated with facility closings was $306 million and $181 million in 2017 and 2016, respectively.

Advertising costs - Advertising costs are expensed when the related advertising takes place. Advertising costs, net of vendor funding (included in operating expenses), were $2 30 million, $216 million and $221 million in 2017, 2016 and 2015, respectively.

Interest expense, net - The following are the components of net interest expense for the years ended December 31:

In millions	2017	2016	2015
Interest expense	$ 1,062	$ 1,078	$ 859
Interest income	(21)	(20)	(21)
Interest expense, net	$ 1,041	$ 1,058	$ 838

Capitalized interest totaled $ 8 million, $13 million and $12 million in 2017, 2016 and 2015, respectively.

Shares held in trust - The Company maintains grantor trusts, which held approximately one million shares of its common stock at December 31, 2017 and 2016, respectively. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Accumulated other comprehensive income - Accumulated other comprehensive income (loss) consists of changes in the net actuarial gains and losses associated with pension and other postretirement benefit plans, net losses on cash flow hedge derivative instruments associated with forecasted debt issuances, and foreign currency translation adjustments. The amount included in accumulated other comprehensive loss related to the Company's pension and postretirement plans was $ 34 million pre-tax ($21 million after-tax) as of December 31, 2017 and $284 million pre-tax ($173 million after-tax) as of December 31, 2016. The net impact on cash flow hedges totaled $24 million pre-tax ($15 million after-tax) and $9 million pre-tax ($5 million after-tax) as of December 31, 2017 and 2016, respectively. Cumulative foreign currency translation adjustments at December 31, 2017 and 2016 were $129 million and $127 million, respectively.

Changes in accumulated other comprehensive income (loss) by component are shown below:

	Year Ended December 31, 2017 [1]			
In millions	Foreign Currency	Losses on Cash Flow Hedges	Pension and Other Postretirement Benefits	Total
Balance, December 31, 2016	$ (127)	$ (5)	$ (173)	$ (305)
Other comprehensive loss before reclassifications	(2)	(11)	—	(13)
Amounts reclassified from accumulated other comprehensive income [2]	—	1	152	153
Net other comprehensive income (loss)	(2)	(10)	152	140
Balance, December 31, 2017	$ (129)	$ (15)	$ (21)	$ (165)

	Year Ended December 31, 2016 [1]			
	Foreign Currency	Losses on Cash Flow Hedges	Pension and Other Postretirement Benefits	Total
Balance, December 31, 2015	$ (165)	$ (7)	$ (186)	$ (358)
Other comprehensive income before reclassifications	38	—	—	38
Amounts reclassified from accumulated other comprehensive income [2]	—	2	13	15
Net other comprehensive income	38	2	13	53
Balance, December 31, 2016	$ (127)	$ (5)	$ (173)	$ (305)

(1) All amounts are net of tax.

(2) The amounts reclassified from accumulated other comprehensive income for cash flow hedges are recorded within interest expense, net on the consolidated statement of income. The amounts reclassified from accumulated other comprehensive income for pension and other postretirement benefits are included in other expense on the consolidated statement of income.

Stock-based compensation - Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the applicable requisite service period of the stock award (generally 3 to 5 years) using the straight-line method.

Variable interest entity - In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. The Red Oak arrangement has an initial term of ten years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company and minimal funding was provided to capitalize Red Oak.

The Company has determined that it is the primary beneficiary of this variable interest entity because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC Segment.

Cardinal is required to pay the Company 39 quarterly payments beginning in October 2014. As milestones are met, the quarterly payments increase. The Company received approximately $183 million, $163 million and $122 million from Cardinal during the years ended December 31, 2017, 2016 and 2015, respectively. The payments reduce the Company's carrying value of inventory and are recognized in cost of revenues when the related inventory is sold. Revenues associated with Red Oak expenses reimbursed by Cardinal for the years ended December 31, 2017, 2016 and 2015, as well as amounts due to or due from Cardinal at December 31, 2017 and 2016 were immaterial.

Related party transactions - The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. The Pharmacy Services and Retail/LTC segments utilize this clinical health information network in providing services to its client plan members and retail customers. The Company expensed fees of approximately $35 million, $39 million and $50 million in the years ended December 31, 2017, 2016 and 2015, respectively, for the use of this network. The Company's investment in and equity in earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services ("Heartland"). Heartland operates several long-term care pharmacies in four states. Heartland paid the Company approximately $139 million, $140 million and $25 million for pharmaceutical inventory purchases during the years ended December 31, 2017, 2016 and 2015, respectively. Additionally, the Company performs certain collection functions for Heartland and then passes those customer cash collections to Heartland. The Company's investment in and equity in earnings of Heartland as of and for the years ended December 31, 2016 and 2015 is immaterial.

In 2016, the Company made charitable contributions of $32 million to the CVS Foundation (the "Foundation") to fund future giving. The Foundation is an unconsolidated non-profit entity managed by employees of the Company that focuses on health, education and community involvement programs. The charitable contributions were recorded as operating expenses in the Company's consolidated statement of income for the year ended December 31, 2016.

Income taxes - The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date.

On December 22, 2017, the President signed into law the "Tax Cuts and Jobs Act" (the "TCJA"). Among numerous changes to existing tax laws, the TCJA permanently reduces the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The effects on deferred tax balances of changes in tax rates are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As the result of the

reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion for year ended December 31, 2017. The Company has not completed all of its processes to determine the TCJA's final impact. The final impact may differ from this provisional amount due to, among other things, changes in interpretations and assumptions the Company has made thus far and the issuance of additional regulatory or other guidance. The accounting is expected to be completed by the time the 2017 federal income tax return is filed in 2018.

The Company recognizes net deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and results of recent operations. To the extent that the Company does not consider it more likely than not that a deferred tax asset will be recovered, a valuation allowance is established.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in income tax expense.

Discontinued operations - In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Bob's Stores and Linens 'n Things which filed for bankruptcy in 2016 and 2008, respectively. Additionally, the Company's recently acquired Bluegrass Pharmacy is considered held for sale and is included in discontinued operations (see Note 2 "Acquisitions" for additional information). The Company's loss from discontinued operations in 2017 and 2016 primarily includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its lease guarantees. The Company's income from discontinued operations in 2015 of $9 million, net of tax, was related to the release of certain store lease guarantees due to a settlement with a landlord. See Note 12 "Commitments and Contingencies" of the consolidated financial statements.

Below is a summary of the results of discontinued operations for the years ended December 31:

In millions	**2017**	**2016**	**2015**
Income (loss) from discontinued operations	$ (13)	$ (2)	$ 15
Income tax benefit (expense)	5	1	(6)
Income (loss) from discontinued operations, net of tax	$ (8)	$ (1)	$ 9

Earnings per common share - Earnings per share is computed using the two-class method. Options to purchase 10.4 million, 6.7 million and 2.7 million shares of common stock were outstanding as of December 31, 2017, 2016 and 2015, respectively, but were not included in the calculation of diluted earnings per share because the options' exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive.

New accounting pronouncements recently adopted - In July 2015, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2015-11, *Inventory* , which amends Accounting Standard Codification ("ASC") Topic 330. This ASU simplifies current accounting treatments by requiring entities to measure most inventories at "the lower of cost and net realizable value" rather than using lower of cost or market. This guidance does not apply to inventories measured using the last-in, first-out method or the retail inventory method. The Company adopted this standard effective January 1, 2017. The adoption of this new guidance did not have any impact on the Company's consolidated results of operations, financial position or cash flows.

In March 2016, the FASB issued ASU No. 2016-09, *Improvements to Employee Share-Based Payment Accounting* , which amends the accounting for certain aspects of shared-based payments to employees in ASC Topic 718,

Compensation - Stock Compensation . The new guidance eliminates the accounting for any excess tax benefits and deficiencies through equity, and requires all excess tax benefits and deficiencies related to employee share-based compensation arrangements to be recorded in the income statement. This aspect of the guidance is required to be applied prospectively. The guidance also requires the presentation of excess tax benefits on the statement of cash flows as an operating activity rather than a financing activity, a change which may be applied prospectively or retrospectively. The guidance further provides an accounting policy election to account for forfeitures as they occur rather than utilizing the estimated amount of forfeitures at the time of issuance. The Company adopted this guidance effective January 1, 2017. The primary impact of adopting this guidance was the recognition of excess tax benefits in the income statement instead of recognizing them in equity. This income statement guidance was adopted on a prospective basis. As a result, a discrete tax benefit of $53 million was recognized in the income tax provision in the year ended December 31, 2017.

The Company elected to retrospectively adopt the guidance on the presentation of excess tax benefits in the statement of cash flows. The following is a reconciliation of the effect of the resulting reclassification of the excess tax benefits on the Company's consolidated statements of cash flows for the years ended December 31, 2016 and 2015:

In millions	**As Previously Reported**	**Adjustments**	**As Revised**
Year Ended December 31, 2016:			
Cash paid to other suppliers and employees	$ (15,550)	$ 72	$ (15,478)
Net cash provided by operating activities	10,069	72	10,141
Excess tax benefits from stock-based compensation	72	(72)	—
Net cash used in financing activities	(6,689)	(72)	(6,761)
Reconciliation of net income to net cash provided by operating activities:			
Accrued expenses	59	72	131
Year Ended December 31, 2015:			
Cash paid to other suppliers and employees	(14,162)	127	(14,035)
Net cash provided by operating activities	8,412	127	8,539
Excess tax benefits from stock-based compensation	127	(127)	—
Net cash provided by financing activities	5,006	(127)	4,879
Reconciliation of net income to net cash provided by operating activities:			
Accrued expenses	765	127	892

The Company elected to continue to estimate forfeitures expected to occur to determine the amount of compensation cost to be recognized in each period. None of the other provisions in this guidance had a material impact on the Company's consolidated financial statements.

In March 2017, the FASB issued ASU 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* , which amends ASC Topic 715, *Compensation – Retirement Benefits* . ASU 2017-07 requires entities to disaggregate the current service cost component from the other components of net benefit cost and present it with other current compensation costs for related employees in the income statement and present the other components of net benefit cost elsewhere in the income statement and outside of operating income. Only the service cost component of net benefit cost is eligible for capitalization. The guidance is effective for interim and annual periods beginning after December 15, 2017. Early adoption is permitted as of the beginning of any annual periods for which an entity's financial statements have not been issued. Entities are required to retrospectively apply the requirement for a separate presentation in the income statement of service costs and other components of net benefit cost and prospectively adopt the requirement to limit the capitalization of benefit costs to the service component. The Company adopted the income statement presentation aspects of this new guidance on a retrospective basis effective January 1, 2017. Nearly all of the Company's net benefit costs for the Company's defined benefit pension and postretirement plans do not contain a service cost component as most of these defined benefit plans have been frozen for an extended period of time.

The following is a reconciliation of the effect of the reclassification of the net benefit cost from operating expenses to other expense in the Company's consolidated statements of income for the years ended December 31 2016 and 2015:

In millions	As Previously Reported	Adjustments	As Revised
Year Ended December 31, 2016:			
Operating expenses	$ 18,519	$ (28)	$ 18,491
Operating profit	10,338	28	10,366
Other expense	—	28	28
Year Ended December 31, 2015:			
Operating expenses	17,074	(21)	17,053
Operating profit	9,454	21	9,475
Other expense	—	21	21

In January 2017, the FASB issued ASU 2017-04, *Simplifying the Test for Goodwill Impairment* , which amends ASC Topic 350, *Intangibles – Goodwill and Other* . This ASU requires the Company to perform its annual, or applicable interim, goodwill impairment test by comparing the fair value of each reporting unit with its carrying amount. An impairment charge must be recognized at the amount by which the carrying amount exceeds the fair value of the reporting unit; however, the charge recognized should not exceed the total amount of goodwill allocated to that reporting unit. Income tax effects resulting from any tax deductible goodwill should be considered when measuring a goodwill impairment charge, if applicable. The guidance in ASU 2017-04 is effective for annual or interim goodwill impairment tests in fiscal years beginning after December 15, 2019. The Company elected to early adopt this standard as of January 1, 2017. At the date of adoption of this new guidance, the guidance did not have any impact on the Company's consolidated results of operations, financial position or cash flows.

In August 2017, the FASB issued ASU 2017-12, *Targeted Improvements to Accounting for Hedging Activities* , which amends ASC Topic 815, *Derivative and Hedging* . ASU 2017-12 expands an entity's ability to hedge nonfinancial and financial risk components and reduces complexity in fair value hedges of interest rate risk. It eliminates the requirement to separately measure and report hedge ineffectiveness and generally requires the entire change in the fair value of a hedging instrument to be presented in the same income statement line as the hedged item. ASU 2017-12 also eases certain documentation and assessment requirements and modifies the accounting for components excluded from the assessment of hedge effectiveness. The guidance is effective for fiscal years beginning after December 15, 2018, and interims periods with those years. Early adoption is permitted. The guidance with respect to cash flow and net investment hedge relationships existing on the date of adoption must be applied on a modified retrospective basis, and the new presentation and disclosure requirements must be applied on a prospective basis. The Company elected to early adopt this standard as of October 1, 2017. As the date of adoption of this new guidance, the guidance did not have any impact on the Company's consolidated results of operations, financial position or cash flows since the Company did not have any outstanding derivative instruments at that time.

New accounting pronouncements not yet adopted - In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers* (Topic 606). ASU 2014-09 outlines a single comprehensive model for companies to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance. In March 2016, the FASB issued ASU 2016-08, " *Principal Versus Agent Considerations (Reporting Revenue Gross Versus Net)* ," which amends the principal-versus-agent implementation guidance and in April 2016 the FASB issued ASU 2016-10, " *Identifying Performance Obligations and Licensing* ," which amends the guidance in those areas in the new revenue recognition standard. The new revenue standard is effective for annual reporting periods (including interim reporting periods within those periods) beginning January 1, 2018. The Company does not expect that the implementation of the new standard will have a material effect on the Company's consolidated results of operations, cash flows or financial position. The new standard will however require more extensive revenue-related disclosures. The Company has identified one difference in its Retail/LTC Segment related to the accounting for its ExtraBucks Rewards customer loyalty program, which is currently accounted for under a cost deferral method. Under the new standard, this program will be accounted for under a revenue deferral method. On

January 1, 2018, the Company adopted the new revenue standard on a modified retrospective basis and recorded an after-tax transition adjustment to reduce retained earnings as of January 1, 2018 by approximately $13 million.

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments – Overall* (Subtopic 825-10) *: Recognition and Measurement of financial Assets and Financial Liabilities* . This ASU requires equity investments, except those under the equity method of accounting or those that result in the consolidation of an investee, to be measured at fair value with changes in fair value recognized in net income. However, an entity may choose to measure equity investments that do not have readily determinable fair values at cost minus impairment, if any, plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issuer. This simplifies the impairment assessment of equity investments previously held at cost. Separate presentation of financial assets and liabilities by measurement category is required. The guidance is effective for fiscal years beginning after December 15, 2017 and interim periods within those years. Early adoption is permitted for fiscal years or interim periods that have not yet been issued as of the beginning of the fiscal year of adoption. Entities are required to apply the guidance retrospectively, with the exception of the amendments related to equity investments without readily determinable fair values, which must be applied on a prospective basis. The Company is evaluating the effect of adopting this guidance but does not expect the adoption to have a material impact on the Company's consolidated results of operations.

In February 2016, the FASB issued ASU 2016-02, *Leases* (Topic 842). Lessees will be required to recognize a right-of-use asset and a lease liability for virtually all of their leases (other than leases that meet the definition of a short-term lease). The liability will be equal to the present value of lease payments. The asset will be based on the liability, subject to adjustment, such as for initial direct costs. For income statement purposes, a dual model was retained, requiring leases to be classified as either operating or finance leases. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). Lessor accounting is similar to the current model, but updated to align with certain changes to the lessee model (e.g., certain definitions, such as initial direct costs, have been updated) and the new revenue recognition standard. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. Early adoption is permitted. The Company believes that the new standard will have a material impact on its consolidated balance sheet. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial position and related disclosures.

In August 2016, the FASB issued ASU No. 2016-15, *Classification of Certain Cash Receipts and Cash Payments* . ASU 2016-15 is intended to add or clarify guidance on the classification of certain cash receipts and payments in the statement of cash flows and to eliminate the diversity in practice related to such classifications. The guidance in ASU 2016-15 is required for annual reporting periods beginning after December 15, 2017, with early adoption permitted. The Company is evaluating the effect of adopting this guidance but does not expect the adoption will have a material impact on the Company's consolidated cash flows.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows* , which amends ASC Topic 230. This ASU requires entities to show the changes in the total of cash, cash equivalents, restricted cash and restricted cash equivalents in the statement of cash flows. As a result, entities will no longer be required to present transfers between cash and cash equivalents and restricted cash and restricted cash equivalents in the statement of cash flows. When cash, cash equivalents, restricted cash and restricted cash equivalents are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Entities will also have to disclose the nature of their restricted cash and restricted cash equivalent balances. The guidance is effective for fiscal years beginning after December 15, 2017 and interim periods within those years. Early adoption is permitted. Entities are required to apply the guidance retrospectively. The Company is evaluating the effect of adopting this guidance but does not expect the adoption will have a material impact on the Company's consolidated cash flows.

2 Acquisitions

Proposed Aetna Acquisition

On December 3, 2017, the Company entered into a definitive merger agreement to acquire all of the outstanding shares of Aetna for a combination of cash and stock. Under the terms of the merger agreement, Aetna shareholders will receive $145.00 per share in cash and 0.8378 CVS Health shares for each Aetna share. The transaction values Aetna at approximately $207 per share or approximately $69 billion based on the Company's 5-day volume weighted average price ending December 1, 2017 of $74.21 per share. Including the assumption of Aetna's debt, the total value of the transaction is approximately $77 billion. The final purchase price will be determined based on the Company's stock price on the date of closing of the transaction.

The proposed acquisition remains subject to approval by CVS Health and Aetna shareholders and customary closing conditions, including the expiration of the waiting period under the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976 and approvals of state departments of insurance and U.S. and international regulators.

If the transaction is not completed, the Company could be liable to Aetna for a termination fee of $2.1 billion in connection with the merger agreement, depending on the reasons leading to such termination.

During the year ended December 31, 2017, the Company recorded $34 million of transaction-related costs in operating expenses in connection with the proposed acquisition.

Wellpartner Acquisition

On November 30, 2017, the Company acquired Wellpartner, Inc. ("Wellpartner") for approximately $380 million. The purchase price is subject to a working capital adjustment. Wellpartner is a provider of specialty pharmacy services which provides products and services under the Section 340B drug discount program, which is a U.S. federal government program that requires drug manufacturers participating in the Medicaid program to provide outpatient drugs to eligible health care organizations and covered entities at significantly reduced prices. Wellpartner has two specialty pharmacies, one in Oregon, and the other, Bluegrass Pharmacy of Lexington, LLC ("Bluegrass Pharmacy"), is located in Kentucky. The fair value of the assets acquired and liabilities assumed were $532 million and $152 million, respectively, which included identifiable intangible assets of $233 million and goodwill of $182 million that were recorded in the PSS. The allocation of the purchase price is preliminary and is based on information that was available to management at the time the consolidated financial statements were prepared, accordingly, the allocation may change. The Company has classified the assets of Bluegrass Pharmacy as held for sale, and has reported Bluegrass Pharmacy as a discontinued operation. The assets held for sale and the operating results of Bluegrass Pharmacy as of and for the month ended December 31, 2017 are immaterial.

Target Pharmacy Acquisition

On December 16, 2015, the Company acquired the pharmacy and clinic businesses of Target for approximately $1.9 billion, plus contingent consideration of up to $60 million based on future prescription growth over a three year period through 2019. The Company acquired Target's 1,672 pharmacies which operate in 47 states and will operate them through a store-within-a-store format, branded as CVS Pharmacy. The Company also acquired 79 Target clinic locations which were rebranded as MinuteClinic. The Company acquired the Target pharmacy and clinic businesses primarily to expand the geographic reach of its retail pharmacy business.

The fair values of the assets acquired at the date of acquisition were approximately as follows:

In millions	
Accounts receivable	$ 2
Inventories	467
Property and equipment	9
Intangible assets	490
Goodwill	900
Total cash consideration	$ 1,868

Intangible assets acquired include customer relationships with an estimated useful life of 13 years. The goodwill represents future economic benefits expected to arise from the Company's expanded geographic presence in the retail pharmacy market, the assembled workforce acquired, expected purchasing and revenue synergies, as well as operating efficiencies and cost savings. The goodwill is deductible for income tax purposes. As of December 31, 2017 and 2016, no liability for any potential contingent consideration has been recorded based on projections for future prescription growth over the relevant period.

In connection with the closing of the transaction, the Company and Target entered into pharmacy and clinic operating and master lease agreements. See Note 7 "Leases" of the consolidated financial statements for disclosures of the Company's leasing arrangements.

During the year ended December 31, 2015, the Company incurred transaction costs of approximately $26 million associated with the acquisition that were recorded within operating expenses. The results of the Target pharmacies and clinics are included in the Company's Retail/LTC Segment beginning on December 16, 2015. Pro forma financial information for this acquisition is not presented as such results are immaterial to the Company's consolidated financial statements.

Omnicare Acquisition

On August 18, 2015, the Company acquired 100% of the outstanding common shares and voting interests of Omnicare, for $98 per share for a total of $9.6 billion and assumed long-term debt with a fair value of approximately $3.1 billion. Omnicare is a leading health care services company that specializes in the management of complex pharmaceutical care. Omnicare's LTC business is the nation's largest provider of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. In addition, Omnicare has a specialty pharmacy business operating primarily under the name of ACS Pharmacy, and provides commercialization services under the name of RxCrossroads ®. The Company includes LTC and the commercialization services business in the Retail/LTC Segment, and includes the specialty pharmacy business in its Pharmacy Services Segment. The Company acquired Omnicare to expand its operations in dispensing prescription drugs to assisted-living and long-term care facilities, and to broaden its presence in the specialty pharmacy business as the Company seeks to serve a greater percentage of the growing senior patient population in the United States.

The following table summarizes the fair values of the assets acquired and liabilities assumed at the date of acquisition:

In Millions	
Current assets (including cash of $298)	$ 1,657
Property and equipment	313
Goodwill	9,139
Intangible assets	3,962
Other noncurrent assets	63
Current liabilities	(773)
Long-term debt	(3,110)
Deferred income tax liabilities	(1,498)
Other noncurrent liabilities	(69)
Redeemable noncontrolling interest	(39)
Total consideration	$ 9,645

The goodwill represents future economic benefits expected to arise from the Company's expanded presence in the pharmaceutical care market, the assembled workforce acquired, expected purchasing and revenue synergies, as well as operating efficiencies and cost savings. Goodwill of $8.7 billion was allocated to the Retail/LTC Segment and the remaining goodwill of $0.4 billion was allocated to the Pharmacy Services Segment. Approximately $0.4 billion of the goodwill is deductible for income tax purposes. Intangible assets acquired include customer relationships and trade names of $3.9 billion and $74 million, respectively, with estimated weighted average useful lives of 19.1 and 2.9 years, respectively, and 18.8 years in total.

During the year ended December 31, 2015, the Company incurred transaction costs of $70 million associated with the acquisition of Omnicare that were recorded within operating expenses.

The Company's consolidated results of operations for the year ended December 31, 2015, include $2.6 billion of net revenues and net income of $61 million associated with the operating results of Omnicare from August 18, 2015 to December 31, 2015. These Omnicare operating results include severance costs and accelerated stock-based compensation.

The following unaudited pro forma information presents a summary of the Company's combined results of operations for the year ended December 31, 2015 as if the Omnicare acquisition and the related financing transactions had occurred on January 1, 2015. The following pro forma financial information is not necessarily indicative of the results of operations as they would have been had the transactions been effected on the assumed date, nor is it necessarily an indication of trends in future results for a number of reasons, including, but not limited to, differences between the assumptions used to prepare the pro forma information, basic shares outstanding and dilutive equivalents, cost savings from operating efficiencies, potential synergies, and the impact of incremental costs incurred in integrating the businesses.

(In millions, except per share data)	
Total revenues	$ 156,798
Income from continuing operations	5,277
Basic earnings per share from continuing operations	4.70
Diluted earnings per share from continuing operations	4.66

Pro forma income from continuing operations for the year ended December 31, 2015, excludes $135 million related to severance costs, accelerated stock-based compensation and transaction costs incurred in connection with the Omnicare acquisition.

3 Goodwill and Other Intangibles

Goodwill and other indefinitely-lived assets are not amortized, but are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate an impairment may exist.

When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess.

During 2017, the Company began pursuing various strategic alternatives for its RxC reporting unit. In connection with this effort, the Company performed an interim goodwill impairment test in the second quarter of 2017. The results of the impairment test determined that the fair value of the RxC reporting unit was lower than the carrying value, resulting in a $135 million goodwill impairment charge within operating expenses during the second quarter of 2017.

During the third quarter of 2017, the Company performed its required annual impairment tests of its reporting units and concluded there was no impairment of goodwill.

On January 2, 2018, the Company sold RxC to McKesson Corporation for $725 million. The transaction is subject to a working capital adjustment.

The TCJA enacted on December 22, 2017 reduces the U.S. federal corporate income tax rate from 35% to 21%, effective January 1, 2018 (see Note 11 “Income Taxes”). As a result, the RxC deferred income tax liabilities were reduced by $47 million and an income tax benefit of $47 million was recorded in the 2017 income statement. The reduction in the deferred income tax liabilities increased the carrying value of the RxC reporting unit by $47 million which triggered an additional goodwill impairment in the RxC reporting unit of $46 million during the fourth quarter of 2017.

The Company has cumulative goodwill impairments of $181 million as of December 31, 2017.

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2017 and 2016:

In millions	**Pharmacy Services**	**Retail/LTC**	**Total**
Balance, December 31, 2015	$ 21,685	$ 16,421	$ 38,106
Acquisitions	—	126	126
Foreign currency translation adjustments	—	17	17
Other [1]	(48)	48	—
Balance, December 31, 2016	21,637	16,612	38,249
Acquisitions	182	203	385
Foreign currency translation adjustments	—	(2)	(2)
Impairments	—	(181)	(181)
Balance, December 31, 2017	$ 21,819	$ 16,632	$ 38,451

(1) “Other” represents immaterial purchase accounting adjustments for acquisitions.

Indefinitely-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinitely-lived trademark using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized and the asset is written down to its estimated fair value. During the third quarter of 2017, the Company performed its annual impairment test of the indefinitely-lived trademark and concluded there was no impairment as of the testing date.

The following table is a summary of the Company's intangible assets as of December 31:

	2017			2016		
In millions	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Trademark (indefinitely-lived)	$ 6,398	$ —	$ 6,398	$ 6,398	$ —	$ 6,398
Customer contracts and relationships and covenants not to compete	12,341	(5,536)	6,805	11,485	(4,802)	6,683
Favorable leases and other	1,190	(763)	427	1,123	(693)	430
	$ 19,929	$ (6,299)	$ 13,630	$ 19,006	$ (5,495)	$ 13,511

The Company amortizes intangible assets with finite lives over the estimated useful lives of the respective assets, which have a weighted average useful life of 15.4 years. The weighted average useful life of the Company's customer contracts and relationships and covenants not to compete is 15.3 years. The weighted average life of the Company's favorable leases and other intangible assets is 16.2 years. Amortization expense for intangible assets totaled $817 million, $ 795 million and $ 611 million in 2017, 2016 and 2015, respectively. The anticipated annual amortization expense for these intangible assets for the next five years is as follows:

In millions	
2018	$ 817
2019	771
2020	600
2021	539
2022	494

4 Share Repurchase Programs

The following share repurchase programs were authorized by the Company's Board of Directors:

In billions Authorization Date	Authorized	Remaining as of December 31, 2017
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—
December 17, 2013 ("2013 Repurchase Program")	6.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board of Directors at any time.

Pursuant to the authorization under the 2014 Repurchase Program, in August 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion. Upon payment of the $3.6 billion purchase price in January 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares, which were placed into treasury stock in January 2017. The ASRs were accounted for as an initial treasury stock transaction for $2.9 billion and a forward contract for $0.7 billion. In April 2017, the Company received 9.9 million shares of common stock, representing the remaining 20% of the $3.6 billion notional amount of the ASRs, thereby concluding the ASRs. The remaining 9.9 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in April 2017.

Pursuant to the authorization under the 2014 Repurchase Program, in December 2015, the Company entered into a $725 million fixed dollar ASR with Barclays. Upon payment of the $725 million purchase price in December 2015, the Company received a number of shares of its common stock equal to 80% of the $725 million notional amount of the ASR or approximately 6.2 million shares. The initial 6.2 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in December 2015. The ASR was accounted for as an initial treasury stock transaction of $580 million and a forward contract of $145 million. The forward contract was classified as an equity instrument and was recorded within capital surplus on the consolidated balance sheet. In January 2016, the Company received 1.4 million shares of common stock, representing the remaining 20% of the $725 million notional amount of the ASR, thereby concluding the ASR. The remaining 1.4 million shares of common stock delivered to the Company by Barclays were placed into treasury stock in January 2016 and the forward contract was reclassified from capital surplus to treasury stock.

Pursuant to the authorization under the 2013 Repurchase Programs, in January 2015, the Company entered into a $2.0 billion fixed dollar ASR agreement with J.P. Morgan Chase Bank ("JP Morgan"). Upon payment of the $2.0 billion purchase price in January 2015, the Company received a number of shares of its common stock equal to 80% of the $2.0 billion notional amount of the ASR agreement or approximately 16.8 million shares, which were placed into treasury stock in January 2015. In May 2015, the Company received approximately 3.1 million shares of common stock, representing the remaining 20% of the $2.0 billion notional amount of the ASR, thereby concluding the ASR. The remaining 3.1 million shares of common stock delivered to the Company by JP Morgan were placed into treasury stock in May 2015. The ASR was accounted for as an initial treasury stock transaction of $1.6 billion and a forward contract of $0.4 billion. The forward contract was classified as an equity instrument and was initially recorded within capital surplus on the consolidated balance sheet and was reclassified to treasury stock upon the settlement of the ASR in May 2015.

In the ASR transactions described above, the initial repurchase of the shares and delivery of the remainder of the shares to conclude the ASR, resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

During the year ended December 31, 2017, the Company repurchased an aggregate of 55.4 million shares of common stock for approximately $4.4 billion under the 2014 and 2016 Repurchase Programs. As of December 31, 2017, there remained an aggregate of approximately $13.9 billion available for future repurchases under the 2016 Repurchase Program and the 2014 and 2013 Repurchase Programs were complete.

During the year ended December 31, 2016, the Company repurchased an aggregate of 47.5 million shares of common stock for approximately $4.5 billion under the 2014 Repurchase Program. During the year ended December 31, 2015, the Company repurchased an aggregate of 48.0 million shares of common stock for approximately $5.0 billion under the 2013 and 2014 Repurchase Programs.

5 Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31:

In millions	2017	2016
Short-term debt		
Commercial paper	$ 1,276	$ 1,874
Long-term debt		
1.9% senior notes due 2018	2,250	2,250
2.25% senior notes due 2018	1,250	1,250
2.25% senior notes due 2019	850	850
2.8% senior notes due 2020	2,750	2,750
2.125% senior notes due 2021	1,750	1,750
4.125% senior notes due 2021	550	550
2.75% senior notes due 2022	1,250	1,250
3.5% senior notes due 2022	1,500	1,500
4.75% senior notes due 2022	399	399
4% senior notes due 2023	1,250	1,250
3.375% senior notes due 2024	650	650
5% senior notes due 2024	299	299
3.875% senior notes due 2025	2,828	2,828
2.875% senior notes due 2026	1,750	1,750
6.25% senior notes due 2027	372	372
3.25% senior exchange debentures due 2035	1	1
4.875% senior notes due 2035	652	652
6.125% senior notes due 2039	447	447
5.75% senior notes due 2041	133	133
5.3% senior notes due 2043	750	750
5.125% senior notes due 2045	3,500	3,500
Capital lease obligations	670	648
Other	43	23
Total debt principal	27,170	27,726
Debt premiums	28	33
Debt discounts and deferred financing costs	(196)	(228)
	27,002	27,531
Less:		
Short-term debt (commercial paper)	(1,276)	(1,874)
Current portion of long-term debt	(3,545)	(42)
Long-term debt	$ 22,181	$ 25,615

The Company had approximately $1.3 billion of commercial paper outstanding at a weighted average interest rate of 2.0% as of December 31, 2017. The Company had approximately $1.9 billion of commercial paper outstanding at a weighted average interest rate of 1.22% as of December 31, 2016. In connection with its commercial paper program, the Company maintains a $1.0 billion 364-day unsecured back-up credit facility, which expires on May 17, 2018, a $1.25 billion, five-year unsecured back-up credit facility, which expires on July 24, 2019, a $1.25 billion, five-year unsecured back-up credit facility, which expires on July 1, 2020, and a $1.0 billion, five-year unsecured back-up credit facility, which expires on May 18, 2022. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.02%, regardless of usage. As of December 31, 2017 and 2016, there were no borrowings outstanding under the back-up credit facilities.

On December 3, 2017, in connection with the proposed acquisition of Aetna, the Company entered into a $49.0 billion unsecured bridge loan facility. The Company paid approximately $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and will be amortized as interest expense over the period the bridge facility is outstanding. The bridge loan facility was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the three months and year ended December 31, 2017, which was recorded in interest expense. On December 15, 2017, in connection with the proposed acquisition of Aetna, the Company entered into a $5.0 billion unsecured term loan agreement. The term loan facility under the term loan agreement consists of a $3.0 billion three-year tranche and a $2.0 billion five-year tranche. The term loan facility allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings and require the Company to pay a weighted average quarterly commitment fee, regardless of usage.

On January 3, 2017, the Company entered into a $2.5 billion revolving credit facility. The credit facility allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. The Company terminated the credit facility in May 2017.

On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the "2016 Notes") for total proceeds of approximately $3.5 billion, net of discounts and underwriting fees. The 2016 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

On May 16, 2016, the Company announced tender offers for (1) any and all of its 5.75% Senior Notes due 2017, its 6.60% Senior Notes due 2019 and its 4.75% Senior Notes due 2020 (collectively, the "Any and All Notes") and (2) up to $1.5 billion aggregate principal amount of its 6.25% Senior Notes due 2027, its 6.125% Senior Notes due 2039, its 5.75% Senior Notes due 2041, the 5.00% Senior Notes due 2024 issued by its wholly-owned subsidiary, Omnicare, Inc. ("Omnicare"), the 4.75% Senior Notes due 2022 issued by Omnicare, its 4.875% Senior Notes due 2035 and its 3.875% Senior Notes due 2025 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion. The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. The Company paid a premium of $486 million in excess of the debt principal in connection with the purchase of the Notes, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on the early extinguishment of debt of $542 million which was recorded in income from continuing operations in the consolidated statement of income for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. The Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of debt of $101 million during the year ended December 31, 2016.

The Company recorded a total loss on the early extinguishment of debt of $643 million which was recorded in the income from continuing operations in the consolidated statement of income for the year ended December 31, 2016.

On May 20, 2015, in connection with the acquisition of Omnicare, the Company entered into a $13 billion unsecured bridge loan facility. The Company paid approximately $52 million in fees in connection with the facility. The fees were capitalized and amortized as interest expense over the period the bridge facility was outstanding. The bridge loan facility

expired on July 20, 2015 upon the Company's issuance of unsecured senior notes with an aggregate principal of $15 billion as discussed below. The bridge loan facility fees became fully amortized in July 2015.

On July 20, 2015, the Company issued an aggregate of $2.25 billion of 1.9% unsecured senior notes due 2018 ("2018 Notes"), an aggregate of $2.75 billion of 2.8% unsecured senior notes due 2020 ("2020 Notes"), an aggregate of $1.5 billion of 3.5% unsecured senior notes due 2022 ("2022 Notes"), an aggregate of $3 billion of 3.875% unsecured senior notes due 2025 ("2025 Notes"), an aggregate of $2 billion of 4.875% unsecured senior notes due 2035 ("2035 Notes"), and an aggregate of $3.5 billion of 5.125% unsecured senior notes due 2045 ("2045 Notes" and, together with the 2018 Notes, 2020 Notes, 2022 Notes, 2025 Notes and 2035 Notes, the "Notes") for total proceeds of approximately $14.8 billion, net of discounts and underwriting fees. The Notes pay interest semi-annually and contain redemption terms which allow or require the Company to redeem the Notes at a defined redemption price plus accrued and unpaid interest at the redemption date. The net proceeds of the Notes were used to fund the Omnicare acquisition and the acquisition of the pharmacies and clinics of Target. The remaining proceeds were used for general corporate purposes.

Upon the closing of the Omnicare acquisition in August 2015, the Company assumed the long-term debt of Omnicare that had a fair value of approximately $3.1 billion, $2.0 billion of which was previously convertible into Omnicare shares that holders were able to redeem subsequent to the acquisition. During the period from August 18, 2015 to December 31, 2015, all but $5 million of the $2.0 billion of previously convertible debt was redeemed and repaid and approximately $0.4 billion in Omnicare term debt assumed was repaid for total repayments of Omnicare debt of approximately $2.4 billion in 2015.

The remaining principal of the Omnicare debt assumed was comprised of senior unsecured notes with an aggregate principal amount of $700 million ($400 million of 4.75% senior notes due 2022 and $300 million of 5% senior notes due 2024). In September 2015, the Company commenced exchange offers for the 4.75% senior notes due 2022 and the 5% senior notes due 2024 to exchange all validly tendered and accepted notes issued by Omnicare for notes to be issued by the Company. This offer expired on October 20, 2015 and the aggregate principal amounts of $388 million of the 4.75% senior notes due 2022 and $296 million of the 5% senior notes due 2024 were validly tendered and exchanged for notes issued by the Company. The Company recorded this exchange transaction as a modification of the original debt instruments. Consequently, no gain or loss on extinguishment was recognized in the Company's consolidated income statement as a result of this exchange transaction and the issuance costs of the new debt were expensed as incurred.

The back-up credit facilities and unsecured senior notes contain customary restrictive financial and operating covenants. The covenants do not materially affect the Company's financial or operating flexibility. As of December 31, 2017, the Company is in compliance with all debt covenants.

The following is a summary of the Company's required principal debt repayments due during each of the next five years and thereafter, as of December 31, 2017:

In millions	
2018	$ 4,821
2019	873
2020	2,775
2021	2,327
2022	3,178
Thereafter	13,196
Total	$ 27,170

6 Store Closures

In December 2016, the Company announced an enterprise streamlining initiative designed to reduce costs and enhance operating efficiencies to allow the Company to be more competitive in the current health care environment. In connection with the enterprise streamlining initiative, the Company announced its intention to rationalize the number of retail stores by closing approximately 70 underperforming stores during the year ending December 31, 2017. During the

year ended December 31, 2017, the Company closed 71 retail stores and recorded charges of $215 million within operating expenses in the Retail/LTC Segment. The charges are primarily comprised of provisions for the present value of noncancelable lease obligations. The noncancelable lease obligations associated with stores closed during the year ended December 31, 2017 extend through the year 2039.

7 Leases

The Company leases most of its retail and mail order locations, 13 of its distribution centers and certain corporate offices under noncancelable operating leases, typically with initial terms of 15 to 25 years and with options that permit renewals for additional periods. The Company also leases certain equipment and other assets under noncancelable operating leases, typically with initial terms of 3 to 10 years. In December 2015, in connection with the acquisition of the pharmacy and clinic businesses of Target, the Company entered into lease agreements with Target for the pharmacy and clinic space within Target stores. Given that the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings being leased, the Company concluded for accounting purposes that the lease term was the remaining economic life of the buildings. Consequently, most of the individual pharmacy leases are capital leases. Approximately $0.3 billion of capital lease obligations were recorded in connection with this transaction.

Minimum rent on operating leases is expensed on a straight-line basis over the term of the lease. In addition to minimum rental payments, certain leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed when incurred.

The following table is a summary of the Company's net rental expense for operating leases for the years ended December 31:

In millions	**2017**	**2016**	**2015**
Minimum rentals	$ 2,455	$ 2,418	$ 2,317
Contingent rentals	29	35	34
	2,484	2,453	2,351
Less: sublease income	(24)	(24)	(22)
	$ 2,460	$ 2,429	$ 2,329

The following table is a summary of the future minimum lease payments under capital and operating leases as of December 31, 2017:

In millions	Capital Leases	Operating Leases [1]
2018	$ 74	$ 2,493
2019	74	2,361
2020	74	2,201
2021	73	2,072
2022	73	1,934
Thereafter	974	16,090
Total future lease payments [2]	1,342	$ 27,151
Less: imputed interest	(672)	
Present value of capital lease obligations	$ 670	

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $171 million due in the future under noncancelable subleases.
(2) The Company leases pharmacy and clinic space from Target. Amounts related to such capital and operating leases are reflected above. Amounts due in excess of the remaining estimated economic life of the buildings of approximately $1.9 billion are not reflected herein since the estimated economic life of the buildings is shorter than the contractual term of the lease arrangement.

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the above table. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. Proceeds from sale-leaseback transactions totaled $265 million in 2017, $230 million in 2016 and $411 million in 2015.

8 Medicare Part D

The Company offers Medicare Part D benefits through SilverScript, which has contracted with CMS to be a PDP and, pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, must be a risk-bearing entity regulated under state insurance laws or similar statutes.

SilverScript is a licensed domestic insurance company under the applicable laws and regulations. Pursuant to these laws and regulations, SilverScript must file quarterly and annual reports with the National Association of Insurance Commissioners ("NAIC") and certain state regulators, must maintain certain minimum amounts of capital and surplus under a formula established by the NAIC and must, in certain circumstances, request and receive the approval of certain state regulators before making dividend payments or other capital distributions to the Company. The Company does not believe these limitations on dividends and distributions materially impact its financial position.

The Company has recorded estimates of various assets and liabilities arising from its participation in the Medicare Part D program based on information in its claims management and enrollment systems. Significant estimates arising from its participation in this program include: (i) estimates of low-income cost subsidy, reinsurance amounts, and coverage gap discount amounts ultimately payable to or receivable from CMS based on a detailed claims reconciliation that will occur in the following year; (ii) an estimate of amounts receivable from or payable to CMS under a risk-sharing feature of the Medicare Part D program design, referred to as the risk corridor and (iii) estimates for claims that have been reported and are in the process of being paid or contested and for our estimate of claims that have been incurred but have not yet been reported.

9 Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

The Company sponsors several voluntary 401(k) savings plans that cover all employees who meet plan eligibility requirements. The Company makes matching contributions consistent with the provisions of the plans.

At the participant's option, account balances, including the Company's matching contribution, can be transferred without restriction among various investment options, including the Company's common stock fund under one of the defined contribution plans. The Company also maintains a nonqualified, unfunded deferred compensation plan for certain key employees. This plan provides participants the opportunity to defer portions of their eligible compensation and receive matching contributions equivalent to what they could have received under the CVS Health 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under the above defined contribution plans were $314 million, $295 million and $251 million in 2017, 2016 and 2015, respectively.

Defined Benefit Pension Plans

As of December 31, 2016 and 2015, the Company sponsored seven defined benefit pension plans, all of which are closed to new participants. Two of the plans are tax-qualified plans that are funded based on actuarial calculations and applicable federal laws and regulations. The other five plans are unfunded nonqualified supplemental retirement plans. In 2015, the Company terminated its largest tax-qualified plan and in 2017, the Company terminated the other tax-qualified plan.

During the year ended December 31, 2017, the Company settled the pension obligations of its two tax-qualified plans by irrevocably transferring pension liabilities to an insurance company through the purchase of group annuity contracts and through lump sum distributions. These purchases, funded with pension plan assets, resulted in pre-tax settlement losses of $187 million in the year ended December 31, 2017, related to the recognition of accumulated deferred actuarial losses. The settlement losses are included in other expense in the consolidated statement of income.

The following tables outline the change in benefit obligations and plan assets over the comparable periods:

In millions	**2017**	**2016**
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 844	$ 844
Interest cost	20	27
Actuarial loss (gain)	(31)	13
Benefit payments	(35)	(37)
Settlements	(667)	(3)
Benefit obligation at end of year	$ 131	$ 844

In millions	**2017**	**2016**
Change in plan assets:		
Fair value of plan assets at the beginning of the year	$ 624	$ 613
Actual return on plan assets	32	26
Employer contributions	46	25
Benefit payments	(35)	(37)
Settlements	(667)	(3)
Fair value of plan assets at the end of the year	—	624
Funded status	$ (131)	$ (220)

The components of net periodic benefit costs for the years ended December 31 are shown below:

In millions	2017	2016	2015
Components of net periodic benefit cost:			
Interest cost	$ 20	$ 27	$ 31
Expected return on plan assets	(20)	(32)	(33)
Amortization of net loss	21	32	21
Settlement losses	187	—	—
Net periodic pension cost	$ 208	$ 27	$ 19

Pension Plan Assumptions

The Company uses a series of actuarial assumptions to determine the benefit obligations and the net benefit costs. The discount rate is determined by examining the current yields observed on the measurement date of fixed-interest, high quality investments expected to be available during the period to maturity of the related benefits on a plan by plan basis. In 2016, the discount rate for the qualified plan that had been terminated was determined by examining the current assumed lump sum and annuity purchase rates. The expected long-term rate of return on plan assets is determined by using the plan's target allocation and historical returns for each asset class on a plan by plan basis. Certain of the Company's pension plans use assumptions on expected compensation increases of plan participants. These increases are determined by an actuarial analysis of the plan participants, their expected compensation increases, and the duration of their earnings period until retirement. Each of these assumptions is reviewed as plan characteristics change and on an annual basis with input from senior pension and financial executives and the Company's external actuarial consultants.

The discount rate for determining plan benefit obligations was 3.5% in 2017 and 4.0% in 2016 for all plans, except the terminated qualified plan. The discount rate for the terminated qualified plan was 3.09% in 2016. The expected long-term rate of return for the plans ranged from 4.0% to 5.5% in 2017 and 2016. The rate of compensation increases for certain of the plans with active participants ranged from 4.0% to 6.0% in 2017 and 2016.

Return on Plan Assets

The Company's investment strategy for its two qualified pension plans was liability management driven. The asset allocation targets were to hold fixed income investments based upon this strategy. The following tables show the fair value allocation of plan assets by asset category as of December 31, 2016.

	Fair value of plan assets at December 31, 2016			
	Level 1	Level 2	Level 3	Total
Cash and money market funds	$ 8	$ —	$ —	$ 8
Fixed income funds	3	580	—	583
Equity mutual funds	33	—	—	33
Total assets at fair value	$ 44	$ 580	$ —	$ 624

As of December 31, 2016, the Company's qualified defined benefit pension plan assets consisted of 5% equity, 94% fixed income and 1% money market securities of which 7% were classified as Level 1 and 93% as Level 2 in the fair value hierarchy. The Company had no investments in Level 3 alternative investments during the year ended December 31, 2016.

As of December 31, 2017, the assets in the Company's qualified defined benefit pension plans had been fully liquidated through the purchase of group annuity contracts and through lump sum distributions.

Cash Flows

The Company contributed $46 million, $25 million and $22 million to the pension plans during 2017, 2016 and 2015, respectively. The Company plans to make approximately $21 million in contributions to the pension plans during 2018. These contributions include contributions made to certain nonqualified benefit plans for which there is no funding requirement. The Company estimates the following future benefit payments which are calculated using the same actuarial assumptions used to measure the benefit obligation as of December 31, 2017:

In millions	
2018	$ 21
2019	14
2020	12
2021	23
2022	8
Thereafter	31

Multiemployer Pension Plans

The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following aspects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. Total Company contributions to multiemployer pension plans were $17 million in 2017, $15 million in 2016 and $14 million in 2015.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2017 and 2016, the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $25 million and $24 million, respectively. Net periodic benefit costs related to these other postretirement benefits were $1 million in both 2017 and 2016, and $2 million in 2015.

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. Total Company contributions to multiemployer health and welfare plans were $58 million, $52 million and $60 million in 2017, 2016 and 2015, respectively.

10 Stock Incentive Plans

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for each of the respective periods:

In millions	2017	2016	2015
Stock options [1]	$ 65	$ 79	$ 90
Restricted stock awards [2]	169	143	140
Total stock-based compensation	$ 234	$ 222	$ 230

(1) Includes the Employee Stock Purchase Plan (the "ESPP")
(2) Stock-based compensation for the year ended December 31, 2015 includes $38 million associated with accelerated vesting of restricted stock replacement awards issued to Omnicare executives who were terminated subsequent to the acquisition.

The ESPP provides for the purchase of up to 30 million shares of common stock. Under the ESPP, beginning in 2016, eligible employees could purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. Prior to 2016, the purchase price was equal to 85% of the lower of the fair market value on the first day or the last day of the offering period. During 2017, approximately one million shares of common stock were purchased under the provisions of the ESPP at an average price of $71.66 per share. As of December 31, 2017, approximately 11 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for each of the respective periods:

	2017	2016	2015
Dividend yield [1]	1.24 %	0.88 %	0.71 %
Expected volatility [2]	22.70 %	20.64 %	13.92 %
Risk-free interest rate [3]	0.86 %	0.45 %	0.11 %
Expected life *(in years)* [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 13.01	$ 14.98	$ 18.72

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is based on the historical volatility of the Company's daily stock market prices over the previous six month period.
(3) The risk-free interest rate is based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP options (i.e., six months).
(4) The expected life is based on the semi-annual purchase period.

The terms of the Company's Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee of the Company's Board of Directors. The ICP allows for a maximum of 74 million shares to be reserved and available for grants. The ICP is the only compensation plan under which the Company grants stock options, restricted stock and other stock-based awards to its employees, with the exception of the Company's ESPP. As of December 31, 2017, there were approximately 32 million shares available for future grants under the ICP.

The Company's restricted awards are considered nonvested share awards and require no payment from the employee. Compensation cost is recorded based on the market price of the Company's common stock on the grant date and is recognized on a straight-line basis over the requisite service period. As of December 31, 2017, there was $350 million of total unrecognized compensation cost related to the restricted stock units that are expected to vest. These costs are

expected to be recognized over a weighted-average period of 2.25 years. The total fair value of restricted shares vested during 2017, 2016 and 2015 was $175 million, $218 million and $164 million, respectively.

The following table is a summary of the restricted stock unit and restricted share award activity for the year ended December 31, 2017.

Units in thousands	Units	Weighted Average Grant Date Fair Value
Nonvested at beginning of year	4,876	$ 55.56
Granted	2,873	$ 78.35
Vested	(2,340)	$ 78.92
Forfeited	(395)	$ 89.21
Nonvested at end of year	5,014	$ 86.92

All grants under the ICP are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model and stock-based compensation is recognized on a straight-line basis over the requisite service period. Stock options granted generally become exercisable over a four-year period from the grant date. Stock options generally expire seven years after the grant date.

Cash received from stock options exercised, which includes the ESPP, totaled $329 million, $296 million and $362 million during 2017, 2016 and 2015, respectively. Payments for taxes for net share settlement of equity awards totaled $71 million in 2017, $72 million in 2016 and $63 million in 2015, respectively. The total intrinsic value of stock options exercised was $176 million, $244 million and $394 million in 2017, 2016 and 2015, respectively. The total fair value of stock options vested during 2017, 2016 and 2015 was $341 million, $298 million and $334 million, respectively.

The fair value of each stock option is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2017	2016	2015
Dividend yield [1]	2.56 %	1.62 %	1.37 %
Expected volatility [2]	18.39 %	17.22 %	18.07 %
Risk-free interest rate [3]	1.77 %	1.24 %	1.24 %
Expected life *(in years)* [4]	4.1	4.2	4.2
Weighted-average grant date fair value	$ 9.43	$ 13.00	$ 14.01

(1) The dividend yield is based on annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is estimated using the Company's historical volatility over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.
(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.
(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option holder exercise experience.

As of December 31, 2017, unrecognized compensation expense related to unvested options totaled $57 million, which the Company expects to be recognized over a weighted-average period of 1.76 years. After considering anticipated forfeitures, the Company expects approximately 9 million of the unvested stock options to vest over the requisite service period.

The following table is a summary of the Company's stock option activity for the year ended December 31, 2017:

Shares in thousands	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at December 31, 2016	23,275	$ 68.60		
Granted	3,513	$ 78.05		
Exercised	(4,814)	$ 43.07		
Forfeited	(889)	$ 94.25		
Expired	(555)	$ 60.00		
Outstanding at December 31, 2017	20,530	$ 75.32	3.62	$ 180,318,054
Exercisable at December 31, 2017	11,365	$ 61.37	2.30	$ 179,628,690
Vested at December 31, 2017 and expected to vest in the future	20,114	$ 75.00	3.57	$ 180,299,134

11 Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31:

In millions	2017	2016	2015
Current:			
Federal	$ 2,594	$ 2,803	$ 3,065
State	464	511	555
	3,058	3,314	3,620
Deferred:			
Federal	(1,435)	5	(180)
State	14	(2)	(54)
	(1,421)	3	(234)
Total	$ 1,637	$ 3,317	$ 3,386

On December 22, 2017, the President signed into law the Tax Cuts and Jobs Act (the "TCJA"). Among numerous changes to existing tax laws, the TCJA permanently reduces the federal corporate income tax rate from 35% to 21% effective on January 1, 2018. The effects on deferred tax balances of changes in tax rates are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As the result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional income tax benefit of approximately $1.5 billion for year ended December 31, 2017. The Company has not completed all of its processes to determine the TCJA's final impact. The final impact may differ from this provisional amount due to, among other things, changes in interpretations and assumptions the Company has made thus far and the issuance of additional regulatory or other guidance. The accounting is expected to be completed by the time the 2017 federal corporate income tax return is filed in 2018.

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31:

	2017	2016	2015
Statutory income tax rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal tax benefit	4.1	4.1	4.0
Provisional effect of the Tax Cuts and Jobs Act	(18.3)	—	—
Other	(1.0)	(0.7)	0.3
Effective income tax rate	19.8 %	38.4 %	39.3 %

The Company has $3.0 billion and $4.2 billion of net deferred income tax liabilities as of December 31, 2017 and 2016, respectively. The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31:

In millions	**2017**	**2016**
Deferred income tax assets:		
Lease and rents	$ 291	$ 375
Inventory	31	57
Employee benefits	246	400
Allowance for doubtful accounts	187	301
Retirement benefits	40	65
Net operating loss and capital loss carryforwards	101	125
Deferred income	93	144
Other	18	336
Valuation allowance	(77)	(135)
Total deferred income tax assets	930	1,668
Deferred income tax liabilities:		
Depreciation and amortization	(3,926)	(5,882)
Total deferred income tax liabilities	(3,926)	(5,882)
Net deferred income tax liabilities	$ (2,996)	$ (4,214)

The Company assesses positive and negative evidence to determine whether it is more likely than not some portion of a deferred tax asset would not be realized. When it would not, a valuation allowance is established for such portion of a deferred tax asset.

A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows:

In millions	**2017**	**2016**	**2015**
Beginning balance	$ 307	$ 338	$ 188
Additions based on tax positions related to the current year	62	68	57
Additions based on tax positions related to prior years	32	70	122
Reductions for tax positions of prior years	(28)	(100)	(11)
Expiration of statutes of limitation	(10)	(22)	(13)
Settlements	(19)	(47)	(5)
Ending balance	$ 344	$ 307	$ 338

The Company and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. The Company is a participant in the Compliance Assurance Process ("CAP"), which is a program made available by the Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax return. The IRS is currently examining the Company's 2016 and 2017 consolidated U.S. federal income tax returns.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2017, no examination has resulted in any proposed adjustments that would result in a material change to the Company's results of operations, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2011. Certain state exams are expected to/likely to be concluded and certain state statutes will lapse in 2018, but the change in the balance of our uncertain tax positions will be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various

examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in income tax expense. The Company accrued interest expense of approximately $11 million in 2017, $10 million in 2016 and $5 million in 2015. The Company had approximately $34 million and $30 million accrued for interest and penalties as of December 31, 2017 and 2016, respectively.

There are no material uncertain tax positions as of December 31, 2017 the ultimate deductibility of which is highly certain but for which there is uncertainty about the timing.

As of December 31, 2017, the total amount of unrecognized tax benefits that, if recognized, would affect the effective income tax rate is approximately $317 million, after considering the federal benefit of state income taxes.

12 Commitments and Contingencies

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser has agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations. As of December 31, 2017, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Legal Matters

The Company is a party to legal proceedings, investigations and claims in the ordinary course of its business, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial position.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters.

- *Indiana State District Council of Laborers and HOD Carriers Pension and Welfare Fund v. Omnicare, Inc.,* et al. (U.S. District Court for the Eastern District of Kentucky). In February 2006, two substantially similar putative class action lawsuits were filed and subsequently consolidated. The consolidated complaint was filed against Omnicare, three of its officers and two of its directors and purported to be brought on behalf of all open-market purchasers of Omnicare common stock from August 3, 2005 through July 27, 2006, as well as all purchasers who bought shares of Omnicare common stock in Omnicare's public offering in December 2005. The complaint alleged violations of the Securities Exchange Act of 1934 and Section 11 of the Securities Act of 1933 and sought, among other things, compensatory damages and injunctive relief. After dismissals and appeals to the United States Court of Appeals for the Sixth Circuit, the United States Supreme Court remanded the case to the district court. In October 2016, Omnicare filed an answer to plaintiffs' third amended complaint, and

discovery commenced. In August 2017, the plaintiffs moved for class certification, which Omnicare has opposed.

- *FTC and Multi-State Investigation.* In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the U.S. Federal Trade Commission ("FTC"). Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company has cooperated with the multi-state investigation.

- *United States* ex rel. *Jack Chin v. Walgreen Company,* et al. (U.S. District Court for the Central District of California). In March 2010, the Company received a subpoena from the U.S. Department of Health and Human Services, Office of the Inspector General requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to the Company's pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. In October 2016, the U.S. District Court for the Central District of California unsealed a *qui tam* complaint, filed in April 2009 against CVS Pharmacy and other retail pharmacies, alleging that the Company violated the federal False Claims Act, and the False Claims Acts of several states, by offering such programs. The complaint was served on the Company in January 2017. In December 2017, the same court unsealed a second *qui tam* complaint filed by the same relator in September 2017. The complaint is based on the same factual allegations but asserts a legal theory the Court did not permit him to add to the original case. The federal government has declined intervention in both cases. The Company is defending both lawsuits.

- *United States* ex rel. *Anthony R. Spay v. CVS Caremark Corporation,* et al. (U.S. District Court for the Eastern District of Pennsylvania). In January 2012, the court unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, Anthony Spay, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that CVS Caremark's processing of Medicare claims on behalf of one of its clients violated the federal False Claims Act. The United States declined to intervene in the lawsuit. In September 2015, the Court granted CVS Caremark's motion for summary judgment in its entirety, and entered judgment in favor of CVS Caremark and against Spay. Spay appealed. In December 2017, the United States Court of Appeals for the Third Circuit affirmed the court's judgment in favor of CVS Caremark.

- *State of Texas* ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation,* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands and has issued a series of subsequent requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the court unsealed a first amended petition. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to Texas Medicaid by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the usual and customary price. The amended petition was unsealed following the Company's filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County District Court), a declaratory judgment action against the State of Texas in December 2016 seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the Medicaid regulation. The State of Texas is also pursuing temporary injunctive relief.

- *Subpoena Concerning PBM Administrative Fees.* In March 2014, the Company received a subpoena from the United States Attorney's Office for the District of Rhode Island, requesting documents and information concerning bona fide service fees and rebates received from pharmaceutical manufacturers in connection with certain drugs utilized under Medicare Part D, as well as the reporting of those fees and rebates to Part D plan

sponsors. The Company has been cooperating with the government and providing documents and information in response to the subpoena.

- *Corcoran* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in United States District Court in the Northern District of California. Plaintiffs seek damages and injunctive relief on behalf of a class of consumers who purchased certain prescription drugs under the consumer protection statutes and common laws of certain states. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the consumer case (Corcoran), the Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The plaintiffs have filed a notice of appeal to the Ninth Circuit. The Company continues to defend these actions.

- *Omnicare DEA Subpoena.* In September 2015, Omnicare was served with an administrative subpoena by the U.S. Drug Enforcement Administration ("DEA"). The subpoena seeks documents related to controlled substance policies, procedures, and practices at eight pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional pharmacy. The Company has been cooperating and providing documents in response to this administrative subpoena.

- *Omnicare Cycle Fill Civil Investigative Demand.* In October 2015, Omnicare received a Civil Investigative Demand from the United States Attorney's Office for the Southern District of New York requesting information and documents concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand. In July 2017, Omnicare also received a subpoena from the California Department of Insurance requesting documents on similar subject matter.

- *PBM Pricing Civil Investigative Demand.* In October 2015, the Company received from the U.S. Department of Justice (the "DOJ") a Civil Investigative Demand requesting documents and information in connection with a federal False Claims Act investigation concerning allegations that the Company submitted, or caused to be submitted, to the Medicare Part D program prescription drug event data that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *United States* ex rel. *Sally Schimelpfenig and John Segura v. Dr. Reddy's Laboratories Limited and Dr. Reddy's Laboratories, Inc.* (U.S. District Court for the Eastern District of Pennsylvania). In November 2015, the court unsealed a second amended *qui tam* complaint filed in September 2015. The DOJ declined to intervene in this action. The relators allege that the Company, Walgreens, Wal-Mart, and Dr. Reddy's Laboratories violated the federal and various state False Claims Acts by dispensing prescriptions in unit dose packaging supplied by Dr. Reddy's that was not compliant with the Consumer Product Safety Improvement Act and the Poison Preventive Packaging Act and thereby allegedly rendering the drugs misbranded under the Food, Drug and Cosmetic Act. In March 2017, the Court granted the Company's motion to dismiss with leave to file an amended complaint. In June 2017, the Company moved to dismiss relators' third amended complaint.

- *Barchock* et al. *v. CVS Health Corporation,* et al. (U.S. District Court for the District of Rhode Island). In February 2016, a class action lawsuit was filed against the Company, the Benefit Plans Committee of the Company, and Galliard Capital Management, Inc., by Mary Barchock, Thomas Wasecko, and Stacy Weller,

purportedly on behalf of the 401(k) Plan and the Employee Stock Ownership Plan of the Company (the "Plan"), and participants in the Plan. The complaint alleged that the defendants breached fiduciary duties owed to the plaintiffs and the Plan by investing too much of the Plan's Stable Value Fund in short-term money market funds and cash management accounts. The court recently granted the Company's motion to dismiss the plaintiffs' amended complaint. In May 2017, plaintiffs appealed that ruling in the United States Court of Appeals for the First Circuit.

- *State of California* ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined intervention in this case. The relator alleges that the Company submitted false claims for payment to California Medicaid in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer.

- *Retail DEA Matters.* The Company has been also undergoing several audits by the DEA Administrator and is in discussions with the DEA and the U.S. Attorney's Offices in several locations concerning allegations that the Company has violated certain requirements of the Controlled Substance Act.

- *National Opioid Litigation* . In December 2017, the United States Judicial Panel on Multidistrict Litigation ordered consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes, and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation is *In re National Prescription Opiate Litigation* (MDL No. 2804), pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes relevant federal court cases that name the Company, including actions filed by several counties in West Virginia; actions filed by several counties and cities in Michigan; actions filed by hospitals in Florida and Mississippi; and an action filed by the St. Croix Chippewa Indians of Wisconsin. Similar cases that name the Company in some capacity have been filed in state courts, including cases filed by Shelby County, Tennessee, *Shelby County (Tennessee) v. Purdue Pharma, L.P., et al.* (Shelby County Circuit Court, No. CT-004500-17), and several counties in West Virginia, *Brooke County (West Virginia) et al. v. Purdue Pharma, L.P., et al.* (Marshall County Circuit Court, Nos. 17-C-248 – 17-C-255). The Company is defending all such matters.

- *Cherokee Nation Opioid Litigation* . In April 2017, the Company was named as a defendant in an action filed on behalf of the Cherokee Nation in the District Court of Cherokee Nation (the "Cherokee Action") asserting various causes of action allegedly arising from the widespread abuse of opioids. In June 2017, the Company filed a motion to dismiss the Cherokee Action. The Cherokee Nation has since filed an amended petition in the Cherokee Action. Also in June 2017, the six defendants in the Cherokee Action collectively filed a complaint in the U.S. District Court for the Northern District of Oklahoma, *McKesson* , et al. *v. Hembree* , et al., seeking a declaration and preliminary injunction prohibiting the District Court of Cherokee Nation from exercising jurisdiction over the Cherokee Action. In January 2018, the U.S. District Court granted the preliminary injunction motion and issued an order enjoining the Cherokee Nation Attorney General and the judicial officers of the Cherokee Nation District Court from taking any action with respect to the Cherokee Action pending resolution of the federal court case.

- *State of Mississippi v. CVS Health Corporation,* et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to Mississippi Medicaid by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, filed a counterclaim, and moved to transfer the case to circuit court. The motion to transfer was granted, which the State has appealed, and the motion to dismiss remains pending.

- *Part B Insulin Products Civil Investigative Demand.* In December 2016, the Company received a Civil Investigative Demand from the U.S. Attorney's Office for the Northern District of New York, requesting documents and information in connection with a False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Medicare Part D rather than Part B. The Company has cooperated with the government and provided documents and information in response to the Civil Investigative Demand.

- *Cold Chain Logistics Civil Investigative Demand* . In September 2016, the Company received from the DOJ a Civil Investigative Demand in connection with an investigation as to whether the Company's handling of certain temperature-sensitive pharmaceuticals violates the federal Food, Drug and Cosmetic Act and the False Claims Act. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *Amburgey,* et al. *v. CaremarkPCS Health, L.L.C.* (U.S. District Court for the Central District of California). In March 2017, the Company was served with a complaint challenging the policies and procedures used by CVS Specialty pharmacies to ship temperature-sensitive medications. The case is similar to a matter already pending against the Company in the Superior Court of California (Los Angeles County), *Bertram v. Immunex Corp.* , et al., which was filed in October 2014. In November 2017, the plaintiffs voluntarily dismissed the *Amburgey* case without prejudice. The Company continues to defend the Bertram matter.

- *Barnett,* et al. v. *Novo Nordisk Inc* ., et al. and *Boss* , et al. v. *CVS Health Corporation* , et al., and *Christensen,* et al., v. *Novo Nordisk Inc.* et al., (all pending in the U.S. District Court for the District of New Jersey). These putative class actions were filed against the Company and other PBMs and manufacturers of insulin in March and April 2017. Plaintiffs in all cases allege that the PBMs and manufacturers have engaged in a conspiracy whereby the PBMs sell access to their formularies by demanding the highest rebates, which in turn causes increased list prices for insulin. The primary claims are antitrust claims, claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), violations of state unfair competition and consumer protection laws and in *Boss* , claims pursuant to the Employee Retirement Income Security Act ("ERISA"). In December 2017, the attorney appointed as interim lead counsel in *Barnet, Boss* and *Christensen* filed a consolidated amended class action complaint in a related action, *In re Insulin Pricing Litigation* , against only the drug manufacturers, and not against the PBMs.

- *Insulin Products Investigation.* In April 2017, the Company received a Civil Investigative Demand from the Attorney General of Washington, seeking documents and information regarding pricing and rebates for insulin products in connection with a pending investigation into unfair and deceptive acts or practice regarding insulin pricing. We have been notified by the Office of the Attorney General of Washington that information provided in response to the Civil Investigative Demand will be shared with the Attorneys General of California, Florida, Minnesota, New Mexico and the District of Columbia. In July 2017, the Company received a Civil Investigative Demand from the Attorney General of Minnesota, seeking documents and information regarding pricing and rebates for insulin and epinephrine products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin and epinephrine pricing.

- *Bewley,* et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed in May 2017 against the Company and other pharmacy benefit managers and manufacturers of glucagon kits (Bewley) and diabetes test strips (Prescott). Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws, and ERISA. These cases have both been transferred to the United States District Court for the District of New Jersey on defendants' motions. The Company is defending these lawsuits.

- *Klein* , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). In June 2017, a putative class action complaint was filed against the Company and other pharmacy benefit managers on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the pharmacy benefit managers are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPen through the process of negotiating increased rebates from EpiPen manufacturer, Mylan. The Company is defending this lawsuit.

- *Medicare Part D Civil Investigative Demand* . In May 2017, the United States Attorney's Office for the Southern District of New York issued a Civil Investigative Demand to the Company concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *Shareholder Matters.* In August and September 2017, four complaints were filed by putative derivative plaintiffs against certain officers and directors of the Company. Three of those actions, *Sherman v. Merlo,* et al., *Feghali v. Merlo,* et al., and *Banchalter v. Merlo,* et al., were filed in the U.S. District Court for the District of Rhode Island. A fourth, *Boron v. Bracken,* et al., was filed in Rhode Island Superior Court. These matters assert a variety of causes of action, including breach of fiduciary duty, waste of corporate assets, unjust enrichment, civil conspiracy and violation of Section 14(a) of the Exchange Act, and are premised on the allegation that the defendants approved business plans that exposed the Company to various litigations and investigations. The three federal matters have been stayed pending resolution of certain of the underlying matters, and the Company has filed a motion to stay the state court action.

- *MSP Recovery Claims Series, LLC* , et al. v. *CVS Health Corporation* , et al. (U.S. District Court for the Western District of Texas). In September 2017, a putative class action complaint was filed against the company, Express Scripts, Inc., and the manufacturers of insulin on behalf of assignees of claims of Medicare Advantage Organizations. Plaintiffs assert that the PBMs and manufacturers have engaged in a conspiracy whereby the PBMs sell access to their formularies by demanding the highest rebates, which in turn causes increased list prices for insulin. The plaintiffs assert claims on behalf of two putative classes: (1) all Medicare C payors and (2) all Medicare D payors. The complaint asserts claims under RICO, and for common law fraud and unjust enrichment.

The Company is also a party to other legal proceedings, government investigations, inquiries and audits, and has received and is cooperating with subpoenas or similar process from various governmental agencies requesting information, all arising in the normal course of its business, none of which is expected to be material to the Company. The Company can give no assurance, however, that its business, financial condition and results of operations will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to the Company's business, the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industries or to the health care industry generally; (iii) pending or future federal or state governmental investigations of the Company's business or the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or of the health care industry generally; (iv) pending or future government enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or the health care industry generally.

13 Segment Reporting

The Company currently has three reportable segments: Pharmacy Services, Retail/LTC and Corporate. The Retail/LTC Segment includes the operating results of the Company's Retail Pharmacy and LTC/RxCrossroads operating segments as the operations and economics characteristics are similar. The Company's segments maintain separate financial information for which operating results are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services and Retail/LTC segments' performance based on net revenue, gross profit and operating profit before the effect of nonrecurring charges and gains and certain intersegment activities. The Company evaluates the performance of its Corporate Segment based on operating expenses before the effect of nonrecurring charges and gains and certain intersegment activities. The chief operating decision maker does not use total assets by segment to make decisions regarding resources, therefore the total asset disclosure by segment has not been included. See Note 1 "Significant Accounting Policies" for a description of the Pharmacy Services, Retail/LTC and Corporate segments and related significant accounting policies.

In 2017, 2016 and 2015, approximately 12.3%, 11.7% and 10.0%, respectively, of the Company's consolidated net revenues were from Aetna, a Pharmacy Services Segment client. More than 99% of the Company's consolidated net revenues are earned in, and long-lived assets are located in the United States.

The following table is a reconciliation of the Company's business segments to the consolidated financial statements:

In millions	Pharmacy Services Segment [1][2]	Retail/LTC Segment [2]	Corporate Segment	Intersegment Eliminations [2]	Consolidated Totals
2017:					
Net revenues	$ 130,596	$ 79,398	$ —	$ (25,229)	$ 184,765
Gross profit [3]	6,040	23,317	—	(812)	28,545
Operating profit (loss) [4][5]	4,755	6,469	(966)	(741)	9,517
Depreciation and amortization	712	1,651	117	—	2,480
Additions to property and equipment	311	1,398	340	—	2,049
2016:					
Net revenues	119,963	81,100	—	(23,537)	$ 177,526
Gross profit [3]	5,901	23,738	—	(782)	28,857
Operating profit (loss) [4][5][6][7]	4,676	7,302	(891)	(721)	10,366
Depreciation and amortization	714	1,642	119	—	2,475
Additions to property and equipment	295	1,732	252	—	2,279
2015:					
Net revenues	100,363	72,007	—	(19,080)	$ 153,290
Gross profit	5,227	21,992	—	(691)	26,528
Operating profit (loss) [4][5][7]	3,992	7,146	(1,035)	(628)	9,475
Depreciation and amortization	654	1,336	102	—	2,092
Additions to property and equipment	359	1,883	125	—	2,367

(5) Net revenues of the Pharmacy Services Segment include approximately $10.8 billion, $10.5 billion and $8.9 billion of Retail Co-Payments for 2017, 2016 and 2015, respectively. See Note 1 "Significant Accounting Policies" to the consolidated financial statements for additional information about Retail Co-Payments.

(6) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services Segment and the Retail/LTC Segment. These occur in the following ways: when members of Pharmacy Services Segment clients ("members") fill prescriptions at the Company's retail pharmacies to purchase covered products, when members enrolled in programs such as Maintenance Choice ® elect to pick up maintenance prescriptions at one of the Company's retail pharmacies instead of receiving them through the mail, or when members have prescriptions filled at the Company's long-term care pharmacies. When these occur, both the Pharmacy Services and Retail/LTC segments record the revenues, gross profit and operating profit on a standalone basis.

(7) The Retail/LTC Segment gross profit for the years ended December 31, 2017 and 2016 includes $2 million and $46 million, respectively of acquisition-related integration costs. The integration costs in 2017 are related to the acquisition of Omnicare and the integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacies and clinics of Target.

(8) The Retail/LTC Segment operating profit for the year ended December 31, 2017 includes $215 million of charges associated with store closures and $181 million of goodwill impairment charges related to its RxCrossroads reporting unit. The Retail/LTC Segment operating profit for the year ended December 31, 2016 includes a $34 million asset impairment charge in connection with planned store closures in 2017 related to the Company's enterprise streamlining initiative. The Retail/LTC Segment operating profit for the years ended December 31, 2017, 2016 and 2015, include $34 million, $281 million and $64 million, respectively, of acquisition-related integration costs. The integration costs in 2017 are related to the acquisition of Omnicare and the integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacies and clinics of Target.

(9) The Corporate Segment operating loss for the year ended December 31, 2017 includes a $3 million reduction in integration costs for a change in estimate related to the acquisition of Omnicare. In addition, the Corporate Segment operating loss for the year ended December 31, 2017 includes $34 million in acquisition-related transaction costs related to the proposed Aetna acquisition and $9 million of transaction costs related to the divestiture of RxCrossroads. For the year ended December 31, 2016, the Corporate Segment operating loss includes $10 million of integration costs related to the acquisitions of Omnicare and the pharmacies and clinics of Target. For the year ended December 31, 2015, the Corporate Segment operating loss includes $156 million of acquisition-related transaction and integration costs related to the acquisitions of Omnicare and the pharmacies and clinics of Target. The Corporate Segment operating loss for 2015 also includes a $90 million charge related to a legacy lawsuit challenging the 1999 legal settlement by MedPartners of various securities class actions and a related derivative claim.

(10) The Pharmacy Services Segment operating profit for the year ended December 31, 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

(11) Amounts revised to reflect the adoption of ASU 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* , which increased consolidated operating profit by $28 and $21 million for the years ended December 31, 2016 and 2015, respectively.

14 Earnings Per Share

The following is a reconciliation of basic and diluted earnings per share from continuing operations for the years ended December 31:

In millions, except per share amounts	**2017**	**2016**	**2015**
Numerator for earnings per share calculation:			
Income from continuing operations	$ 6,631	$ 5,320	$ 5,230
Income allocated to participating securities	(24)	(27)	(26)
Net income attributable to noncontrolling interest	(1)	(2)	(2)
Income from continuing operations attributable to CVS Health	$ 6,606	$ 5,291	$ 5,202
Denominator for earnings per share calculation:			
Weighted average shares, basic	1,020	1,073	1,118
Effect of dilutive securities	4	6	8
Weighted average shares, diluted	1,024	1,079	1,126
Earnings per share from continuing operations:			
Basic	$ 6.48	$ 4.93	$ 4.65
Diluted	$ 6.45	$ 4.91	$ 4.62

15 Quarterly Financial Information (Unaudited)

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2017:					
Net revenues	$ 44,514	$ 45,685	$ 46,181	$ 48,385	$ 184,765
Gross profit	6,580	6,935	7,126	7,904	28,545
Operating profit	1,793	2,117	2,499	3,108	9,517
Income from continuing operations	962	1,097	1,285	3,287	6,631
Income (loss) from discontinued operations, net of tax	(9)	1	—	—	(8)
Net income attributable to CVS Health	952	1,098	1,285	3,287	6,622
Basic earnings per share:					
Income from continuing operations attributable to CVS Health	$ 0.93	$ 1.07	$ 1.26	$ 3.23	$ 6.48
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.23	$ 6.47
Diluted earnings per share:					
Income from continuing operations attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.22	$ 6.45
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.22	$ 6.44
Dividends per share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00
Stock price: (New York Stock Exchange)					
High	$ 83.92	$ 82.79	$ 83.31	$ 80.91	$ 83.92
Low	$ 74.80	$ 75.95	$ 75.35	$ 66.80	$ 66.80

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2016:					
Net revenues	$ 43,215	$ 43,725	$ 44,615	$ 45,971	$ 177,526
Gross profit	6,744	7,015	7,492	7,606	28,857
Operating profit	2,185	2,357	2,824	3,000	10,366
Income from continuing operations	1,147	924	1,542	1,707	5,320
Loss from discontinued operations, net of tax	—	—	(1)	—	(1)
Net income attributable to CVS Health	1,146	924	1,540	1,707	5,317
Basic earnings per share:					
Income from continuing operations attributable to CVS Health	$ 1.04	$ 0.86	$ 1.44	$ 1.60	$ 4.93
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income attributable to CVS Health	$ 1.04	$ 0.86	$ 1.44	$ 1.60	$ 4.93
Diluted earnings per share:					
Income from continuing operations attributable to CVS Health	$ 1.04	$ 0.86	$ 1.43	$ 1.59	$ 4.91
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income attributable to CVS Health	$ 1.04	$ 0.86	$ 1.43	$ 1.59	$ 4.90
Dividends per share	$ 0.425	$ 0.425	$ 0.425	$ 0.425	$ 1.70
Stock price: (New York Stock Exchange)					
High	$ 104.05	$ 106.10	$ 98.06	$ 88.80	$ 106.10
Low	$ 89.65	$ 93.21	$ 88.99	$ 73.53	$ 73.53

Five-Year Financial Summary

In millions, except per share amounts	2017	2016	2015	2014	2013
Statement of operations data:					
Net revenues	$ 184,765	$ 177,526	$ 153,290	$ 139,367	$ 126,761
Gross profit	28,545	28,857	26,528	25,367	23,783
Operating expenses [1]	19,028	18,491	17,053	16,545	15,713
Operating profit	9,517	10,366	9,475	8,822	8,070
Interest expense, net	1,041	1,058	838	600	509
Loss on early extinguishment of debt	—	643	—	521	—
Other expense [1]	208	28	21	23	33
Income tax provision	1,637	3,317	3,386	3,033	2,928
Income from continuing operations	6,631	5,320	5,230	4,645	4,600
Income (loss) from discontinued operations, net of tax	(8)	(1)	9	(1)	(8)
Net income	6,623	5,319	5,239	4,644	4,592
Net income attributable to noncontrolling interest	(1)	(2)	(2)	—	—
Net income attributable to CVS Health	$ 6,622	$ 5,317	$ 5,237	$ 4,644	$ 4,592
Per share data:					
Basic earnings per share:					
Income from continuing operations attributable to CVS Health	$ 6.48	$ 4.93	$ 4.65	$ 3.98	$ 3.78
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ 0.01	$ —	$ (0.01)
Net income attributable to CVS Health	$ 6.47	$ 4.93	$ 4.66	$ 3.98	$ 3.77
Diluted earnings per share:					
Income from continuing operations attributable to CVS Health	$ 6.45	$ 4.91	$ 4.62	$ 3.96	$ 3.75
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ 0.01	$ —	$ (0.01)
Net income attributable to CVS Health	$ 6.44	$ 4.90	$ 4.63	$ 3.96	$ 3.74
Cash dividends per share	$ 2.00	$ 1.70	$ 1.40	$ 1.10	$ 0.90
Balance sheet and other data:					
Total assets	$ 95,131	$ 94,462	$ 92,437	$ 73,202	$ 70,550
Long-term debt	$ 22,181	$ 25,615	$ 26,267	$ 11,630	$ 12,767
Total shareholders' equity	$ 37,695	$ 36,834	$ 37,203	$ 37,963	$ 37,938
Number of stores (at end of year)	9,846	9,750	9,681	7,866	7,702

(1) As of January 1, 2017, the Company adopted Accounting Standards Update ("ASU") 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* , which resulted in a retrospective reclassification of $28 million, $21 million, $23 million and $33 million of net benefit costs from operating expenses to other expense in the years ended December 31, 2016, 2015, 2014, and 2013, respectively.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2017 and 2016, the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2017, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Company at December 31, 2017 and 2016, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2017, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 14, 2018 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2007.

Boston, Massachusetts
February 14, 2018

Exhibit 21

SUBSIDIARIES OF THE REGISTRANT

As of December 31, 2017, CVS Health Corporation had the following significant subsidiaries:

Caremark, L.L.C. (a California limited liability company)
CaremarkPCS Health, L.L.C. (a Delaware limited liability company)
Caremark Rx, L.L.C. (a Delaware limited liability company) (1)
CVS Caremark Part D Services, L.L.C. (a Delaware limited liability company)
CVS Pharmacy, Inc. (a Rhode Island corporation) (2)
Omnicare, Inc. (a Delaware corporation) (3)
SilverScript Insurance Company (a Tennessee corporation)

(1) Caremark Rx, L.L.C., the parent of the Registrant's pharmacy services subsidiaries, is the immediate or indirect parent of many mail order, pharmacy benefit management, infusion, Medicare Part D, insurance, specialty mail and retail specialty pharmacy subsidiaries, all of which operate in the United States and its territories.

(2) CVS Pharmacy, Inc. is the immediate or indirect parent of approximately 60 entities that operate drugstores, all of which drugstores are in the United States and its territories except approximately 42 drugstores that are operated by Drogaria Onofre Ltda., a Brazil limited liability company that is an indirect subsidiary of CVS Pharmacy, Inc.

(3) Omnicare, Inc., the parent of the Registrant's long-term care subsidiaries, is the immediate or indirect parent of many long-term care and specialty subsidiaries, all of which operate in the United States and its territories.

Exhibit 23

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3ASR No. 333-217596) of CVS Health Corporation,

(2) Registration Statement (Form S-4 No 333-222412) of CVS Health Corporation, and

(3) Registration Statements (Form S-8 Nos. 333-49407, 333-34927, 333-28043, 333-91253, 333-63664, 333-139470, 333-141481, 333-167746, 333-208805, and 333-217853) of CVS Health Corporation;

of our reports dated February 14, 2018, with respect to the consolidated financial statements of CVS Health Corporation and the effectiveness of internal control over financial reporting of CVS Health Corporation incorporated by reference in this Annual Report (Form 10-K) of CVS Health Corporation for the year ended December 31, 2017.

Boston, Massachusetts
February 14, 2018

Exhibit 31.1

Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, Larry J. Merlo, President and Chief Executive Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;

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

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

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

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

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

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

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

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

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

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

Date: February 14, 2018

By: /s/ LARRY J. MERLO

Larry J. Merlo
President and
Chief Executive Officer

Exhibit 31.2

Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, David M. Denton, Executive Vice President and Chief Financial Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;

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

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

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

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

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

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

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

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

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

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

Date: February 14, 2018

By: /s/ DAVID M. DENTON

David M. Denton
Executive Vice President and Chief Financial Officer

Exhibit 32.1

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

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2017 (the "Report"), for the purpose of complying with Rule 13(a)-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Larry J. Merlo, President and Chief Executive Officer of the Company, certify that, to the best of my knowledge:

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

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

February 14, 2018

/ s / LARRY J. MERLO

Larry J. Merlo
President and
Chief Executive Officer

Exhibit 32.2

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

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2017 (the "Report"), for the purpose of complying with Rule 13(a)-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, David M. Denton, Executive Vice President and Chief Financial Officer of the Company, certify that, to the best of my knowledge:

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

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

February 14, 2018

/ s / DAVID M. DENTON

David M. Denton
Executive Vice President and Chief Financial Officer

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CVS Form 10-K 2018

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

FORM 10-K

☑ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2018
OR
☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from _____ to_____
Commission file number 001-01011

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☑ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☑ No

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☑ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

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

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). ☐ Yes ☑ No

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $65,262,991,789 as of June 30, 2018 , based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 19, 2019 , the registrant had 1,297,082,165 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Portions of the Annual Report to Stockholders for the fiscal year ended December 31, 2018 (the "Annual Report") are incorporated by reference in response to Items 1, 1A, 2 and 3 of Part I and Items 5, 6, 7, 7A, 8 and 9A of Part II, in each case to the extent described therein.

Information contained in the definitive proxy statement for CVS Health Corporation's 2019 Annual Meeting of Stockholders, to be filed on or about April 5, 2019 (the "Proxy Statement"), is incorporated by reference in response to Items 10 through 14 of Part III to the extent described therein.

TABLE OF CONTENTS

PART I

Item 1. Business

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45.0 billion of new debt, including senior notes and term loans. For additional information, see Note 2 ''Acquisition of Aetna'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

On October 10, 2018, the Company and Aetna entered into a consent decree with the United States Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. ("WellCare") for the divestiture of Aetna's standalone Medicare Part D prescription drug plans effective December 31, 2018. On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans. Aetna's standalone Medicare Part D prescription drug plans had an aggregate of approximately 2.3 million members as of December 31, 2018 . Aetna will provide administrative services to, and will retain the financial results of, the divested plans through 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

Business Strategy

The combined company expects to transform the consumer health care experience and build healthier communities through a new innovative health care model that is local, easier to use, less expensive and puts consumers at the center of their care. The Company believes that improving the consumer's health care experience will improve consumer engagement with their health which will lead to improved health outcomes and lower total health care costs. The Company believes there are three imperatives to accomplishing this transformation: be local, make it simple and improve health. These imperatives also guide the Company's five key strategies for delivering medical cost savings for its customers: improve common chronic disease management, reduce unnecessary hospital readmissions, improve the efficiency of the sites at which medical members receive care, optimize primary care delivery and improve the Company's complex chronic disease management capabilities.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care ("Managed Medicaid") plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges ("Private Exchanges" and together with Public Exchanges, "Insurance Exchanges"), other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2018, the Company's PBM filled or managed approximately 1.9 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow a plan member to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. Beginning in 2018, clients had new capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes CVS Pharmacy locations) and 27,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the United States Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. The Company is also able to build client-specific pharmacy networks and

managed pharmacy network solutions to further drive savings for clients. These include a performance-based pharmacy network with approximately 30,000 stores that is anchored by CVS Pharmacy and Walgreens, along with up to 10,000 independent pharmacies across the United States. The performance-based network is designed to deliver unit cost savings and to improve clinical outcomes in order to help to lower overall health care costs for participating payors and their members.

Mail Order Pharmacy Services
The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies via mail, telephone, fax, e-prescribing or the Internet, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. The Company's mail order dispensing pharmacies have been awarded Mail Order Pharmacy accreditation from Utilization Review Accreditation Commission ("URAC"), a health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. These specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies also have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's mail service specialty mail order pharmacies also have been accredited by the Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care programs and organizations in the United States.

Medicare Part D Services
The Company participates in the administration of the Medicare Part D prescription drug program through the provision of PBM services to those health plan clients and other clients that have qualified as a PDP or as a Medicare Advantage prescription drug plan and by offering Medicare Part D pharmacy benefits through its SilverScript subsidiary that is a PDP that has contracted with the United States Centers for Medicare & Medicaid Services ("CMS"). The Company also assists employer, union and other health plan clients that qualify for the retiree drug subsidy made available under Medicare Part D by collecting and submitting eligibility and/or drug cost data to CMS in order for such clients to obtain the subsidy and offers Medicare Part D pharmacy benefits to such clients' retirees through Employer Group Waiver Plans ("EGWPs") sponsored by SilverScript.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes, and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address the opioid epidemic, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy; limits the daily dosage of opioids dispensed based on the strength of the opioid; and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with health care providers ("providers") and other third parties. The Company's integrated disease management programs cover diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis. The majority of these integrated programs are accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations.

Medical Benefit Management
The Company's NovoLogix ® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Pharmacy Services Information Systems

The majority of the Pharmacy Services segment's clients have migrated to a single claim adjudication platform. This platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine ® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serve an essential role in cost management and health improvement. This capability transforms pharmacy data into actionable interventions at key points of care such as mail and specialty pharmacists to help provide quality care.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on public and private health insurance exchanges, other sponsors of health benefit plans and individuals located throughout the United States. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenue is generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients. In 2018 , 2017 and 2016 , revenues from Aetna accounted for approximately 9.8% , 12.3% and 11.7% , respectively, of the Company's consolidated total revenues. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, revenues from Aetna will continue to be reported in the Pharmacy Services segment; however, these revenues are eliminated in the consolidated financial statements.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature. However, quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of PDP membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in employers or other entities that sponsor the Company's products ("plan sponsors") sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating income generally increases as the year progresses.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors (e.g., the Express Scripts business of Cigna Corporation, OptumRx, Prime Therapeutics, MedImpact and Humana) offering PBM services, including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic ® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, the Retail/LTC segment also provided commercialization services under the name RxCrossroads ®. The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, the Retail/LTC segment operated more than 9,900 retail locations, over 1,100 MinuteClinic ® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2018, the Retail/LTC segment filled approximately 1.3 billion prescriptions

on a 30-day equivalent basis. In December 2018, the Company held approximately 26% of the United States retail pharmacy market.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, beauty products, cosmetics and personal care products. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. The Company's MinuteClinics offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2018	**2017**	**2016**
Pharmacy [(1)]	76.4%	75.0%	75.0%
Front store and other [(2)]	23.6%	25.0%	25.0%
	100.0%	100.0%	100.0%

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation stores.
(2) "Other" represents less than 5% of the "Front store and other" revenue category.

Pharmacy
Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2018 , 2017 and 2016 . The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare ® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best customers by providing them with automatic sale prices, customized coupons, ExtraBucks ® rewards and other benefits. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 7,000 CVS Health and proprietary brand products, which accounted for approximately 23% of front store revenues during 2018 .

MinuteClinic
As of December 31, 2018 , the Company operated approximately 1,100 MinuteClinic ® locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. As a result, visits paid for by employers, health insurers or other third parties accounted for approximately 91% of MinuteClinic's total revenues in 2018 . MinuteClinic is collaborating with the Pharmacy Services and Health Care Benefits segments to help meet the needs of CVS Caremark's client plan members and the Company's health plan members by offering programs that can improve member health and lower costs.

MinuteClinic is now affiliated with more than 75 major health systems and continues to build a platform that supports primary care.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Onsite Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Retail Store Development

The addition of new retail locations has played, and will continue to play, a key role in the Company's continued growth and success. The Company's store development program focuses on three areas: entering new markets, adding stores within existing markets and relocating stores to more convenient sites. During 2018 , the Company opened 145 new retail locations, relocated approximately 35 stores and closed approximately 30 locations. During the last five years, the Company opened approximately 900 new and relocated locations, and acquired approximately 1,825 locations, including the pharmacies acquired from Target Corporation ("Target") in 2015. The Company believes that continuing to grow its store base appropriately and locate retail stores in more accessible markets are essential components of competing effectively in the current health care environment. As a result, the Company believes that its store development program is an integral part of its ability to meet the needs of customers and maintain its leadership position in the retail pharmacy market given the changing health care landscape.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances the customer experience, as well as providing a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. The Health Engagement Engine technology and proprietary clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview ® , improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Pharmacy benefit managers, managed care organizations, government funded health care programs, commercial employers and other third party payors accounted for 99.5% of the Retail/LTC segment's pharmacy revenues. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2018 , 2017 or 2016 .

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and results of operations.

Retail/LTC Competition

The retail drugstore business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the markets it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Wal-Mart), independent pharmacies, restrictive pharmacy networks, membership clubs, Internet companies, and retail health clinics (including urgent care centers), as well as mail order dispersing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018 . The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology ("HIT") products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, governmental units, government-sponsored plans, labor groups and expatriates.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical* : The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under this product, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.
- *Government Medical* : In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:
    - *Medicare Advantage and PDP:* Through annual contracts with CMS, the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 1,317 counties in 40 states and Washington, D.C. in 2018 . The Company has expanded to 1,416 counties in 45 states and Washington, D.C. for 2019 . The Company is a national provider of drug benefits under the Medicare Part D prescription drug program to both individuals and EGWPs. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive

coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. On November 30, 2018, Aetna completed the sale of all of its standalone Medicare Part D prescription drug plans to WellCare effective on December 31, 2018. Aetna will provide administrative services to, and retain the financial results of, the divested plans through 2019. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.

- *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2018 .
- *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2018 .
- *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs. During 2018 , the Company offered services on an Insured basis to Duals in four states under demonstration projects.

- *Pharmacy* : The Company offers PBM services and specialty and home delivery pharmacy services. The Company also performs various PBM services for Aetna pharmacy customers consisting of: product development, Commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs. The Pharmacy Services segment performs the administration of selected functions for retail pharmacy network contracting and claims administration; home delivery and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services. Other suppliers also provide certain PBM services.
- *Specialty* : The Health Care Benefits segment has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products and workers' compensation administrative services.
- *Consumer Health Products and Services* : The Company has a portfolio of products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and enable enhanced delivery to and experience for customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization of medical services and the provision of data to providers to enable them to improve health care quality. At December 31, 2018 , the Company's underlying nationwide provider network had approximately 1.3 million participating providers, including over 697 thousand primary care and specialist physicians and approximately 5,700 hospitals. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the NCQA. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company (“ALIC”), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2018 , all of the Company’s Commercial HMO and all of ALIC’s PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company’s provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization (“CVO”) certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company’s networks begin with the initial review of health care practitioners. Practitioners’ licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner’s affiliated group or organization. The Company generally requires participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end to end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in digital products to offer innovative solutions and a seamless experience to the Company’s members through mobile and web channels. Capabilities available to members include digital wallet, provider search, cost transparency and behavioral monitoring. The Health Care Benefits segment care management solution supports the Company’s clinicians with data and recommendations. The Company continues to scale its clinical platform and its local personalized care model. The Company aims to build an integrated 360 degree view of the member to ensure that it can guide them through their healthcare journey and provide them a high level of service. Through its analytics platform the Company is beginning to harness the power of data to help drive healthier outcomes and proactive care and enable consumers to take the next best action for their health.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. See Note 17 ‘‘Segment Reporting’’ contained in the “Notes to Consolidated Financial Statements” in the Annual Report, which is incorporated by reference herein, for additional information on foreign customers. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by United States and other geographic region and funding arrangement at December 31, 2018 :

In thousands	**Insured**	**ASC**	**Total**
Northeast	1,961	3,232	5,193
Southeast	1,752	2,886	4,638
Mid-America	1,632	2,530	4,162
West	1,618	4,510	6,128
Other	587	1,393	1,980
Total medical membership	7,550	14,551	22,101

For additional information on medical membership, see the caption “Management’s Discussion and Analysis of Financial Condition and Results of Operations — Health Care Benefits Segment” in the Annual Report, which section is incorporated by reference herein.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through the Company's sales personnel; through independent brokers, agents and consultants who assist in the production and servicing of business; and Private Exchanges. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The United States federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals, federal employee-related benefit programs and Medicaid products and services. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. For additional information, see Note 17 ''Segment Reporting'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future results of operations could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed capitation payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some of Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial Medical products, Medicare contracts generate higher per member per month revenues and health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released 2019

star ratings in October 2018. The 2019 star ratings will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on membership at December 31, 2018 , 79% of the Company's Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy called the Health Insurer Fee (the "HIF"). In December 2015, the Consolidated Appropriation Act was enacted, which included a one year suspension of the HIF for 2017. In January 2018, the HIF was suspended for 2019. For additional information on the ACA fees, assessments and taxes, see Note 1 ''Significant Accounting Policies'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein. The Company's goal is to collect in premiums and fees where possible, or solve for all of these ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

The majority of Health Care Benefits segment revenues are not seasonal in nature. However, the Health Care Benefits segment's quarterly operating income progression is impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses which are generally the highest during the fourth quarter due to increased marketing spending associated with Medicare annual enrollment. As a result, the Health Care Benefits segment's operating income generally is the highest in the first quarter of the year and lowest in the fourth quarter of the year.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Public and Private Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks currently faced from new entrants and disruptive actions by existing competitors compared to prior periods. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of

provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The Health Care Benefits segment's international products compete with local, global and United States based health plans and commercial health care benefit insurance companies, many of whom have a longer operating history and better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. (“Cardinal”) each have a 50% ownership in Red Oak Sourcing, LLC (“Red Oak”), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on the Company’s working capital practices, see the caption “Management’s Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources” in the Annual Report, which section is incorporated by reference herein. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company’s consolidated pharmacy revenues, typically settle in less than 30 days. With the exception of the Medicare Part D services, described further below, the remainder of the Company’s consolidated pharmacy revenues are paid in cash, or with debit or credit cards. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters which impacts working capital from year to year.

Colleague Development

As of December 31, 2018 , the Company employed approximately 295,000 colleagues in 50 states, the District of Columbia, Puerto Rico and a number of countries outside the United States. To deliver the highest levels of service to customers, the Company devotes considerable time and attention to its people and service standards. The Company emphasizes attracting and training knowledgeable, friendly and helpful associates to work in the organization.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company’s proprietary rights. The Company regards its intellectual property as having significant value in the Pharmacy Services, Retail/LTC and Health Care Benefits segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company’s operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry’s business and reporting practices. In addition, many of the Company’s PBM clients and the Company’s payors in the Retail/LTC Segment, including insurers, Medicare Part D plans, Managed Medicaid plans and managed care organizations (“MCOs”), are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company’s LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company’s businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company’s businesses creates areas of uncertainty. Further, there are numerous proposed health care laws and regulations at the federal, state and international levels, some of which could adversely affect the Company’s businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or

court proceedings, including future United States Congressional appropriations, will change various aspects of the industries in which it operates or the health care industry generally or the impact those changes will have on the Company's businesses, results of operations and/or cash flows, but the effects could be materially adverse. Any failure or alleged failure to comply with applicable laws and regulations as summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's results of operations, financial condition and/or cash flows. See Item 3, "Legal Proceedings" for further information.

The Company cannot give any assurances that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that it will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in other pending or future legal proceedings against the Company or affecting one or more of the industries in which it operates and/or the health care industry generally.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims for reimbursement by Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute, state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the federal anti-kickback statute.

Both federal and state false claims laws permit private individuals to file qui tam or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The ACA made broad-based changes to the United States health care system. If the ACA is not further amended, repealed or replaced, certain of its components will continue to be phased in until 2022. While the Company anticipates continued efforts in 2019 and beyond to invalidate, modify, repeal or replace the ACA, the Company expects aspects of the ACA to continue to significantly impact its business operations and results of operations, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, regulations and guidance as well as ongoing litigation. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing federal and state budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. For example, if any elements of the ACA are invalidated or repealed at the federal level, the Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements the Company and other health plans are paid by the federal government for Medicare members, among other sources. While not all-inclusive, the following are some of the key provisions of the ACA (assuming it continues to be implemented in its current form) that become effective on or after January 1, 2019. The Company continues to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on its business operations and results of operations:

- The imposition on the Company and other health insurers, health plans and other market participants of significant fees, assessments and taxes, including an annual non-tax deductible industry-wide HIF that was $14.3 billion for 2018 and has been suspended for 2019. As currently enacted, the HIF will apply for 2020, be higher for 2020 than for 2018 and increase in 2021 and annually thereafter.
- A non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold beginning in 2022.
- Reduced funding for Medicaid expansion, which began in 2017.

The ACA also specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in Commercial benefit designs, limits Commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and significantly increases federal and state oversight of health plans, including regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of congressional and state level elections, the December 2018 U.S. District Court decision invalidating the ACA and other pending litigation challenging aspects of the law or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. The pending litigation challenging the ACA includes challenges by various states of the federal government's decision to curtail payments related to the Cost-Sharing Subsidy Program. The time frame for conclusion and final outcome and ultimate impact of this litigation are uncertain. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to the ACA. It is reasonably possible that invalidation, repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's businesses, results of operations and cash flows.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company expects to further expand its Medicare service area and products in 2019 and is seeking to substantially grow its Medicare membership, revenue and results of operations over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, since the 2014 contract year, the ACA has required minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage contract pays rebates for five consecutive years, it will be terminated by CMS.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the Office of Inspector General ("OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes

that result from enforcement or audit actions, could materially affect the fairness of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level.

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS currently conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012, CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. The Company is evaluating the potential adverse effect, which could be material, on the Company's results of operations, financial condition, and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' results of operations in 2019 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2019 star ratings in October 2018. The Company's 2019 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on the Company's membership at December 31, 2018, 79% of its Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars. CMS will release updated stars ratings in October 2019 that will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2021. CMS also gives PDPs star ratings which affect PDP's enrollment and result in contract termination if the PDP is rated less than three stars for three consecutive years. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in maintaining high star ratings and other quality measures for 2019 and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Overall, the Company projects the benchmark payment rates in CMS's April 2018 final notice detailing final Medicare Advantage benchmark payment rates for 2019 (the "Final Notice") will increase funding for the Company's Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments received and will receive in the near term are adequate to justify

the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the United States Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDP, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' role. It is not possible to predict the outcome of this Congressional or regulatory activity, any of which could adversely affect the Company.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a PBM or Health Care Benefits segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, health care providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires us and other covered entities to report any breaches of PHI to impacted individuals and to the United States Department of Health and Human Services ("HHS") and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public

personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency. States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company's businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, Public Exchanges are required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-Public Exchange entities, which include insurers offering plans through the Public Exchanges and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act, the Consumer Product Safety Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company's direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the California Consumer Privacy Act will become effective in 2020, and the Company expects additional federal and state regulation of consumer privacy protection to be enacted in 2019. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other healthcare professionals; registration of facilities with the United States Drug Enforcement Administration ("DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the United States Food and Drug Administration ("FDA"), the Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies, with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the United States Department of Justice, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular

basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to recent and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital, or "RBC", requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2018, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as the Company's parent company, CVS Health Corporation) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, Medicare Part D prescription drug plans, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's stores, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws

and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with United States Department of Labor ("DOL") regulations, the Company may have ERISA fiduciary duties with respect to PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts.

Other Legislative Initiatives and Regulatory Initiatives - The United States federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Significant uncertainty remains as to whether and how the United States Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or results of operations, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and results of operations.
- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.
- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:
    - Elimination of the payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. In January 2019, HHS proposed regulations that would exclude such rebates from the safe harbor that currently is available for such payments under the federal anti-kickback statute.
    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefits plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to configure its health plan and retail pharmacy networks; and restricting or eliminating the use of certain drug pricing methodologies.
    - Increased federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.

- Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).
- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
- Mandating coverage by the Company and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (for example, high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
- Regulating electronic connectivity.
- Mandating or regulating the disclosure of provider fee schedules and other data about the Company's payments to providers.
- Mandating or regulating disclosure of provider outcome and/or efficiency information.
- Prescribing or limiting members' financial responsibility for health care or other covered services they utilize.
- Assessing the medical device status of HIT products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.
- Imposing payment levels for services rendered to the Company's members by providers who do not have contracts with the Company.
- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
- Amending or supplementing ERISA to impose greater requirements on PBMs, the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its results of operations or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the United States Department of the Treasury and the Internal Revenue Service.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage, and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these agreements are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the

OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Disease Management Services Regulation - The Company provides disease management programs to health plan and PBM plan members for complex medical conditions and arranges for those members to receive disease management programs for common medical conditions. State laws regulate the practice of medicine, the practice of pharmacy and the practice of nursing. Clinicians engaged in a professional practice in connection with the provision of disease management services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company currently has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company is taking steps to be able to continue to serve customers in the European Economic Area following the United Kingdom's pending exit from the EU ("Brexit"). However, the impact of Brexit on the Company's international business and results of operations is uncertain.

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of the Company's operations into foreign countries increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of United States law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the United States Securities and Exchange Commission (the "SEC") and the DOJ have increased their enforcement activities with respect to the FCPA. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. The Company has internal control policies and procedures and conducts training and compliance programs for its employees to deter prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its international operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their

compliance with the regulations. The Company also may be subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by OFAC. OFAC administers and enforces economic and trade sanctions based on United States foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company may be subject to similar regulations in the non-U.S. jurisdictions in which it operates.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation seeking to regulate PBM activities in a comprehensive manner has been introduced or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to them and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and federal and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWPs") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); disclosure of data to third parties; drug utilization management practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's results of operations and/or cash flows.

PDPs and the Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in several states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a few states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits.

Pharmacy Pricing Legislation - Several states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, networks and other plan design features on behalf of its insurer, MCO and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

FDA Regulation - The FDA generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, medical devices (including mobile medical devices), cosmetics, dietary supplements and certain food items. The FDA regulates the Company's activities as a distributor of store brand products.

Retail Clinics - States regulate retail clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations governing the practice of optometry, the practice of audiology, the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses, hearing aids and alcohol.

Laws and Regulations Related to the Health Care Benefits Segment

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In

addition, some of the Company's businesses and related activities may be subject to PPO, managed care organization, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies and state boards of pharmacy have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;
- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company's ability to price for the risk it assumes, which could adversely affect its MBRs and results of operations, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company's projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing its various restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can

earn in its Insured Commercial business while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested significant increases in its premium rates in its Commercial small group Health Care Benefits business for 2019 and expects to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products, which the Company expects to continue and potentially worsen in 2019. These significant rate increases heighten the risks of adverse public and regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage. In addition, HHS' rules on rates impose additional public disclosure requirements on any rate filings that exceed the "reasonableness" threshold and require additional review of those rates.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

Since 2017, Managed Medicaid products, including those the Company offers, are subject to a minimum MLR of 85%. A Medicaid managed care quality rating system and provider network adequacy requirements also apply to Medicaid products. Because the minimum MLR is structured as a "floor", states have the latitude to enact more stringent rules governing these various restrictions. For Managed Medicaid products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

The impact of Medicaid expansion under the ACA is uncertain. The future of the ACA is uncertain, and states may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, a number of states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2019 and beyond, including the possibility of converting federal Medicaid support to block grants and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation may adversely affect Medicaid payment rates, the Company's revenues and its Medicaid membership in those states.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (for example, when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS

contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or results of operations, but the effects could be materially adverse.

State Workers' Compensation Laws - The Company's workers' compensation business includes the comparison of medical claims data against the applicable state's fee schedule pricing, including applicable regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. The Company's workers' compensation business also includes PBM and care management services, both of which are regulated at the state level. The Company's workers' compensation customers include insurance carriers and TPAs who also are regulated at the state level. The laws and regulations applicable to the Company and other participants in the workers' compensation business are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its workers' compensation compliance efforts will continue to require significant resources. The Company may be subject to significant fines, penalties and litigation if it fails to comply with those laws and regulations.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to its health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. The Company's common stock is listed on the New York Stock

Exchange under the trading symbol “CVS.” General information about CVS Health is available through the Company’s website at *http://www.cvshealth.com* . The Company’s financial press releases and filings with the SEC are available free of charge within the Investors section of the Company’s website at *http://www.cvshealth.com/investors* . In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company’s website is neither a part of nor incorporated by reference in this Annual Report on Form 10-K or any of the Company’s other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under Regulation FD, CVS Health Corporation (the “Registrant”) hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (http://investors.cvshealth.com/) and its Twitter feed (@CVSHealthIR) to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

Item 1A. Risk Factors

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this Annual Report on Form 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this Annual Report on Form 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, these events or circumstances could have a material adverse effect on our businesses, results of operations, cash flows and/or financial condition. In that case, our stock price could decline materially, among other effects on us. You should read the following section in conjunction with “Management’s Discussion and Analysis of Financial Condition and Results of Operations” (which includes our “Cautionary Statement Concerning Forward-Looking Statements” at the end of such section) in the Annual Report, which is incorporated by reference herein, and our consolidated financial statements and the related notes.

Overarching Risks

Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.

We expect to face significant business challenges and uncertainties in 2019. Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond. There can be no assurance regarding our ability to avoid harm to our brand and reputation, our ability to manage the risks inherent in the Aetna Acquisition or our data governance risks, our ability to manage and align our talent to our business needs or our ability to manage the risks presented by changes in public policy, laws or regulations. In addition, there can be no assurance that the Aetna Acquisition, United States government fiscal policy, changes to the United States health care system (including changes to the ACA, to drug reimbursement and/or drug pricing laws and regulations and/or to laws and regulations governing PBMs’ interactions with government funded health care programs) or other unanticipated risks will not require us to revise the ways in which we conduct business, put us at risk of loss of business or materially adversely affect our businesses, cash flows, financial condition or results of operations.

Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.

Reputational risk is inherent in many of the risks we face. The industries in which we operate regularly are negatively perceived by the public and subject to negative publicity, including as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, government involvement in drug pricing and purchasing, PBMs and the future of the ACA, governmental hearings and/or investigations and actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing, insurance coverage determinations and social media and other media relations activities). This risk may be increased as the federal government continues to consider increased involvement in drug reimbursement, pricing and/or purchasing and changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, and as states seek to maintain, replace or repeal elements of the ACA such as Public Exchanges and Medicaid expansion within increasingly challenging budget constraints. This risk also may be increased as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers. Significant reductions or interruptions in funding for government health programs we serve also may lead us to reduce our exposure to these programs, which could adversely affect our brand and reputation.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our results of operations and our stock price by:

- Adversely affecting our brand and reputation;
- Adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- Requiring us to change our products and/or services;
- Reducing or restricting the compensation we can receive for our products and/or services; and/or
- Increasing or significantly changing the regulatory and legislative requirements with which we must comply.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member, customer or other constituent information, whether by us, by one of our vendors or by another third party, could require us to expend significant resources to remediate any damage, interrupt our operations and damage our brand and reputation, and could also result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, results of operations and cash flows.

Our businesses depend on our customers' and members' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our members', customers' and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and results of operations and also can and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings,

material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, cash flows, results of operations or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased salaries or other benefits. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses and results of operations.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses and results of operations. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and results of operations could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing and/or purchasing, increased regulation of PBMs, changes to Medicare, Medicaid or the regulatory environment for health care benefits, including the ACA, changes to drug reimbursement and/or pricing laws and regulations, changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changes to immigration policies and/or many other public policy initiatives. For example, in January 2019, HHS proposed regulations that would exclude from the current safe harbor under the federal anti-kickback statute manufacturer's rebates on prescription drugs paid to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of United States Presidential Executive Orders). Other significant changes to health care system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries are also possible and could adversely affect us. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not do so as effectively as our competitors, our businesses, operations and results of operations may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Potential modification to the ACA, including changes in enforcement and/or funding that further destabilize the Public Exchanges, as well as significant changes to Medicaid funding could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to federal health care laws, including the ACA, drug reimbursement and pricing laws and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care legislation, future changes to the ACA or the implementation or failure to implement the outstanding provisions of ACA, may have on our retail pharmacy, LTC pharmacy, specialty pharmacy, pharmacy services and/or Health Care Benefits operations and/or results of operations. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs.

In addition, much of the branded and generic drug product that we sell in our retail, mail and specialty pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material

adverse effect on our businesses, cash flows and results of operations. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in United States trade regulations, could adversely affect our businesses.

We cannot predict the enactment or content of new legislation and regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or results of operations, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we operate. Examples of such change include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing and/or purchasing, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence. For more information on these matters, see "Government Regulation" included in Item 1 of this Annual Report on Form 10-K.

Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.

Our strategy includes effectively investing our capital and human resources in appropriate strategic projects, current operations and acquisitions to transform our businesses in response to the changing dynamics in the industries in which we operate. Our strategic projects include, among other things: integrating the Aetna Acquisition; significant investments in human and technology resources to expand our consumer-oriented products and services; optimizing our business platforms; managing certain significant technology projects; further improving relations with manufacturers, suppliers and health care providers; negotiating contract changes with customers, manufacturers, suppliers and health care providers and implementing other business process improvements. Implementing our strategic initiatives will require significant investments of capital and human resources. Among other things, we will need to simultaneously acquire and develop new personnel, products and systems to serve existing and new customers with existing and new products and to enhance our existing customer service, information technology, control and compliance processes and systems. The future performance of our businesses will depend in large part on our ability to design and implement our strategic initiatives, some of which will occur over several years. If these initiatives do not achieve their objectives, our results of operations could be adversely affected.

Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, and we may fail to recognize and position ourselves to capitalize upon market opportunities. We may not have sufficient advance notice and resources to develop and effectively implement an alternative strategy. If our existing competitors and/or new entrants (whether vertical, horizontal or online/digital/e-commerce) into one or more of our businesses create new disruptive business models and/or develop new offerings that customers, members and/or health care providers prefer to our offerings, we may lose customers, members and/or providers, and our results of operations, cash flows and/or prospects may be adversely affected. In addition, our results of operations, cash flows and/or prospects may be adversely affected by consolidation among the participants in the industries in which we operate and/or our customer base. Our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

Risks Related to Our Businesses

Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.

The continued efforts of HMOs, MCOs, PBMs, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, as well as litigation and other legal proceedings relating to how drugs are priced, may adversely affect our profitability. In particular, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail, specialty, LTC and mail order pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Historically, the effect of this trend on generic profitability has been mitigated by the introduction of new multi-source generic drugs as well as inflation on brand name drugs and by our efforts to negotiate reduced acquisition costs of generic drugs with manufacturers. However, in recent years, there has been significant consolidation within the generic manufacturing industry and in 2019 we expect fewer new multi-source generic drugs to be introduced and lower brand name drug inflation than in recent prior years, and it is possible that these and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced acquisition costs. Any inability to offset increased brand name or

generic prescription drug costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our results of operations.

In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and audits at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are continuing at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices. For example, we anticipate that federal and state governments will continue to review and assess alternative health care delivery systems, payment methodologies and operational requirements for health care providers, including LTC facilities and pharmacies, and participants in government funded health care programs. A change in the composition of pharmacy prescription volume toward programs offering lower reimbursement rates could adversely affect our profitability. Any action taken to repeal or replace all or significant parts of ACA also could adversely affect our profitability, though it is unclear at this time what the full effects of any such changes would be.

The ACA made several significant changes to Medicaid rebates and to reimbursement rates. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for generic drugs. This change has adversely affected the reimbursements we receive when we dispense prescription drugs to Medicaid recipients. In addition, the ACA made other changes that affect the coverage and plan designs that are or will be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum MLR to avoid having to pay rebates to enrollees. These ACA changes may not affect our businesses directly, but they could indirectly impact our services, business practices and/or results of operations.

Gross margins in the industries in which we operate may decline.

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, enhanced service offerings and/or higher service levels. In that regard, we maintain contractual relationships with generic drug manufacturers and brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our businesses and results of operations could be adversely affected. Further, competitive pressures in the PBM industry have resulted in our clients sharing in a larger portion of rebates and/or discounts received from drug manufacturers. Marketplace dynamics and regulatory changes also have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could adversely affect our future profitability, and we expect these trends to continue. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs, drug pricing or purchasing, patent term extensions, purchase discount and/or rebate arrangements with drug manufacturers, or additional regulation of PBMs, formulary management or other PBM services could also reduce the discounts or rebates we receive. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, could adversely affect our profitability.

Our retail pharmacy, specialty pharmacy and LTC pharmacy operations also have been affected by the margin pressures described above, including client demands for lower prices, generic pricing and network reimbursement pressure. In addition, as competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in general pricing pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive. A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions. Finally, the margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements. These actions could also adversely affect the margins of our LTC business.

Our results of operations are affected by the health of the economy in general and in the geographies we serve.

Our businesses are affected by the United States economy and consumer confidence in general and in the geographies we serve, including various economic factors, inflation and changes in consumer purchasing power, preferences and/or spending patterns. It is possible that an unfavorable, uncertain or volatile economic environment will cause a decline in drug utilization, an increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores. Further, economic conditions including interest rate fluctuations, changes in capital market conditions and

regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms and our ability to execute sale-leaseback transactions under acceptable terms. Adverse changes in the United States economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results. This adverse effect could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

In addition, our Health Care Benefits membership remains concentrated in certain geographic areas in the United States and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits results of operations. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the United States geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenue and results of operations may be disproportionately affected by adverse changes affecting our customers.

We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.

Each of our businesses currently operates in a highly competitive and evolving business environment. We must compete successfully with existing competitors and new entrants, including strategic alliances and online, digital and e-commerce companies.

The competitive success of our retail pharmacy business, as well as our specialty pharmacy operations with third-party payors, is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. As a pharmacy retail business, we compete with other drugstore chains, supermarkets, online and other discount retailers, independent pharmacies, membership clubs, convenience stores and mass merchants, some of which are aggressively expanding into markets we serve. We also face competition from other retail health care clinics, as well as other mail order pharmacies and PBMs. Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such changes and make timely and effective changes to our strategies and business model to compete effectively. Competition may also come from other sources in the future. Changes in market dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks, could materially and adversely affect our businesses, results of operations, cash flows and prospects.

We also could be adversely affected if we fail to identify or effectively respond to changes in market dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the United States, a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy operations focus on complex and high-cost medications that serve a relatively limited universe of patients, the future growth of this business depends to a significant extent upon expanding our ability to access key drugs and successfully penetrate key treatment categories.

The competitive success of our LTC pharmacy operations is dependent upon our ability to compete in each geographic region where we have operations. In the geographic regions we serve, we compete with PharMerica, our largest LTC pharmacy competitor, as well as with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Our LTC pharmacy customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. One of our growth opportunities is to increase our penetration rate in the assisted living segment, where residents can choose which pharmacy will provide them with prescription drugs. The ability of a resident of an assisted living facility to select the pharmacy that supplies him or her with prescription drugs could adversely affect our business, financial condition and results of operations because there can be no assurance that such resident will select us.

The competitive success of our pharmacy services business is impacted by its ability to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. Competitors in the PBM industry (e.g., the Express Scripts business of Cigna Corporation,

OptumRx, Prime Therapeutics, MedImpact and Humana), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Competition also may come from other sources in the future. In addition, changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could adversely affect our claims volume and/or our competitiveness generally.

Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and results of operations. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and results of operations, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy. These actions may adversely affect our membership, revenues and results of operations

Competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. For example, strong competition in the PBM marketplace has generated greater client demand for lower pricing, increased revenue sharing and enhanced product and service offerings. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings, particularly in a rapidly changing health care industry, we may be unable to remain competitive.

We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM's client base typically is subject to renewal each year. In some cases, however, PBM clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Our clients are generally well informed and organized, can move between our competitors and often seek competing bids prior to expiration of their contracts. In addition, the reputational impact of a service-related incident could adversely affect our businesses. These factors, together with the impact of competitive pressures, could make it difficult for us to attract new clients, retain existing clients and cross-sell additional products and/or services. Further, the PBM industry has been affected by consolidation activity that may continue in the future. If one or more of our PBM clients is acquired by an entity that is not also our client, we may be unable to retain all or a portion of the acquired client's business. These circumstances, either individually or in the aggregate, could result in an adverse effect on our businesses and financial results. Therefore, we continually face challenges in competing for new PBM business and retaining or renewing our existing PBM business. With respect to our LTC pharmacy business, reimbursement from skilled nursing facilities for prescriptions we dispense is determined pursuant to our agreements with those skilled nursing facilities. The termination of these agreements generally terminates our ability to provide services to any of the residents of that facility, resulting in the loss of revenue from any source for those residents. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to us as the present terms.

Additionally, with respect to our retail and LTC pharmacy businesses, reimbursement under Medicare Part D, as well as reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their PBM representatives. The loss of those agreements, or a material change in the terms of those agreements, could adversely affect our results of operations and cash flows. In addition, restricted networks that exclude our retail or specialty pharmacies adversely affect those businesses.

The health care and related benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the marketplace. Our Health Care Benefits segment faces significant competition in all of the geographies and product areas in which it operates. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the

increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods.

Our Health Care Benefits segment competes on the basis of many factors, including perceived overall quality, quality of service, comprehensiveness of coverage, cost (including premium, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, providers available in such networks, and quality of member support and care management programs. Our Health Care Benefits segment's competitors include, among others, UnitedHealth Group Incorporated, Anthem, Inc., Humana Inc., Cigna Corporation, WellCare Health Plans, Inc., Centene Corporation, Molina Healthcare, Inc., Kaiser Permanente, health system owned health plans and new entrants into the marketplace, and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The Health Care Benefits segment's largest competitor in its Medicare products is Original Medicare. Additional competitors in this segment's businesses include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), TPAs, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefit plans, provider-owned health plans, new joint ventures (including for-profit and not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. In particular geographies, competitors may have greater capabilities, resources or membership; a more established reputation; superior supplier or health care professional pricing and contract terms; better business relationships; or other factors that give such competitors a competitive advantage. The Health Care Benefits segment competes for sales on Insurance Exchanges and is developing and expanding its Consumer Health Products and Services product and service offerings, where we face additional risks from existing and new competitors (including our vendors) who have lower cost structures, greater experience marketing to consumers and/or who target the higher margin portions of our business. Among the Health Care Benefits segment's international and HIT competitors, many have longer operating histories, better brand recognition and greater market presence in many of the areas in which the segment is seeking to expand and more experience at rapidly innovating products.

There can be no assurance that the Aetna Acquisition will not adversely affect any of our segments' respective abilities to attract new clients or retain existing clients or our ability to cross-sell additional products and/or services within any segment or between segments. If we do not compete effectively in the geographies and product areas in which we operate, our businesses, results of operations, financial condition and cash flows could be materially and adversely affected.

We are exposed to risks relating to the solvency of our customers and of other insurers.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, financial condition and results of operations. In addition, both state and federal government sponsored payers, as a result of budget deficits or reductions, may suspend payments or seek to reduce their healthcare expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us. Any delay or reduction in payments by such government sponsored payers may adversely affect our businesses, financial condition and results of operations.

We are subject to assessments under guaranty fund laws for obligations of insolvent insurance companies (such as the discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for Penn Treaty Network America Insurance Company and one of its subsidiaries that Aetna recorded in the first quarter of 2017), HMOs, ACA co-ops and other payors to policyholders and claimants.

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs that we purchase and sell.

We dispense significant volumes of brand-name and generic drugs from our retail, LTC, specialty and mail order pharmacies and through our PBM's network of retail pharmacies. When increased safety risk profiles or manufacturing or other supply issues of specific drugs or classes of drugs occur, or drugs become subject to greater restrictions as controlled substances, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced.

Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can

result in lower prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our results of operations and cash flows may decline as a result of such regulatory rulings or market changes.

Further, we acquire a substantial amount of our mail and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers are often short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the agreement and may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations. Moreover, many products distributed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our results of operations and cash flows.

In addition, our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

A disruption in our business operations could occur as a result of contamination of drugs, a failure to maintain necessary shipment and storage conditions, errors in mail order processing, the unavailability of prescription drugs provided by suppliers, labor disruptions or other unanticipated disruptions at our mail order dispensing pharmacy facilities, specialty pharmacy facilities, call centers, data centers or corporate facilities, among other factors. Such disruption could reduce our ability to process and dispense prescriptions and provide products and services to our customers.

If any products we distribute are in limited supply for significant periods of time, our financial condition and results of operations could be materially and adversely affected.

We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription drugs as well as lower-priced generic alternatives to existing brand name products because we generally earn higher gross margins on the sale of generic alternatives than on brand name equivalents. In addition, inflation in the price of brand name drugs can affect utilization, particularly given the increase in high deductible health plans. Accordingly, our businesses and results of operations could be adversely affected by a slowdown or delay in the number or magnitude of new and successful prescription drugs and/or generic alternatives, as well as inflation in the price of brand name drugs. For example, we project that the operating income of our Pharmacy Services and Retail/LTC segments may be reduced in 2019 compared to 2018 due in part to fewer new multi-source generic drugs being introduced and lower brand name drug price inflation in 2019 than 2018.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace AWP or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs ("FFS Medicaid") have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact on reimbursement practices in other commercial and government products. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our results of operations. Additionally, any future changes in drug prices could be significantly different than our projections. The effect of these possible changes on our businesses cannot be predicted at this time.

Product liability, product recall or personal injury issues could damage our reputation.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of drugs and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, that exposes us to professional liability claims. Should a product or other liability issue arise, the coverage limits under our insurance programs and the indemnification amounts available to us may not be adequate to protect us against claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. Damage to our reputation in the event of a product liability or personal injury issue or judgment against us or a product recall could have a significant adverse effect on our businesses, financial condition and results of operations.

We face challenges in growing our Medicare Advantage and Medicare Part D membership.

We are seeking to substantially grow our Medicare Advantage and Medicare Part D membership, revenue and results of operations in 2019 and over the next several years, including by significantly expanding our Medicare Advantage service area. The organic expansion of our Medicare Advantage service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations. If we are not successful in expanding our Medicare Advantage service area, we may not be able to achieve our Medicare Advantage growth goals.

We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.

We are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders. Our ability to maintain and grow membership, revenues and results of operations in our Medicaid products is dependent on our remaining competitive on price, performance and preparing successful bids. In cases where a successful bid is challenged, we incur defense costs and may incur unreimbursed implementation and other costs to meet contractual deadlines even if we ultimately lose the challenge.

If we are successful in expanding our Medicaid membership, we may increase our exposure to states that face budgetary pressures, hospitals and other providers that face revenue challenges associated with uncompensated care and pressures on our operating margins driven by the projected rapid growth in the size of and cost of care for the Medicaid eligible population.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although recently even relatively small employers have moved to ASC products. We also serve government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and regulatory requirements and have lower profit margins than the Insured Commercial products in our Health Care Benefits segment. Although our Health Care Benefits membership is projected to continue to shift towards Government products in 2019, the profitability of each of those products differs and may be less than the profitability of an Insured Commercial product. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our results of operations.

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's results of operations. There can be no assurance that the future health care and other benefit costs of our Insured Health Care Benefits products will not exceed our projections.

Premiums for our Insured Health Care Benefits products, which comprised 87% of our Health Care Benefits revenues for 2018, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and healthcare utilization patterns and require a significant degree of

judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our results of operations.

Our health care and other benefit costs can be affected by external events that we cannot forecast or anticipate and over which we have little or no control, such as emerging changes in the economy and/or public policy, additional government mandated benefits or other regulatory changes, changes in our members' behavior and healthcare utilization patterns, changes in health care practices, new technologies, increases in the cost of prescription drugs, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), direct-to-consumer marketing by drug manufacturers, clusters of high cost cases, epidemics, pandemics, terrorist attacks or other man-made disasters, natural disasters or other events that materially increase utilization of medical and/or other covered services, including prescription drugs, as well as changes in provider billing practices. Our health care and other benefit costs also can be affected by changes in our business mix, product designs, contracts with providers, medical management, underwriting, rating and/or claims processing methods and processes, and our medical management initiatives may not deliver the reduction in utilization and/or medical cost trend that we project.

It is particularly difficult to accurately anticipate, detect, price, forecast, manage and reserve for medical cost trends and utilization of medical and/or other covered services during and following periods when such utilization and/or trends are below recent historical levels, during periods of changing economic conditions and employment levels and for products with substantial membership growth and/or turnover. For example, as of December 31, 2018, we held a premium deficiency reserve of $16 million for the 2019 coverage year related to our Medicaid products. We expect utilization to increase in 2019 when compared to 2018.

If health care and other benefit costs are higher than the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our prices will not reflect the risk we assume, and our results of operations will be adversely affected. If health care and other benefit costs are lower than we predict, our prices may be higher than those of our competitors, which may cause us to lose Health Care Benefits membership.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and healthcare utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' utilization and other behavior, changes in health care practices and inflation. In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, changes in health care practices, general economic conditions (such as inflation and employment levels), new technologies, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

Our Health Care Benefits segment's results of operations and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and results of operations.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be

insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the ACA's, CMS's and OPM's minimum MLR rules and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period results of operations within benefit costs. For example, as of December 31, 2018, we held a premium deficiency reserve of $16 million for the 2019 coverage year related to our Medicaid products. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2018 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our results of operations. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the United States economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which would also be affected by the government's actions and the responsiveness of public health agencies and other insurers. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses, cash flows and results of operations, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

Changes in Public Policy and Other Legal and Regulatory Risks

Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.

Medicare Advantage payment rates to health plans have been cut over the last several years, with additional reductions to be phased in through 2019. CMS issued the Final Notice in April 2018. Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only slightly offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications), the HIF and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on the Medicare Advantage program and our Medicare Advantage results of operations. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare results of operations.

In addition, the "star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' results of operations. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below 4 for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues and results of operations may be significantly adversely affected.

Payments we receive from CMS for our Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the fairness of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.

Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; if changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; if the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if the government mandates the use of point-of-sale manufacturer's rebates or up front drug pricing discounts, makes drug manufacturer's rebates illegal, or makes changes to how pharmacy pay-for-performance is calculated; or if reinsurance thresholds are reduced below their current levels, our Medicare Part D results of operations and our ability to expand our Medicare Part D business could be adversely affected.

More generally, our Medicare results of operations and our ability to expand our Medicare membership and revenues also could be adversely affected if we fail to design and maintain programs that are attractive to Medicare Advantage or Part D participants; if CMS imposes restrictions on our Medicare business as a result of audits or other regulatory actions; if we fail to successfully implement corrective actions or other remedial measures sufficient to prevent or remove any applicable restrictions that may be imposed by CMS; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare's competitive bidding process.

Federal funding for expanded Medicaid coverage began to decrease in 2017. This reduction is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our MBRs and our results of operations.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and results of operations and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins and results of operations of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. The risk of increases in utilization of medical and/or other covered services and/or in health care and other benefit costs is particularly acute during and following periods when utilization has been below recent historical levels, during periods of changing economic conditions and/or employment levels and in products where there is significant turnover in our membership each year. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and/or CHIP premium rates is limited due, among other things, to the budgetary pressures currently facing many state governments. This could magnify the adverse impact on our operating margins and results of operations of increases in utilization of medical and other covered services, health care and other benefit costs and/or medical cost trends that exceed our projections.

Since 2013, HHS has issued determinations to health plans that their rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in a number of states also have conducted hearings on proposed premium rate increases, which can result, in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. We requested significant increases in our premium rates in our small group Commercial Health Care Benefits products for 2019 and expect to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for the applicable products (also known as "adverse selection") in our products, particularly in small group products, which we expect to continue and potentially worsen in 2019 following the expiration of the ACA's risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory reaction and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in any product line or geography. If we are unable to obtain adequate rates and/or rate increases, it could materially and adversely affect our operating margins and our ability to earn adequate returns on Insured Health Care Benefits business in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our results of operations.

The ACA requires us to pay minimum MLR rebates each year with respect to prior years. The ACA's minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and FEHB program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with the OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our results of operations.

Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently and can be inconsistent or conflicting. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors. In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. In connection with the Aetna Acquisition, we also agreed to undertakings with certain state regulators that place various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries.

Our Pharmacy Services products are subject to:

- The clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by us to adhere to the laws and regulations applicable to the dispensing of drugs could subject our Pharmacy Services businesses to civil and criminal penalties).
- Federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers.
- Compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings.
- Federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs are complex, are subject to interpretation and can expose us to penalties for non-compliance, including penalties under the False Claims Act and state false claims acts. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products that are sold on Public Exchanges or otherwise subject to the ACA. The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a health program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan and other programs, cash flows, financial condition and results of operations.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.

Our businesses are subject to extensive and complex regulations, and many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems in place to ensure that we comply with all applicable legal, regulatory and contractual requirements. These systems frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, cash flows, results of operations or financial condition.

Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.

Historically, we focused primarily on providing Retail/LTC and Pharmacy Services products and services. As a result of the Aetna Acquisition, we have significantly expanded our presence in Health Care Benefits products and services (including

products and services offered in multiple countries outside of the United States), which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core business and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Retail/LTC and Pharmacy Services products and services and increase significantly our exposure to other risks.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and results of operations.

Pharmacy services, retail pharmacy, LTC pharmacy and health care benefits are highly regulated and litigious industries. We are currently subject to various litigation matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings. Litigation, and particularly securities, collective or class action and *qui tam* litigation, is often expensive and disruptive. Certain of the lawsuits against us are or are purported to be class actions or *qui tam* actions. Litigation related to our provision of professional services in our pharmacies, specialty pharmacies, medical clinics and LTC facilities also has increased as we expand our services along the continuum of health care.

The majority of these proceedings relate to the conduct of our Retail/LTC, Pharmacy Services and Health Care Benefits operations and allege various violations of law. In addition, we operate in jurisdictions outside the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and are therefore more likely to be subject to dispute by customers, members, governmental authorities and others. We are incurring expenses to resolve these proceedings. The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur.

Litigation has been and may be brought against us by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit. Under the provisions of the federal and various state false claims acts, private citizens may bring lawsuits alleging that a violation of the federal anti-kickback statute or similar laws has resulted in the submission of "false" claims to federal and/or state health care programs, including Medicare and Medicaid, and we are a defendant in a number of such proceedings. When a private individual brings a whistleblower suit, the defendant often will not be made aware of the suit for many months or even years, until the government commences its own investigation or determines whether it will intervene. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided under the Financial Reform Act increase the risk of whistleblower suits.

Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

We cannot predict the outcome of any of these matters, and the costs incurred may be substantial regardless of outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses or results of operations because of brand and reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this Annual Report on Form 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail and LTC pharmacy, pharmacy services and health care benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the United States Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the

DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. Several such audits, investigations and reviews currently are pending, some of which may be resolved in 2019, and the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our financial condition, results of operations or businesses or result in significant liabilities and negative publicity for our company. For example, since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. In addition, federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.

Premiums and/or fees for Medicare members, certain federal government employee groups and Medicaid beneficiaries are subject to retroactive adjustments and/or withholding by the federal and applicable state governments. Our business that is subject to the ACA, including amounts payable to us or payable by us under the ACA's premium stabilization programs and our risk adjustment and reinsurance data, also is subject to audit by governmental authorities. CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members.

CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes.

Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted RADV audits of a subset of Medicare Advantage plans for various contract years, including certain of our plans for various contract years, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The OIG also is auditing our risk adjustment data and that of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data. We also have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified

in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. We are evaluating the potential adverse effect, which could be material, on our results of operations, financial condition and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would require us to change our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years.

If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our financial condition, cash flows and results of operations.

CMS has issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our results of operations, financial condition and/or cash flows.

Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid results of operations and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

Any premium or fee refunds, adjustments or withholding or civil or criminal fines or penalties, or other sanctions, including restrictions on or changes in the way we do business, loss of licensure or exclusion from participation in government programs, resulting from regulatory audits or investigations, whether as a result of RADV, Public Exchange related, recovery audit program or other audits or investigations by CMS, the OIG, HHS, the DOJ or otherwise, including audits of our minimum MLR rebates, methodology and/or reports, could be material and could adversely affect our results of operations, financial condition and cash flows.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a

significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.

Programs funded in whole or in part by the United States federal government account for a significant portion of our revenue, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

Our revenues from government funded programs, including our Medicare, Medicaid, dual eligible and dual eligible special needs plan businesses and our government customers in our Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

For example, CMS is transitioning the process of calculating Medicare members' risk scores from using diagnoses data from the Risk Adjustment Processing System, or RAPS, to using diagnoses data from the Encounter Data System, or EDS. The RAPS process requires Medicare Advantage plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires Medicare Advantage plans to submit all encounter data, and CMS applies the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score will be calculated from claims data submitted through EDS, up from 15% in 2018. For 2020, the EDS percentage will increase to 50%. The transition from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues or filtering logic differences between RAPS and EDS and could have a material adverse effect on our results of operations, financial condition and/or cash flows.

In addition, while the ACA provided substantial federal funding for the expansion of the number of people who qualify to enroll in Medicaid beginning in 2014, that funding began to decrease in 2017, and the future of that funding is uncertain. As a result, in 2019, states are preparing for the adverse impact on their budgets and programs by seeking to reduce their Medicaid expenditures and/or changing the design of their Medicaid programs. These changes could have a material adverse effect on the revenues, medical benefit ratios and results operations of our Medicaid contracts and/or our ability to grow our Medicaid membership, revenues and results of operations.

Our government customers also determine the eligibility criteria, premium levels and other aspects of Medicare, Medicaid, dual eligible and dual eligible special needs plan programs that affect the number of persons enrolled in these programs, the services provided to enrollees under these programs, the conditions for participating in these programs and our administrative and health care and other benefit costs under these programs. For example, states may require participation on their Public Exchange as a condition to participating in their Medicaid or state employee health benefit programs and/or take program design actions that shift provider costs from state employee plans to Commercial and Medicare plans. In the past, determinations of this type have at times adversely affected our results of operations from and willingness to participate in such programs, and they may do so again in the future. If a government customer reduces premium levels or increases premiums by less than the increase in our costs (such as by not allowing us to recover ACA and other applicable fees, taxes and assessments), and we cannot offset the adverse impact of these actions with supplemental premiums and/or changes in benefit plans, then our businesses and results of operations could be adversely affected. In addition, if states allow certain programs to expire, reduce the number of firms with which they contract for Managed Medicaid services or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment or reduced Medicaid enrollment growth, which would adversely affect our businesses, revenues and results of operations.

The federal government's "debt ceiling", or the amount of debt the federal government is permitted to borrow to meet its legal obligations (including, among other things, interest on the national debt, Medicare and Medicaid premiums and contributions to the FEHB program), is limited by statute and can only be raised by an act of Congress.

During a federal government shutdown or if Congress does not raise the debt ceiling before the federal government's current obligations approach or exceed its cash on hand and incoming receipts, federal government spending may be subject to delay, reduction, suspension or cancellation, which may be prolonged. Over 30% of our Health Care Benefits segment's revenues are derived from health care coverage programs that are funded in whole or in part by the federal government, including the Medicare, Medicaid, dual eligible and dual eligible specials needs plan programs, CHIP and the FEHB program. When federal spending is delayed, suspended or curtailed, we continue to receive claims from providers providing services to beneficiaries of these programs, and we remain liable for, and are required to fund, such claims. A federal government shutdown or a failure to

timely raise the debt ceiling could have a material adverse effect on our businesses, results of operations, cash flows, brand and reputation and, in the case of a prolonged shutdown or failure to raise the debt ceiling, our financial condition.

If the United States defaults on its obligations due to a failure to timely raise the debt ceiling or otherwise, or its credit rating is downgraded by any of the credit rating agencies, interest rates could rise, financial markets could become volatile and/or the availability of credit (and short-term credit in particular) could be adversely affected, thereby increasing our borrowing costs, adversely affecting the value of our investment portfolio, and/or adversely affecting our ability to access the capital markets, which could have a material adverse effect on our results of operations, financial condition and cash flows and could adversely affect our liquidity.

Our results of operations may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

The federal and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave. In addition, our employee related operating costs may be increased by union organizing activity. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our results of operations will be adversely affected.

Risks Related to Customer Perceptions of our Products and Services

We must develop and maintain a relevant omni-channel experience for our retail customers.

Our business has evolved from a retail store experience to interaction with customers across numerous channels, including in-store, online, mobile and social media, among others. Omni-channel retailing is rapidly evolving and we must keep pace with changing customer expectations and new developments by our competitors. Our customers are increasingly using mobile phones, tablets, computers and other devices to comparison shop, determine product availability and complete purchases through mobile commerce applications. As a result, the portion of total consumer expenditures with all retailers occurring online and through mobile commerce applications is increasing and the pace of this increase could accelerate. We must compete by offering a consistent and convenient shopping experience for our customers regardless of the ultimate sales channel and by investing in, providing and maintaining mobile commerce applications for our customers that have the right features and are reliable and easy to use. If we are unable to make, improve or develop relevant customer-facing technology in a timely manner that keeps pace with technological developments and dynamic customer expectations, our ability to compete and our results of operations could be materially and adversely affected. In addition, if our online activities or our other customer-facing technology systems do not function as designed, we may experience a loss of customer confidence, data security breaches, lost sales, or be exposed to fraudulent purchases, any of which could materially and adversely affect our business operations, reputation and results of operations.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in our markets, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, results of operations and financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers which, consequently, could adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner,

is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our financial performance and erode customer loyalty.

Our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs), that serve a relatively limited universe of patients. As a result, the future growth of our specialty pharmacy business is dependent largely upon expanding our base of drugs or penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, results of operations and cash flows.

We operate in rapidly evolving industries. Our customers generally, and our larger customers in particular, are well-informed and organized and, along with our individual customers, can easily move between us and our competitors. These factors require us to differentiate our products and solutions, anticipate changes in customer and consumer preferences, anticipate and effectively compete with the products and solutions of new and existing competitors and innovate and deliver new and existing products and solutions that demonstrate value to our customers and members, particularly in response to marketplace changes from public policy. Any failure to do so may adversely affect our ability to retain or grow customers and/or profitable medical membership, which can adversely affect our results of operations.

In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.

Historically, employers have been the most significant customers driving purchases of our Pharmacy Services and Health Care Benefits segments. However, decisions to buy our Pharmacy Services and Health Care Benefits products and services increasingly are made or influenced by consumers, either through direct purchasing (for example, Medicare Advantage plans and PDPs) or through Insurance Exchanges that allow individual choice. Similarly, consumers increasingly seek to access health care products and services locally and through other direct channels such as mobile devices and our websites. In response to this demand, we are expanding our consumer focus. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

We also will have to respond to pricing and other actions taken by existing competitors as well as potentially disruptive new entrants. Regulatory and participation requirements for Insurance Exchange-based plans tend to emphasize price and make competitive differentiation of our Health Care Benefits products and services based on other attributes more difficult. Price competition from existing and potentially new disruptive competitors in the industries in which each of our segments compete also continues to increase. Accordingly, we face competitive pricing pressures from existing and new competitors (including our vendors and others who may have lower cost structures than we do), and these pressures may reduce our operating margins or limit sales of our products and services. Our competitors may bring their consumer-oriented products and services to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our businesses. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of Private Exchanges or encourage their employees to purchase health insurance on the Public Exchanges. We can provide no assurance that we will be able to develop or operate successful or profitable consumer-oriented products and services, or that our Health Care Benefits segment will be able to compete successfully or profitably on Public Exchanges or Private Exchanges or benefit from any opportunities presented by Public Exchanges or Private Exchanges, or that we will be able to benefit from opportunities available to any of our segments in the industries in which we operate. If we do not develop and expand competitive and profitable consumer products, are not competitive in the industries in which we operate, or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely affected.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers often are short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the

agreement and may allow the supplier to distribute through channels other than the Company. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with health care providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow membership, and our ability to profitably grow our business and/or our results of operations may be adversely affected.

While we believe joint ventures, ACOs and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our results of operations and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint venture. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our results of operations and cash flows.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to litigation against us.

These risks are particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, where third parties perform PBM, medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, cash flows, results of operations and/or financial condition.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other health care providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and results of operations.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, on October 15, 2018, an arbitrator awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Risks Related to Our Operations

Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, home delivery pharmacy prescription delivery, specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customer and other service and performance. If we misjudge the effects of such measures, customer and other service may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitable growing our customer base and/or membership, which can adversely affect our results of operations. For example, noncompliance with any privacy or security laws or regulations or any security breach involving one of our third party vendors could have a material adverse effect on our businesses, results of operations, brand and reputation.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our results of operations.

Our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and results of operations.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to the Company or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We may also be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we

have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and, as such, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, financial condition and results of operations could be adversely affected.

We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced and continue to experience a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we and our vendors have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. Although the impact of such attacks has not been material to our operations or results of operations through December 31, 2018, we can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future. As we expand our consumer-oriented products and services, increase the amount and types of data we acquire, generate and use, increase the amount of information we make available to members, consumers and providers on mobile devices, expand our use of vendors, expand internationally and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access to and/or disruption of our systems and the customer, member, provider, employee, ACO, joint venture, vendor and other third party information they contain, increases, and the cost of attempting to protect against these risks also increases.

Although we deploy a layered approach to address information security (including cybersecurity) threats and vulnerabilities that is designed to protect confidential information against data security breaches, a compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, financial condition, and results of operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our members' and customers' sensitive information. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers' and members' private information and our customers and members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our businesses, brand, reputation, cash flows and results of operations.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, results of operations and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM

claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in United States and foreign privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

Our business success and results of operations depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, ExtraCare customer loyalty program, finance and other processes. Throughout our operations, we receive, retain and transmit certain confidential information, including PII and PHI, that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report results of operations; and interact with providers, employer plan sponsors, members and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented products and services we are developing, operating and expanding and/or to meet current and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our results of operations may be adversely affected.

Our business strategy involves providing customers with differentiated, easy to use, secure products and solutions that use information to meet customer needs. The types of technology and levels of service that are acceptable to customers and members today will not necessarily be acceptable in the future, requiring us to anticipate and meet marketplace demands for technology. Our success therefore is dependent in large part on our ability, within the context of a limited budget of human resources and capital and our existing and future business relationships, to timely secure, integrate, develop, redesign and enhance our (or contract with vendors to provide) technology systems that support our business strategy initiatives and processes in a compliant, secure, and cost and resource efficient manner. Integration of our acquisitions increases these challenges, and we may not be successful in integrating various systems in a timely or cost-effective manner.

Information technology projects frequently are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of customers, providers and members, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our results of operations may be adversely affected.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately

provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our Consumer Health Products and Services products and services and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:

- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;
- Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and
- Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.

Financial Risks

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2018, we had $115.2 billion of goodwill and other intangible assets. During the year ended December 31, 2018, we took $6.1 billion of goodwill impairment charges related to our LTC reporting unit. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our results of operations, which could have a material adverse effect on our financial condition and results of operations.

We would be adversely affected if we do not effectively deploy our capital . Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, cash flows, financial condition and results of operations.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by recognized rating organizations. Credit ratings issued by nationally-recognized organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of

our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. In connection with the completion of the Aetna Acquisition, each of Standard & Poor's, Moody's and Fitch downgraded certain of our debt, financial strength and/or other credit ratings. Downgrades in our ratings could adversely affect our businesses, cash flows, financial condition and results of operations.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our results of operations and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the United States. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the United States, and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the United States credit markets, and governments' monetary policy, particularly United States monetary policy, can significantly and adversely affect the value of our investment portfolio, our results of operations and/or our financial condition by:

- Significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our results of operations and/or unrealized capital losses that reduce our shareholders' equity;
- Keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and results of operations as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- Reducing the fair values of our investments if interest rates rise;
- Causing non-performance or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our results of operations; and
- Reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

Risks Relating to Our Acquisition of Aetna

We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.

We have limited experience operating an insurance and managed health care business, and are relying in large part on the existing management of Aetna to continue to manage our Health Care Benefits business. However, there is no assurance that we will be able to continue to retain the services of such management. If we fail to retain the existing management of Aetna, our ability to realize the anticipated benefits of the transaction may be adversely affected.

The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.

Although we currently project that the Aetna Acquisition will result in a number of benefits, including that it will be accretive to our earnings per share, changes in the estimates we use for these projections and the impact of future events and conditions, some of which we do not control, could cause actual results to be lower than these projections. In addition, future events and

conditions could decrease or delay the accretion that is currently projected or could result in dilution. These events and conditions include adverse changes in market conditions, changes in the regulatory environment, additional transaction and integration-related costs and other factors such as the failure to realize some or all of the anticipated benefits of the Aetna Acquisition. Any dilution of, decrease in or delay of any accretion to, our earnings per share could cause our stock price to decline or grow at a reduced rate.

We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.

The success of the Aetna Acquisition will depend, in part, on our ability to realize the anticipated benefits and cost savings from combining the businesses of CVS Health and Aetna. Our ability to realize these anticipated benefits and cost savings is subject to certain risks, including:

- Our ability to successfully combine the businesses of CVS Health and Aetna;
- whether the combined businesses will perform as expected;
- the possibility that we paid more for Aetna than the value we will derive from the acquisition;
- the reduction of our cash available for operations and other uses and the incurrence of indebtedness to finance the acquisition; and
- the assumption of known and unknown liabilities of Aetna.

If we are not able to successfully combine the businesses of CVS Health and Aetna within the anticipated time frame, the anticipated cost savings and other benefits of the Aetna Acquisition may not be realized fully or may take longer to realize than expected, the combined businesses may not perform as expected, and our stock price may be adversely affected.

Until the completion of the Aetna Acquisition, we and Aetna operated independently, and there can be no assurances that our respective businesses can be integrated successfully. It is possible that the integration process could result in the loss of key CVS Health or Aetna employees, the disruption of either company's or both companies' ongoing businesses or in unexpected integration issues, higher than expected integration costs and an overall post-completion integration process that takes longer than originally anticipated. Specifically, issues that must be addressed in integrating the operations of CVS Health and Aetna in order to realize the anticipated benefits of the Aetna Acquisition so the combined business performs as expected include, among other things:

- combining the companies' separate operational, financial, reporting and corporate functions;
- integrating the companies' technologies, products and services;
- identifying and eliminating redundant and underperforming operations and assets;
- harmonizing the companies' operating practices, employee development, compensation and benefit programs, internal controls and other policies, procedures and processes;
- addressing possible differences in business backgrounds, corporate cultures and management philosophies;
- consolidating the companies' corporate, administrative and information technology infrastructure;
- coordinating sales, distribution and marketing efforts;
- managing the movement of certain businesses and positions to different locations;
- maintaining existing agreements with customers, providers and vendors and avoiding delays in entering into new agreements with prospective customers, providers and vendors;
- operating in industry sectors in which we and our current management may have little or no experience;
- coordinating geographically dispersed organizations;
- consolidating offices of CVS Health and Aetna that are currently in or near the same location; and
- effecting the actions that are required by regulatory approvals we obtained in connection with completing the Aetna Acquisition.

In addition, at times, the attention of certain members of our management and our resources will be focused on the integration of the businesses of the two companies and diverted from day-to-day business operations, which may adversely affect our businesses.

Our future results may be adversely impacted if we do not effectively manage our expanded operations following completion of the Aetna Acquisition.

Following completion of the Aetna Acquisition our business is significantly larger than the size of either CVS Health's or Aetna's respective pre-transaction businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to implement an effective integration of the two companies and its ability to manage a combined business with significantly larger size and scope with the associated increased costs and complexity. There can be no assurances that the management of the combined company will be successful or that the combined company will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the Aetna Acquisition. If we are not able to fully realize the expected operating efficiencies, cost savings and other benefits anticipated from the Aetna Acquisition, or such benefits take longer to realize than expected, our combined businesses may not perform as expected and our stock price may be adversely affected.

We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.

Our future success will depend in part on our ability to retain key executives and other employees of Aetna. Uncertainty about the effect of the Aetna Acquisition on CVS Health and Aetna employees may have an adverse effect on the combined company and consequently the combined business. This uncertainty may impair our ability to attract, retain and motivate key personnel. Employee retention may be particularly challenging during the integration process, as employees of CVS Health and Aetna may experience uncertainty about their future roles in the combined business.

Furthermore, if key employees of CVS Health or Aetna depart or are at risk of departing, including because of issues relating to the uncertainty and difficulty of integration, financial security or a desire not to remain as employees of the combined business, we may have to incur significant costs in retaining such individuals or in identifying, hiring and retaining replacements for departing employees and may lose significant expertise and talent relating to the business of Aetna, and our ability to realize the anticipated benefits of the Aetna Acquisition may be materially and adversely affected. Accordingly, no assurance can be given that we will be able to attract or retain key employees of Aetna to the same extent that Aetna was able to attract or retain employees in the past.

The Aetna integration process could disrupt our ongoing businesses and/or operations.

Parties with which we do business may experience uncertainty associated with the Aetna Acquisition and/or the post-closing integration process, including with respect to current or future business relationships with the combined business. Our business relationships (including business relationships of our Health Care Benefits segment) may be subject to disruption as customers, members, manufacturers, providers, vendors and others may attempt to negotiate changes in existing business relationships or consider entering into business relationships with parties other than the combined business. These disruptions could have a material adverse effect on the businesses, financial condition, results of operations or prospects of one or more of the combined company's businesses, including a material adverse effect on our ability to realize the anticipated benefits of the Aetna Acquisition.

Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.

In order to complete the Aetna Acquisition, we incurred acquisition-related debt financing of approximately $45.0 billion and assumed Aetna's existing indebtedness with a fair value of approximately $8.1 billion. Our substantially increased indebtedness and higher debt-to-equity ratio following completion of the Aetna Acquisition in comparison to that of CVS Health prior to the Aetna Acquisition has the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increases our interest expense compared to pre Aetna Acquisition periods. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources are greater than the amount of cash flows required to service the indebtedness of CVS Health or Aetna individually prior to the Aetna Acquisition. The increased levels of indebtedness could also reduce funds available to fund our efforts to combine our business with Aetna and realize expected benefits of the Aetna Acquisition and/or engage in investments in product development, capital expenditures, dividend payments, share repurchases and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.

We expect to continue to incur significant non-recurring costs associated with combining the operations of CVS Health and Aetna. We expect to continue to incur significant integration-related costs related to formulating and implementing integration plans, including facilities and systems consolidation costs and employment-related costs. We continue to assess the magnitude of these costs, and additional unanticipated costs may be incurred in the integration of the two companies' businesses. We may not achieve the net benefit of such expenditures that we project associated with the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of our businesses in the near term, or at all. If we fail to realize the expected expense and other efficiencies we project, our results of operations, cash flows and stock price may be adversely affected.

Risks Related to Our Acquisitions, Joint Ventures and International Operations

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to integration risks, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- We frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- The acquired, alliance and/or joint venture businesses may not perform as projected;
- The goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become non-recoverable;
- We may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- The acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- We may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our shareholders;
- We may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- We may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;
- We may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, material disruptions to our businesses and operations and adversely affect our brand and reputation;
- In order to complete a proposed acquisition, we may be required to divest certain portions of our business;
- We may be involved in litigation related to mergers or acquisitions, including for matters which occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- The integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

We expect joint ventures to be an important part of our business model transformation and inorganic growth strategies. Joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the customers, and member and business disruption that may occur upon joint venture termination.

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company may also be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disruption of management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and results of operations. Furthermore, acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or geographic markets, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.

We significantly expanded our international operations as a result of the closing of the Aetna Acquisition in November 2018. As a result of our expanded international operations, we face political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, privacy, data storage, location, protection and security.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and management, financial and other resources over a number of years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our businesses, results of operations, financial condition, brand, reputation and/or long-term growth.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, results of operations and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Item 1B. Unresolved Staff Comments

There are no unresolved SEC Staff Comments.

Item 2. Properties

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. In addition, the Company leases corporate offices in Arizona, Illinois, Ohio, Pennsylvania, Texas, and Brazil.

Pharmacy Services Segment

As of December 31, 2018 , the Pharmacy Services segment had the following properties:

- An owned mail service dispensing pharmacy located in Texas;
- Leased mail order dispensing pharmacies located in Hawaii, Illinois and Pennsylvania;
- Leased call centers located in California, Missouri, Pennsylvania, Tennessee and Texas;
- Approximately 40 leased on-site pharmacy stores, approximately 25 leased retail specialty pharmacy stores, approximately 20 specialty mail order pharmacies and approximately 90 branches for infusion and enteral services.

Retail/LTC Segment

As of December 31, 2018 , the Retail/LTC segment had the following properties:

- Approximately 8,200 retail stores, of which approximately 4% were owned. Net selling space for retail stores was approximately 80.5 million square feet as of December 31, 2018 . Approximately 25% of the store base was opened or significantly remodeled within the last five years;
- Approximately 1,700 retail pharmacies and approximately 80 clinics in Target stores;
- Nine owned distribution centers located in eight states and 13 leased distribution facilities located in twelve additional states and Brazil. The 22 distribution centers totaled approximately 10.4 million square feet as of December 31, 2018 ; and
- Six owned LTC pharmacies, approximately 150 leased LTC pharmacies in 46 states and one owned LTC repackaging facility.

In connection with certain business dispositions completed between 1991 and 1997, the Company continues to guarantee lease obligations for approximately 85 former stores. The Company is indemnified for these guarantee obligations by the respective purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 "Commitments and Contingencies" contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex that is approximately 1.7 million square feet in size and is located in Hartford, Connecticut. The Health Care Benefits segment also owns or leases other space in the greater Hartford area, Maryland, Pennsylvania, and various field locations in the United States and several other countries.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by

alternative space. For additional information on the amount of rental obligations for the Company's leases, see Note 6 ''Leases'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Item 3. Legal Proceedings

I. Legal Proceedings

The information contained in Note 16 ''Commitments and Contingencies'' of the "Notes to Consolidated Financial Statements" in the Annual Report is incorporated by reference herein.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of environmental legal proceedings with a governmental authority if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with LTC pharmacies in the State of New York. These proceedings are not material to the Company's business or financial condition.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market information

The Company's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Holders of common stock

The information under the heading "Holders of Common Stock" in the Annual Report is incorporated by reference herein.

Dividends

The quarterly cash dividend declared by the Company's Board of Directors (the "Board") was $0.50 per share in 2018 and 2017.

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Issuer purchases of equity securities

The following share repurchase programs were authorized by the Board:

In billions				
Authorization Date		**Authorized**		**Remaining as of December 31, 2018**
November 2, 2016 ("2016 Repurchase Program")	$	15.0	$	13.9
December 15, 2014 ("2014 Repurchase Program")		10.0		—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2018 the Company did not repurchase any shares of common stock.

See Note 12 ''Shareholders' Equity'' of the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein, for additional information regarding the Company's share repurchases.

Item 6. Selected Financial Data

The selected consolidated financial data of CVS Health Corporation as of and for the periods indicated in the five-year period ended December 31, 2018 , have been derived from the consolidated financial statements of CVS Health Corporation and is incorporated herein by reference to the information contained in the Annual Report under the heading "Five-Year Financial Summary." The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated by reference elsewhere in this Annual Report on Form 10-K.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The information contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Annual Report, which includes the "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section, is incorporated by reference herein.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

The information contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations — Quantitative and Qualitative Disclosures About Market Risk" in the Annual Report is incorporated by reference herein.

Item 8. Financial Statements and Supplementary Data

The information contained in "Consolidated Statements of Operations," "Consolidated Statements of Comprehensive Income (Loss)," "Consolidated Balance Sheets," "Consolidated Statements of Shareholders' Equity," "Consolidated Statements of Cash Flows," "Notes to Consolidated Financial Statements," and "Report of Independent Registered Public Accounting Firm" in the Annual Report, is incorporated by reference herein.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2018 , have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Internal control over financial reporting

The "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm" sections of the Annual Report are incorporated by reference herein. These sections contain management's report on the Company's internal control over financial reporting and the Independent Registered Public Accounting Firm's report with respect to the effectiveness the Company's internal control over financial reporting.

Changes in internal control over financial reporting

On November 28, 2018, the Company completed its acquisition of Aetna. In conducting its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018 , management has elected to exclude Aetna from that assessment, as permitted under SEC rules. The Company is in the process of integrating the historical internal control over financial reporting of Aetna with the rest of the Company. Aetna's operations are included in the Company's 2018 consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and represented 21% of the Company's consolidated total assets as of December 31, 2018 and 3% of the Company's consolidated total revenues for the year ended December 31, 2018.

Other than the foregoing, there has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2018 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

No events have occurred during the fourth quarter ended December 31, 2018 that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The sections of the Proxy Statement under the captions "Committees of the Board," "Code of Conduct," "Audit Committee Report," "Biographies of our Incumbent Board Nominees," and "Section 16(a) Beneficial Ownership Reporting Compliance" are incorporated by reference herein.

Executive Officers of the Registrant

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 28, 2019 . In each case the officer's term of office extends to the date of the board of directors meeting following the next annual meeting of stockholders of the Company. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Lisa G. Bisaccia , age 62, Executive Vice President of CVS Health Corporation since March 2016 and Chief Human Resources Officer of CVS Health Corporation since January 2010; Senior Vice President of CVS Health Corporation from January 2010 through February 2016; Vice President, Human Resources of CVS Pharmacy, Inc. from September 2004 through December 2009. Ms. Bisaccia is also a member of the board of directors of Aramark, a leading global provider of food, facilities and uniform services.

Eva C. Boratto , age 52, Executive Vice President and Chief Financial Officer of CVS Health Corporation since November 2018; Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from March 2017 through November 2018; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017; Senior Vice President of PBM Finance from July 2010 through June 2013.

Troyen A. Brennan, M.D ., age 64, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

James D. Clark , age 54, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Joshua M. Flum , age 49, Executive Vice President, Enterprise Strategy and Digital since November 2018; Executive Vice President, Corporate Strategy and Business Development of CVS Pharmacy, Inc. from June 2016 through October 2018; Executive Vice President - Pharmacy Services of CVS Pharmacy, Inc. from March 2015 through May 2016; Senior Vice President of Retail Pharmacy of CVS Pharmacy, Inc. from December 2010 through February 2015. Mr. Flum is a member of the board of directors of CreditRiskMonitor.com, Inc., a company that facilitates the analysis of corporate financial risk, mostly in the context of the extension of trade credit from one business to another.

Kevin P. Hourican , age 45, Executive Vice President of CVS Health Corporation and President of CVS Pharmacy since April 2018; Executive Vice President - Retail Pharmacy and Supply Chain of CVS Pharmacy, Inc. from June 2016 through March 2018; Senior Vice President, Field Operations and Supply Chain of CVS Pharmacy, Inc. from June 2014 through May 2016; Senior Vice President, Field Operations of CVS Pharmacy, Inc. from June 2012 through May 2014.

Alan M. Lotvin, M.D ., age 57, Executive Vice President - Transformation of CVS Health Corporation since June 2018; Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

Karen S. Lynch , age 56, Executive Vice President of CVS Health Corporation and President of Aetna since November 2018; President of Aetna from January 2015 to the present; Executive Vice President, Local and Regional Businesses of Aetna from February 2013 through December 2014; Executive Vice President, Head of Specialty Products of Aetna from July 2012 through January 2013. Ms. Lynch is a member of the board of directors of U.S. Bancorp, a banking and financial services company.

Larry J. Merlo , age 63, President and Chief Executive Officer of CVS Health Corporation since March 2011; President and Chief Operating Officer of CVS Health Corporation from May 2010 through March 2011; President of CVS Pharmacy from January 2007 through August 2011; Executive Vice President of CVS Health Corporation from January 2007 through May 2010; also a director of CVS Health Corporation since May 2010.

Thomas M. Moriarty , age 55, Executive Vice President and General Counsel of CVS Health Corporation since October 2012 and Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Derica W. Rice , age 54, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2018; Executive Vice President of Global Services and Chief Financial Officer of Eli Lilly & Co. from May 2006 through December 2017. Mr. Rice was formerly a director of Target Corporation from September 2007 until January 2018, and is a candidate for election to the board of directors of The Walt Disney Company in March 2019.

Jonathan C. Roberts , age 63, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017; Executive Vice President of CVS Health Corporation and Chief Operating Officer of CVS Caremark from October 2010 through August 2011.

Item 11. Executive Compensation

The sections of the Proxy Statement under the captions “Non-Employee Director Compensation” and “Executive Compensation and Related Matters,” including “Compensation Discussion and Analysis,” “Letter from the Management Planning and Development Committee,” “Compensation Committee Report” and “Executive Compensation Tables” are incorporated by reference herein.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The sections of the Proxy Statement under the captions “Share Ownership of Directors and Certain Executive Officers” and “Share Ownership of Principal Stockholders” are incorporated by reference herein. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the Company’s common stock that may be issued upon the exercise of options, warrants and rights under all of equity compensation plans as of December 31, 2018 .

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1][2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	27,102	$ 77.51	25,927
Equity compensation plans not approved by stockholders [4][5]	5,136	43.01	31,633
Total	32,238	$ 75.04	57,560

(1) Shares in thousands.

(2) Consists of: (i) 18,597 shares of common stock underlying outstanding options, (ii) 1,435 shares of common stock issuable upon the exercise of outstanding stock appreciation rights (“SARs”) and (iii) 12,206 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to

outstanding SARs is the number of shares of the Company's common stock that would have been issued had the SARs been exercised based on the closing price per share of the Company's common stock on December 31, 2018, as reported on the NYSE, which was $65.52.

(3) Consists of the CVS Health 2017 Incentive Compensation Plan.

(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan").

(5) Amount in column (c) consists of the maximum number of shares of the Company's common stock available for future issuance under the Aetna Stock Plan as of December 31, 2018.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Aetna Acquisition. The Aetna Stock Plan is designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan has not been submitted to the Company's stockholders and will expire on May 21, 2020.

Under the Aetna Stock Plan, eligible participants can be granted stock options to purchase shares of the Company's common stock, SARs, time vesting and/or performance vesting incentive stock or incentive units and other stock based awards. As of December 31, 2018, the maximum number of shares of the Company's common stock that may be issued under the awards outstanding under the Aetna Stock Plan was 5.1 million shares, subject to adjustment for corporate transactions and 31.6 million shares remained available for future awards. If an award under the Aetna Stock Plan is paid solely in cash, no shares are deducted from the number of shares available for issuance under the Aetna Stock Plan.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The sections of the Proxy Statement under the captions "Independence Determinations for Directors" and "Related Person Transaction Policy" are incorporated by reference herein.

Item 14. Principal Accounting Fees and Services

The section of the Proxy Statement under the caption "Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm" is incorporated by reference herein.

PART IV

Item 15. Exhibits, Financial Statement Schedules

The following documents are filed as part of this Annual Report on Form 10-K:

1. Financial Statements. The following financial statements, related notes and report are incorporated by reference from the Annual Report in Item 8 hereof:

Consolidated Statements of Operations for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Statements of Comprehensive Income (Loss) for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Balance Sheets as of December 31, 2018 and 2017

Consolidated Statements of Cash Flows for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Statements of Shareholders' Equity for the Years Ended December 31, 2018, 2017 and 2016

Notes to Consolidated Financial Statements

Report of Independent Registered Public Accounting Firm

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed May 21, 2015; Commission File No. 001-01011).
2.2	Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011).
2.3	Master Transaction Agreement by and between Aetna Inc. and Hartford Life and Accident Insurance Company dated as of October 22, 2017.
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).
3.2	By-laws of the Registrant, as amended and restated (incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996; Commission File No. 001-01011).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006; Commission File No. 001-01011).
4.3	Form of the Registrant's 2020 Floating Rate Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.4	Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).

4.5	Form of the Registrant's 2020 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.6	Form of the Registrant's 2021 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.7	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.8	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.9	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.10	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.11	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
10	**Material Contracts**
10.1	Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2015 (Commission File No. 001-01011).
10.2	Amendment No. 1 to Credit Agreement dated as of December 15, 2017, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.5 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01-011).
10.3	Amendment No. 2 to Credit Agreement dated as of May 17, 2018, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01-011).
10.4	Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.5	Amendment No. 1 to Five Year Credit Agreement dated as of December 15, 2017, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.6	Amendment No. 2 to Five Year Credit Agreement dated as of May 17, 2018, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.7	Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as administrative agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.8	Amendment No. 1 to Term Loan Agreement dated as of May 17, 2018, to the Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.9	364-Day Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.10	Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.11	Bridge Facility Commitment Letter dated December 3, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., and Merrill Lynch, Pierce Fenner & Smith Incorporated (incorporated by reference to Exhibit 2.2 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011).

10.12	Joinder to Bridge Facility Commitment Letter dated as of December 15, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and each of the Additional Commitment Parties party thereto (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.13	364-Day Bridge Term Loan Agreement, dated October 26, 2018, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed October 26, 2018; Commission File No. 001-010011).
10.14*	The Registrant's 1996 Directors Stock Plan, as amended and restated November 5, 2002 (incorporated by reference to Exhibit 10.18 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 28, 2002; Commission File No. 001-01011).
10.15*	Caremark Rx, Inc. 2004 Incentive Stock Plan (incorporated by reference to Exhibit 99.2 of the Registrant's Registration Statement No. 333-141481 on Form S-8 filed March 22, 2007; Commission File No. 011-01011).
10.16*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011).
10.17*	The Registrant's 1997 Incentive Compensation Plan, as amended through December 31, 2008 (incorporated by reference to Exhibit 10.8 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011).
10.18*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011).
10.19*	The Registrant's 2010 Incentive Compensation Plan, as amended through January 15, 2013 (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 27, 2015; Commission File No. 001-01011).
10.20*	The Registrant's Deferred Stock Compensation Plan, as amended (incorporated by reference to Exhibit 10.17 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.21*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 10.20 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.22*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.23*	The Registrant's Deferred Compensation Plan, as amended (incorporated by reference to Exhibit 10.19 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.24*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.25*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.26*	The Registrant's 2017 Incentive Compensation Plan (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 31, 2017; Commission File No. 001-01011).
10.27*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.28*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.29*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.30*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).

10.31*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.32*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.33*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.34*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011).
10.35*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011).
10.36*	The Registrant's 2018 Management Incentive Plan.
10.37*	The Registrant's Severance Plan for Non-Store Employees amended as of November 28, 2018.
10.38*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended.
10.39*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant.
10.40*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant.
10.41*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant.
10.42*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax).
10.43*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011).
10.44*	Amended Aetna Inc. 2010 Stock Incentive Plan, as amended May 19, 2017 (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed November 30, 2018; Commission File No. 001-01011).
10.45*	Form of Aetna Inc. 2010 Stock Incentive Plan - Market Stock Unit Terms of Award.
10.46*	Form of Aetna Inc. 2010 Stock Incentive Plan - Performance Stock Unit Terms of Award (2015).
10.47*	Form of Aetna Inc. 2010 Stock Incentive Plan - Executive Restricted Stock Unit Terms of Award (2015).
10.48*	Form of Aetna Inc. 2010 Stock Incentive Plan - Stock Appreciation Right Terms of Award (2015).
10.49*	Amended and Restated Employment Agreement dated as of December 21, 2012 between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.50*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.51*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.52*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015; Commission File No. 001-01011).
10.53*	Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010; Commission File No. 001-01011).
10.54*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.55*	Confidential Separation Agreement effective as of June 25, 2018, between the Registrant and David Denton (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2018; Commission File No. 001-01011).

10.56*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.57*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.58*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan C. Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.59*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan C. Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.60*	Change in Control Agreement dated December 22, 2008 between the Registrant and Helena Foulkes (incorporated by reference to Exhibit 10.43 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.61*	Amendment dated as of December 31, 2012 to the Change in Control Agreement between the Registrant and Helena Foulkes (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.62*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarity (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
10.63*	Restrictive Covenant Agreement dated June 1, 2014 between the Registrant and Thomas Moriarity (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
13	**Annual Report to security holders, Form 10-Q or quarterly report to security holders**
13.1	Portions of the 2018 Annual Report to Stockholders of CVS Health Corporation, which are specifically designated in this Annual Report on Form 10-K as being incorporated by reference.
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.
32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2018 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income, (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements.

Item 16. Form 10-K Summary

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS HEALTH CORPORATION

Date: February 28, 2019

By: /s/ EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 28, 2019
/s/ MARK T. BERTOLINI **Mark T. Bertolini**	Director	February 28, 2019
/s/ RICHARD M. BRACKEN **Richard M. Bracken**	Director	February 28, 2019
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 28, 2019
/s/ EVA C. BORATTO **Eva C. Boratto**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 28, 2019
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 28, 2019
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 28, 2019
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 28, 2019
/s/ DAVID W. DORMAN **David W. Dorman**	Chair of the Board and Director	February 28, 2019
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 28, 2019
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 28, 2019
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 28, 2019
/s/ LARRY J. MERLO **Larry J. Merlo**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 28, 2019
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 28, 2019
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 28, 2019
/s/ RICHARD J. SWIFT **Richard J. Swift**	Director	February 28, 2019
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 28, 2019
/s/ TONY L. WHITE **Tony L. White**	Director	February 28, 2019

Exhibit 2.3
EXECUTION AGREEMENT

MASTER TRANSACTION AGREEMENT

by and between

AETNA INC.

and

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Dated as of October 22, 2017

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EXHIBITS

MASTER TRANSACTION AGREEMENT

This Master Transaction Agreement (this " Agreement"), dated as of October 22, 2017, is entered into by and between Aetna Inc., a Pennsylvania corporation (" Seller"), and Hartford Life and Accident Insurance Company, a Connecticut insurance company (" Purchaser").

WITNESSETH:

WHEREAS, Seller owns 100% of the issued and outstanding shares of capital stock of Aetna Life Insurance Company, an insurance company organized under the laws of the State of Connecticut (the " Ceding Company");

WHEREAS, Seller and its Affiliates (as hereinafter defined), including the Ceding Company and Aetna Health and Life Insurance Company, an insurance company organized under the laws of the State of Connecticut (" AHLIC"), are engaged, among other things, in the operation of the Business (as hereinafter defined) in the United States; and

WHEREAS, the parties hereto desire to enter into this Agreement pursuant to which, on the terms and subject to the conditions set forth herein, at the Closing (as hereinafter defined), among other things:

(a) the Ceding Company will enter into a commutation agreement with AHLIC substantially in the form attached hereto as Exhibit A (the " Commutation Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the Ceding Company will recapture the portion of the Business reinsured by AHLIC effective as of immediately prior to the effectiveness of the Reinsurance Agreement (as defined below) (the " Pre-Closing Commutation");

(b) the Ceding Company will enter into a reinsurance agreement with Purchaser substantially in the form attached hereto as Exhibit B (the " Reinsurance Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the Ceding Company shall cede to Purchaser, and Purchaser shall reinsure, all "Policy Liabilities" (as such term is defined in such attached form of the Reinsurance Agreement, the " Reinsured Liabilities"), on a 100% coinsurance basis;

(c) the Ceding Company and Purchaser will enter into a trust agreement with the Trustee (as hereinafter defined) substantially in the form attached hereto as Exhibit C (the " Trust Agreement "), pursuant to which, on the terms and subject to the conditions set forth therein, Purchaser will establish and maintain a trust account (the " Trust Account") with the Trustee for the benefit of the Ceding Company to secure Purchaser's obligations to the Ceding Company under the Reinsurance Agreement;

(d) the Ceding Company will enter into an administrative services agreement with Purchaser substantially in the form attached hereto as Exhibit D (the " Administrative Services Agreement "), pursuant to which, on the terms and subject to the conditions set forth therein, Purchaser will provide to the Ceding Company administrative services with respect to the Business reinsured under the Reinsurance Agreement;

(e) the Ceding Company and Purchaser will enter into a transition services agreement substantially in the form attached hereto as Exhibit E (the " Transition Services Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the Ceding Company will, or will cause its Affiliates or third party service providers to, perform certain transition services with respect to the Business for Purchaser or its designated Affiliates;

(f) Seller and Purchaser will enter into an intellectual property assignment and license agreement substantially in the form attached hereto as Exhibit F (the " Intellectual Property Agreement"), pursuant to which Seller and the Ceding Company will, on the terms and subject to the conditions set forth therein, transfer, assign and license the Transferred Intellectual Property to Purchaser, and Purchaser will license certain Transferred Intellectual Property back to Seller;

(g) the Ceding Company, Carefree Insurance Services, Inc., a company organized under the laws of Florida and a Subsidiary of Seller, Purchaser and one or more Affiliates of Purchaser will enter into a distribution agreement substantially in the form attached hereto as Exhibit G (the " Distribution Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the parties thereto will market and sell insurance policies to each other's customers and joint customers;

(h) subject to obtaining relevant third party consents, Purchaser and Seller or their applicable Affiliates will enter into a lease assignment agreement substantially in the form attached hereto as Exhibit J (the " Portland Location Assignment Agreement"), pursuant to which Purchaser or its applicable Affiliate(s) will accept assignment of the Assigned Lease on the terms and subject to the conditions set forth herein and therein;

(i) subject to obtaining relevant third party consents, Purchaser and Seller or their applicable Affiliates will enter into sublease agreements substantially in the form attached hereto as Exhibit K , pursuant to which Seller or its applicable Affiliate(s) will sublease certain real property to Purchaser or its applicable Affiliate(s), on the terms and subject to the conditions set forth herein and therein; and

(j) Seller and its applicable Affiliates will sell to Purchaser, and Purchaser will purchase from Seller and its Affiliates, the Transferred Assets (as hereinafter defined), and Seller and its applicable Affiliates will assign to Purchaser, and Purchaser will assume from Seller and its applicable Affiliates, the Assumed Liabilities and the Assigned Contracts (as hereinafter defined).

NOW, THEREFORE, in consideration of the representations, warranties, covenants and agreements set forth herein, the parties hereto hereby agree as follows:

ARTICLE I.

DEFINITIONS

Section 1.01. Definitions. For purposes of this Agreement, the following terms have the respective meanings set forth below:

"Accounting Date" has the meaning given to such term in Section 2.06.

"Accounting Value" means, with respect to any Investment Asset as of any date of determination, the sum of: (i) the Book Value of such Investment Asset as of the applicable date of determination; plus (ii) all accrued but unpaid interest on such Investment Asset through the applicable date of determination.

"Action" means any civil, criminal, administrative or other claim, action, suit, litigation, arbitration hearing, charge, complaint, demand, notice or other similar proceeding, in each case by or before any Governmental Authority or arbitral body.

"Actuarial Report" has the meaning given to such term in Section 3.21.

"Adjusted Required Asset Value" means, as of any applicable date of determination, an amount equal to (i) the Required Asset Value as of such date, plus (if positive) or minus (if negative) (ii) the sum of all Capital Gain or Loss Adjustments required with respect to the period from the Reference Date through the applicable date of determination, plus (if positive) or minus (if negative) (iii) the sum of all Reallocated Asset Value Adjustments required with respect to the period from the Reference Date through the applicable date of determination. The Capital Gain or Loss Adjustments and Reallocated Asset Value Adjustments required with respect to the period from the Reference Date to the date hereof are required to be set forth on Section 3.19(b) of the Seller Disclosure Schedule. All Capital Gain or Loss Adjustments and Reallocated Asset Value Adjustments required with respect to the period beginning on the date hereof and ending at the Closing will be determined in accordance with Section 5.11.

"Administrative Services Agreement" has the meaning given to such term in the Recitals.

"Affiliate" means, with respect to any Person at the time in question, any other Person controlling, controlled by or under common control with such Person. For purposes of the foregoing, "control," including the terms "controlling," "controlled by" and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. Notwithstanding anything to the contrary contained in this Agreement, none of the following nor any of their respective Subsidiaries shall be deemed to be an Affiliate of Seller or any of its Subsidiaries for purposes of this Agreement: (i) bswift LLC, a Delaware limited liability company, or Prodigy Health Group, Inc., a Delaware corporation; and (ii) (x) any joint venture, accountable care organization or similar arrangement for the establishment, management or operation of a provider collaboration, network or group in which Seller and its Affiliates collectively own 50% or less of the outstanding equity securities or

economic interest and (y) any other joint venture entity formed with health systems or health care providers to the extent such joint venture entity owns or operates a health plan.

"Agreement" has the meaning given to such term in the Preamble.

"AHLIC" has the meaning given to such term in the Recitals.

"Allocable Amount" has the meaning given to such term in Section 7.01.

"Applicable Law" means all laws, common law, rules, regulations, ordinances, codes, statutes, judgments, injunctions, Governmental Orders and decrees of all Governmental Authorities applicable to the Person, place and situation in question.

"ASO Contracts" means: (i) the contracts pursuant to which the Ceding Company provides to plan sponsors of self-funded groups administrative or related services for the management of disability benefits prior to the Effective Time; and (ii) the contracts pursuant to which the Ceding Company provides to employers administrative services or software for the management of leaves of absence by employees and related rights and benefits under Applicable Law (including the Family and Medical Leave Act of 1993, as amended, the Americans with Disabilities Act of 1990, as amended, and similar U.S. state and municipal laws, and including as a result of long-term or short-term disability) and internal policies and practices of such employers, in each case of (i) and (ii) in connection with the Business.

"Asset Consideration" has the meaning given to such term in Section 2.07(a)(ii).

"Assigned Contracts" means: (i) those contracts and other agreements to which Seller or an Affiliate of Seller is a party and which are listed on Schedule I; (ii) any renewals or replacement of those contracts and other agreements to which Seller or an Affiliate of Seller is a party that are listed on Schedule I , to the extent such agreements or divisible sub-agreements thereof are entered into prior to the Closing in the ordinary course of business and in accordance with this Agreement; (iii) any vendor contracts and other vendor agreements to which Seller or an Affiliate of Seller is a party, to the extent such agreements or divisible sub-agreements thereof relate primarily or exclusively to the Business and are entered into between the date hereof and the Closing, in the ordinary course of business and in accordance with this Agreement; and (iv) each Business Employee Benefit Plan.

"Assigned Lease" has the meaning given to such term in Section 2.01.

"Assumed Liabilities" has the meaning given to such term in Section 2.04.

"Bill of Sale and Assumption and Assignment Agreement" means a bill of sale and assumption and assignment agreement, substantially in the form attached hereto as Exhibit H , to be entered into by Seller and its applicable Affiliates, on the one hand, and Purchaser, on the other hand, at the Closing.

"Board Materials" has the meaning given to such term in the definition of "Books and Records."

"Books and Records" means all records (including computer generated, recorded or stored records) relating directly and primarily to the Business that are in the possession or control of Seller, or any of its Affiliates; provided , however , that "Books and Records" excludes (the following, collectively, the " Excluded Books and Records"): (1) Tax Returns, Tax records and all other data and information with respect to Taxes of Seller and its Affiliates (other than Tax records of individual insureds under Group Contracts); (2) files, records, data and information with respect to the employees of Seller or its Affiliates, any Employee or any Employee Benefit Plan (except data and information provided pursuant to this Agreement or the Employee Leasing Agreement, in either case, with respect to any Business Employee Benefit Plan and Employee, unless prohibited by Applicable Law); (3) any materials prepared for the boards of directors or similar governing bodies of Seller or any of its Affiliates (" Board Materials"); (4) any corporate minute books, stock records or similar corporate records of Seller or any of its Affiliates; (5) any materials that are legally privileged, it being understood that Seller shall use commercially reasonable efforts to obtain waivers or make other arrangements (including redacting information or entering into joint defense agreements) that would enable such item to be transferred to or shared with Purchaser without destroying such privilege; (6) any information the disclosure or transfer of which is prohibited or restricted by Applicable Law, including antitrust, Privacy and Data Security Laws or pursuant to a contract (it being understood that Seller shall identify the records that are prohibited or restricted to be disclosed or transferred under Applicable Law and the basis for such prohibition or restriction, and shall use commercially reasonable efforts to obtain waivers or make other arrangements (including redacting information) that would enable such item to be transferred to Purchaser without so contravening any such Applicable Law or obligation under contract) (7) any internal drafts, opinions, valuations, correspondence, documents or other materials produced by, or provided between or among, Seller, its Affiliates or their respective Representatives in connection with the sale of the Business (including the negotiation, evaluation and consummation of the transactions contemplated by this Agreement and the other Transaction Agreements) or the terms of engagement of Representatives with respect thereto; and (8) consolidated financial records (including general ledgers) of Seller or its Affiliates, consolidated regulatory filings made by Seller or its Affiliates and any related correspondence with Governmental Authorities, except to the extent the information contained therein specifically or separately identifies the Business and is not otherwise included in a Book and Record. For purposes of this definition, the term " primarily" means records that relate to the Business more than any other business area of Seller or any of its Affiliates.

"Book Value" means, with respect to any Investment Asset as of any date of determination, the statutory book value thereof determined in accordance with SAP; provided that, until the Closing has occurred, the statutory book value of any asset that is transferred from AHLIC to the Ceding Company in connection with the Pre-Closing Commutation will be its statutory book value prior to such transfer.

"Burdensome Condition" has the meaning given to such term in Section 5.06(c).

"Business" means: (i) the Ceding Company's business of issuing, underwriting, reinsuring, selling, entering into, distributing, marketing, delivering, pricing, servicing, canceling, terminating and administering, as applicable, Group Contracts in the United States; and (ii) prior to the Closing, AHLIC's business of reinsuring certain Group Insurance Contracts

from the Ceding Company; provided , however , that the Business does not include any insurance business or administrative services sold by (a) the Ceding Company's "Strategic Resource Company" business unit to (x) plan sponsors seeking coverage primarily for part-time, temporary, seasonal, interim, hourly or transient employees, or (y) plan sponsors seeking coverage to meet requirements under the Davis-Bacon Act of 1931, as amended, for governmental contractors; or (b) the Ceding Company's "International" business unit to (x) plan sponsors located in Canada to cover fewer than 750 employees and beneficiaries located in the U.S., (y) plan sponsors (whether located in the United States or outside the United States) where the number of employees and beneficiaries located in the United States is fewer than (A) 25% of the total number of employees and beneficiaries on cover, or (B) 100 lives.

"Business Day" means any day other than a Saturday, Sunday or a day on which banking institutions in New York, New York or Hartford, Connecticut are permitted or obligated by Applicable Law to be closed.

"Business Employee" means each employee of Seller or any of its Affiliates who, to the Knowledge of Seller, provides, as of the Reference Date, 60 percent or more of his or her services to the Business; whose names are set forth on Section 6.01(a)(ii) of the Seller Disclosure Schedule, as such section of the Seller Disclosure Schedule may be updated in accordance with Section 6.01(a). For the avoidance of doubt, such section of the Seller Disclosure Schedule shall include such employees who as of the date hereof are actively employed as well as such employees who are on (i) a leave of absence (including temporary leave for purposes of jury or military duty, maternity or paternity leave, leave under the Family Medical Leave Act of 1993, approved personal leave or disability or medical leave) or (ii) vacation or paid time off).

"Business Employee Benefit Plan" means each plan, program or agreement set forth on Section 3.10(b) of the Seller Disclosure Schedule.

"Capital Gain or Loss Adjustment" has the meaning given to such term in Section 5.11(b)(ii).

"Ceded Reinsurance Contracts" has the meaning given to such term in Section 3.16(a).

"Ceding Commission" has the meaning given to such term in Section 2.07(a)(i).

"Ceding Company" has the meaning given to such term in the Recitals.

"Closing" has the meaning given to such term in Section 2.06.

"Closing Date" has the meaning given to such term in Section 2.06.

"Closing Required Asset Value" means the Adjusted Required Asset Value as of the Accounting Date calculated after taking into account all Capital Gain or Loss Adjustments and all Reallocated Asset Value Adjustments required pursuant to Section 5.11 or Section 3.19(b) from the Reference Date through the Closing.

"Closing Statement" means, as of any date of determination, a statement as of such date prepared in the same format as the Reference Closing Statement (assuming, for this purpose, the Closing occurred, and that the Reinsurance Agreement became effective, as of the end of the day on such date) and in accordance with the Transaction Accounting Principles.

"COBRA" means Part 6 of Subtitle B of Title I of ERISA, Section 4980B of the Code and any similar state law.

"Code" means the Internal Revenue Code of 1986.

"Commutation Agreement" has the meaning given to such term in the Recitals.

"Competing Businesses" has the meaning given to such term in Section 5.13.

"Competing Person" has the meaning given to such term in Section 5.13(e).

"Condition Satisfaction" has the meaning given to such term in Section 2.06.

"Confidentiality Agreement" has the meaning given to such term in Section 5.04(a).

"Data Input Inaccuracies" means inaccuracies or omissions to the extent arising from (i) the inputting of factual data relating to the Group Contracts or (ii) the coding, compilation or aggregation of such factual data in connection with such inputting.

"Deductible" has the meaning given to such term in Section 10.03(a).

"Discretionary Turnover Allowance" has the meaning given to such term in Section 5.11(b)(i)(B).

"Distribution Agreement" has the meaning given to such term in the Recitals.

"Effective Time" means 12:00:01 a.m. on the first calendar day of the month in which the Closing occurs.

"Employee" means each employee of Seller or any of its Affiliates whose name is set forth on Section 6.01(a)(i) of the Seller Disclosure Schedule, as such section of the Seller Disclosure Schedule may be updated in accordance with Section 6.01(a). For the avoidance of doubt, such section of the Seller Disclosure Schedule shall include such employees who as of the Closing Date are actively employed as well as such employees who are (i) on a leave of absence (including temporary leave for purposes of jury or military duty, maternity or paternity leave, leave under the Family Medical Leave Act of 1993, approved personal leave or disability or medical leave), (ii) on a vacation or paid time off or (iii) hired by Seller or any of its Affiliates in accordance with the terms and conditions of the Employee Leasing Agreement.

"Employee Benefit Plan" means each written or unwritten plan, policy, program, agreement and arrangement, other than a Business Employee Benefit Plan, whether covering a single individual or a group of individuals, that is (a) an "employee benefit plan" within the

meaning of Section 3(3) of ERISA, (b) a stock bonus, stock purchase, stock option, restricted stock, stock appreciation right, incentive stock or similar equity-based plan or (c) any other employment, severance, deferred-compensation, retention, change in control, retirement, welfare benefit, bonus, incentive or fringe benefit plan, policy, program, agreement or arrangement, in each case, which is maintained, sponsored or contributed to by Seller or any of its Affiliates and in which any Employee participates or is eligible to participate or with respect to which Seller or any of its Affiliates has any liability with respect to any Employee.

"Employee Leasing Agreement" has the meaning given to such term in Section 2.08(a)(xv).

"Employee Lease Term" has the meaning given to such term in the Employee Leasing Agreement.

"Enforceability Exceptions" has the meaning given to such term in Section 3.02.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Estimated Asset Value Statement" has the meaning given to such term in Section 2.07(d)(iii).

"Estimated Closing Required Asset Value" has the meaning given to such term in Section 2.07(d)(i).

"Estimated Closing Statement" has the meaning given to such term in Section 2.07(c)(iii).

"Estimated Required Balance" has the meaning given to such term in Section 2.07(d)(iii).

"Excluded Assets" has the meaning given to such term in Section 2.02.

"Excluded Benefits Liabilities" means any Liabilities in respect of the Employee Benefit Plans and any other benefit plans, programs, policies, arrangement or agreements maintained or contributed to by, or with respect to which Seller or its Affiliates may have any liability, other than the Business Employee Benefit Plans or as set forth in Section 6.01(i).

"Excluded Books and Records" has the meaning given to such term in the definition of "Books and Records."

"Excluded Liabilities" has the meaning given to such term in Section 2.05.

"Excluded Taxes" has the meaning given to such term in Section 2.05(c).

"Fair Market Value" means: (i) in the case of cash and cash equivalents, the face amount thereof; (ii) in the case of securities listed on an exchange or in an over-the-counter market (other than securities that constitute cash equivalents as described in clause (i) above), the final bid price on such exchange or market (provided that such bid price includes all accrued and

unpaid interest on such security through the date of determination; otherwise the amount of such accrued and unpaid interest shall be added to such bid price); and (iii) in the case of any other asset, the fair market value or valuation thereof (including accrued but unpaid interest), as determined in accordance with GAAP; provided that (a) the Fair Market Value of any Investment Asset for which a price is available through Bloomberg's "BVAL" valuation service shall be the sum of (x) the 4:00 p.m. Eastern Time bid price set for that Investment Asset by such valuation service on the applicable date of determination plus (y) all accrued and unpaid interest on such asset through the applicable date of determination, and (b) the Fair Market Value of any Investment Asset for which a price is not available through Bloomberg's "BVAL" valuation service but is available through IDC's valuation service shall be the sum of (x) the 4:00 p.m. Eastern Time bid price set for that Investment Asset by IDC's valuation service on the applicable date of determination plus (y) all accrued and unpaid interest on such asset through the applicable date of determination. Notwithstanding the foregoing, the Fair Market Value of any Investment Asset that is sold by the Ceding Company or AHLIC to a third party during the Interim Period for a price that differs from the amount determined pursuant to the prior sentence shall be the gross proceeds received by the Ceding Company or AHLIC, as applicable, in such sale, including, for the avoidance of doubt, the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset.

"Final Allocation" has the meaning given to such term in Section 7.01.

"Final Asset Value Statement" has the meaning given to such term in Section 2.09(f).

"Final Closing Required Asset Value" has the meaning given to such term in Section 2.09(f).

"Final Closing Required Asset Value Statement" has the meaning given to such term in Section 2.09(f).

"Final Closing Statement" has the meaning given to such term in Section 2.09(f).

"FMV Ex-Accrued" means, with respect to any Investment Asset as of any date of determination, the Fair Market Value thereof as of such date, excluding the amount of all accrued but unpaid interest on such Investment Asset through such date; provided that, notwithstanding the foregoing, (a) the FMV Ex-Accrued of any Investment Asset for which a price is available through Bloomberg's "BVAL" valuation service shall be the 4:00 p.m. Eastern Time bid price set for that Investment Asset by such valuation service on the applicable date of determination, and (b) the FMV Ex-Accrued of any Investment Asset for which a price is not available through Bloomberg's "BVAL" valuation service but is available through IDC's valuation service shall be the 4:00 p.m. Eastern Time bid price set for that Investment Asset by IDC's valuation service on the applicable date of determination. Notwithstanding the foregoing, the FMV Ex-Accrued of any Investment Asset that is sold by the Ceding Company or AHLIC to a third party in the period from the Reference Date through the Closing Date for a price (excluding accrued but unpaid interest) that differs from the amount determined pursuant to the prior sentence shall be the gross proceeds received by the Ceding Company or AHLIC, as

applicable, in such sale, less the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset.

"GAAP" means generally accepted accounting principles in the United States.

"Governmental Approval" has the meaning given to such term in Section 3.05.

"Governmental Authority" means any governmental, legislative, judicial, administrative or regulatory authority, agency, commission, board, body, court, self-regulatory body or entity or any instrumentality thereof, including any Tax Authority, whether United States federal, state, local or non-U.S.

"Governmental Order" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"Group Contracts" means the Group Insurance Contracts and the ASO Contracts.

"Group Insurance Contracts" means (i) the contracts, policies, certificates, binders, slips, covers or other agreements of employer and employee paid (a) group life insurance, including group term life insurance, voluntary spouse and dependent term life insurance, group universal life insurance, supplemental life insurance and accidental death and dismemberment insurance, (b) group disability insurance, including long-term and short-term disability insurance and statutory disability insurance and New York Paid Family Leave, and (c) individual or group life insurance issued or established as a result of the exercise of any conversion or other portability option or feature under any of the contracts, policies, certificates, binders, slips, covers or other agreements described in clause (i)(a) above, (ii) all funding or premium deposit agreements used to fund the group long-term disability or group life insurance contracts described in clause (i) above, (iii) all reserve buy out agreements for disability insurance and life insurance and (iv) all retained asset accounts relating to the agreements described in clause (i) above, in each case of clause (i) through (iv) that are issued or assumed by the Ceding Company prior to the Effective Time in connection with the Business and including all supplements, riders, endorsements and ancillary agreements issued or written in connection therewith and extensions thereto.

"Hannover Consent" means the consent and waiver, dated as of October 11, 2017, by Hannover Life Reassurance Company of America of Section 13.1 of that certain Yearly Renewable Term Reinsurance Agreement by and between the Ceding Company and Hannover Life Reassurance Company of America, effective January 1, 2017.

"Hartford License Agreement" has the meaning given to such term in Section 2.08(a)(xiv).

"Hartford Fire" means Hartford Fire Insurance Company, an insurance company organized under the laws of the State of Connecticut.

"HCERA" has the meaning given to such term in Section 3.10(g).

"Health Plan" has the meaning given to such term in Section 3.10(g).

"IMR" means interest maintenance reserve, calculated in accordance with SAP.

"Indemnifiable Losses" has the meaning given to such term in Section 10.04(iii).

"Indemnitee" has the meaning given to such term in Section 10.04(i).

"Indemnitor" has the meaning given to such term in Section 10.04(ii).

"Indemnity Payment" has the meaning given to such term in Section 10.04(iv).

"Independent Accountant" has the meaning given to such term in Section 2.09(e).

"Initial Asset Value Statement" has the meaning given to such term in Section 2.09(a).

"Initial Closing Required Asset Value Statement" has the meaning give to such term in Section 2.09(a).

"Initial Closing Statement" has the meaning given to such term in Section 2.09(a).

"Insurance Regulator" means, with respect to any jurisdiction, the Governmental Authority charged with the supervision of insurance companies in such jurisdiction.

"Intellectual Property" means, in any and all jurisdictions, any: (i) Trademarks; (ii) copyrights, rights in copyrightable subject matter in published and unpublished works of authorship and database rights, (iii) registrations and applications to register or renew the registration of any of the foregoing, (iv) patents and patent applications, including all reissues, divisionals, renewals, extensions, provisionals, continuations and continuations-in-part thereof, (v) rights in Trade Secrets, and (vi) intellectual property rights embodied in Software.

"Investment Assets" means any interest in any bonds, notes, debentures, mortgage loans, real estate, instruments of indebtedness, stocks, joint venture or partnership interests, and all other equity interests, certificates issued by or interests in trusts, derivatives or other assets acquired or held for investment purposes, including without limitation, any assignment instruments relating thereto.

"Investment Guidelines" means the investment policies and guidelines applicable to the investment activities of the Ceding Company (in respect of the Business) as in effect as of the date hereof, a true and complete copy of which is set forth in Section 1.01(a) of the Seller Disclosure Schedule.

"Intellectual Property Agreement" has the meaning given to such term in the Recitals.

"IT Systems" means the hardware, Software, data, databases, data communication lines, network and telecommunications equipment, Internet-related information technology infrastructure, wide area network and other information technology equipment, owned, leased or licensed by Seller or any of its Affiliates and used in the Business.

"Knowledge" means, unless otherwise expressly provided herein, the actual knowledge, after reasonable inquiry of direct reports, of those individuals listed (a) with respect to Seller, on Section 1.01(b) of the Seller Disclosure Schedule, and (b) with respect to Purchaser, on Section 1.01(b) of the Purchaser Disclosure Schedule.

"Leases" has the meaning given to such term in Section 3.15.

"Lease Consents" has the meaning given to such term in Section 5.12(b).

"Leave Recipient" has the meaning given to such term in Section 6.01(b).

"Legal Hold" means any requirement to preserve documents and records in connection with any pending or reasonably contemplated litigation or arbitration (or other form of dispute resolution), nonparty subpoena, regulatory inquiry or investigation by a Governmental Authority or other legal process or proceedings (i) for which Seller provides notice to Purchaser or (ii) arising out of, relating to or in respect of any Indemnifiable Loss for which a Purchaser Indemnified Person seeks indemnification pursuant to Article X. For purposes of this definition, the term "documents" is defined as synonymous with the term "documents or electronically stored information" in Federal Rule of Civil Procedure 34(a)(1)(A).

"Liabilities" means, with respect to any Person, any liability or obligation of such Person of any kind, character or description, whether known or unknown, absolute or contingent, accrued or unaccrued, disputed or undisputed, liquidated or unliquidated, secured or unsecured, joint or several, due or to become due, vested or unvested, executory, determined, determinable or otherwise.

"Lien" means any pledge, security interest, mortgage, lien, attachment, right of first refusal, or option, including any restriction on receipt of income or exercise of any other attribute of ownership, except such restrictions as may be contained in any Applicable Law relating to insurance.

"Listed Sales Employee" has the meaning given to such term in Section 6.01(c).

"Material Adverse Effect" means a material adverse effect on (A) the financial condition, business, assets (when compared to liabilities) or results of operations of the Business, but excluding any such effect to the extent resulting from or arising out of: (i) changes occurring after the date of this Agreement in general political, economic or securities, currency, capital, credit or financial market conditions (including changes in interest rates and changes in equity prices in general); (ii) any occurrence or condition generally affecting participants in any jurisdiction or geographic area in any segment of the industries or markets in which the Business is operated; (iii) any change or proposed change in GAAP, SAP or Applicable Law, or the interpretation or enforcement thereof; (iv) natural or man-made catastrophe events, hostilities, acts of war or terrorism, or any escalation or worsening thereof; (v) any pandemic or similar outbreak; (vi) the negotiation, execution and delivery of, or compliance with the terms of, or the taking of any action required by, this Agreement or the other Transaction Agreements, the failure to take any action prohibited by this Agreement or the other Transaction Agreements, or the public announcement of, or consummation of, any of the transactions contemplated hereby or thereby (including the effect thereof on the relationships (contractual or otherwise) of the Ceding

Company and its Affiliates with policyholders, clients, customers, employees, suppliers, vendors, service providers, members or Governmental Authorities); (vii) the identity of or facts related to Purchaser or its Affiliates or the effect of any action taken by Purchaser or its Affiliates, or taken by Seller or any of its Affiliates at the request of Purchaser or with Purchaser's prior consent (including the effect thereof on the relationships (contractual or otherwise) of the Ceding Company and its Affiliates with policyholders, clients, customers, employees, suppliers, vendors, service providers, members or Governmental Authorities); (viii) any downgrade or threatened downgrade in the rating assigned to Seller or any of its Affiliates by any rating agency (provided , that this clause (viii) shall not by itself exclude the underlying cause of any such downgrade or threatened downgrade); (ix) the fair market value of, or any change or development in the fair market value of, any of the Investment Assets of the Ceding Company or any of the Investment Assets that are to be transferred to Purchaser or the Trust Account pursuant to the terms of any Transaction Agreement; or (x) any failure of the Business to meet any financial projections or targets (provided , that this clause (x) shall not by itself exclude the underlying causes of any such failure); except, in the cases of clauses (i) through (iii), to the extent such effect disproportionately affects the Business relative to other Persons engaged in businesses similar to the Business; or (B) the ability of Seller or any of its Affiliates to perform any of their respective material obligations under this Agreement or any of the other Transaction Agreements or to consummate the material transactions contemplated by this Agreement and the other Transaction Agreements (including the ability to consummate the Closing prior to the Outside Date).

"Material Contract" has the meaning given to such term in Section 3.06(a).

"Milliman" has the meaning given to such term in Section 3.21.

"Monthly Asset Value Statement" has the meaning given to such term in Section 5.11(a)(i).

"Munich Consent" means the consent and waiver, dated as of October 21, 2017, by Munich American Reassurance Company of Section 17.4 of that certain Yearly Renewal Term Reinsurance Agreement by and between the Ceding Company and Munich American Reassurance Company, effective January 1, 2017.

"New Award" has the meaning given to such term in Section 6.01(m).

"Non-Assignable Asset" has the meaning given to such term in Section 2.03.

"Non-Assigned Leases" has the meaning given to such term in Section 3.15.

"Non-Occupied Properties" has the meaning given to such term in Section 5.12(a).

"Notice of Disagreement" has the meaning given to such term in Section 2.09(c).

"Occupied Properties" has the meaning given to such term in Section 5.12(a).

"Omaha Sublease" has the meaning given to such term in Section 2.08(a)(xiii).

"One Common Solution" means the comprehensive vendor integration Software platform for the Business.

"Open Source Software" means all Software that is distributed as "free software," "open source software," or under a similar licensing or distribution model, including the GNU General Public License, GNU Lesser General Public License, Mozilla Public License, BSD Licenses, the Artistic License, the Netscape Public License, the Sun Community Source License, the Sun Industry Standards License, the Apache License, and any license identified as an open source license by the Open Source Initiative (www.opensource.org).

"Operating Permits" has the meaning given to such term in Section 3.11.

"Outside Date" has the meaning given to such term in Section 9.01(b).

"PPACA" has the meaning given to such term in Section 3.10(g).

"Permit" means any license, permit, order, approval, consent, registration, membership, authorization or qualification under any Applicable Law or with any Governmental Authority or under any industry or non-governmental self-regulatory organization.

"Permitted Liens" means: (a) materialmen's, mechanics', construction, carriers', workmen's and repairmen's liens and other similar liens arising in the ordinary course of business; (b) Liens for Taxes, assessments and governmental charges or levies which are not yet due or delinquent, which are being contested in good faith and for which appropriate reserves are maintained in accordance with GAAP or SAP, as applicable; (c) easements, rights-of-way, encroachments, restrictions, conditions and other similar Liens which, individually or in the aggregate, do not materially impair the use or value of the applicable real property or materially interfere with the ordinary conduct of the Business; (d) statutory landlords' liens and liens granted to landlords under any lease; (e) Liens contemplated by this Agreement or any Transaction Agreement, and any custodian or similar liens contemplated or permitted thereunder; (f) in the case of the Assigned Lease, Liens affecting the interest of the lessor; (g) licenses of Intellectual Property made in the ordinary course of business (excluding any source code escrow agreements or any other agreement requiring the deposit of source code or related materials for any such Developed Software); (h) Liens incurred or pledges or deposits made in compliance with workers' compensation, unemployment insurance or other social security laws or regulations; and (i) any other Liens that do not materially impair the value of or interfere with or prohibit the current use or operation of the relevant asset in the Business.

"Person" means any individual, corporation, partnership, firm, joint venture, association, limited liability company, limited liability partnership, joint-stock company, trust, unincorporated organization, governmental, judicial or regulatory body, business unit, division or other entity.

"Personal Data" has the same meaning as the term "personal data," "personal information," or the equivalent under the applicable Privacy and Data Security Law.

"Plantation Sublease" has the meaning given to such term in Section 2.08(a)(xi).

"Portland Location" has the meaning given to such term in Section 3.15.

"Portland Location Assignment Agreement" has the meaning given to such term in the Recitals.

"Pre-Closing Commutation" has the meaning given to such term in the Recitals.

"Pre-Closing Investment Guidelines" means the investment policies and guidelines applicable to the investment activities of the Ceding Company and AHLIC with respect to the Specified Portfolio as set forth on Schedule IV.

"Pre-Closing Period" means a Tax period (or portion thereof) that ends on or before the Closing Date

"Primary Contract" has the meaning given to such term in Section 3.06(vi).

"Privacy and Data Security Law" means any Applicable Laws relating to data privacy, data security, cybersecurity, or data protection, including with respect to the collection, storage, transmission, transfer (including cross-border transfers), processing, breach notification, unauthorized access, encryption, security, safeguarding, loss, disclosure and use of Personal Data.

"Producer" means any producer, broker, agent, general agent, managing general agent, master broker agency, broker general agency, financial specialist or other Person responsible for marketing or producing Group Insurance Contracts prior to the Closing Date.

"Pro Forma Financial Statements" has the meaning given to such term in Section 3.18(b).

"Properties" has the meaning given to such term in Section 5.12.

"Purchase Price" has the meaning given to such term in Section 2.07(a).

"Purchaser" has the meaning given to such term in the Preamble.

"Purchaser 401(k) Plan" has the meaning given to such term in Section 6.01(f).

"Purchaser Disclosure Schedule" has the meaning given to such term in Article IV.

"Purchaser FSA" has the meaning given to such term in Section 6.01(k).

"Purchaser Indemnified Persons" has the meaning given to such term in Section 10.02(a).

"Purchaser Material Adverse Effect" means a material adverse effect on the ability of Purchaser or any of its Affiliates to perform its respective obligations under this Agreement or any Transaction Agreement or to consummate the material transactions contemplated by this Agreement or any of the other Transaction Agreements. For the avoidance

of doubt and without limiting the foregoing, "Purchaser Material Adverse Effect" includes a material impairment on the ability of Purchaser to obtain any Governmental Approval required to be obtained by Purchaser in connection with the consummation of the transactions contemplated by the Transaction Agreements, notwithstanding the compliance by Purchaser with the terms of this Agreement (including Section 5.06).

"Purchaser Permits" has the meaning given to such term in Section 4.08(a).

"Purchaser Specified Representations" means the representations and warranties made in Section 4.01 , Section 4.02 , Section 4.07(a) and Section 4.09.

"Reallocated Asset Value Adjustment" has the meaning given to such term in Section 5.11(c).

"Reallocated Investment Asset" means any Investment Asset or portion thereof that is designated for inclusion in the Specified Portfolio during the period from the Reference Date through the Closing Date pursuant to terms of Section 5.11 or Section 3.19(b) and was, immediately prior to such designation, held by the Ceding Company or AHLIC but not allocated to the Specified Portfolio.

"Reference Closing Statement" means the pro forma balance sheet of the Business as of the Reference Date set forth, for illustrative purposes, in Section 2.07(c)(i) of the Seller Disclosure Schedule (assuming, for this purpose, the Closing occurred, and that the Reinsurance Agreement became effective, as of the Reference Date).

"Reference Date" means June 30, 2017.

"Registered" means issued by, registered or filed with, renewed by or the subject of a pending application before, any Governmental Authority, social media service provider or Internet domain name registrar.

"Reinsurance Agreement" has the meaning given to such term in the Recitals.

"Reinsured Liabilities" has the meaning given to such term in the Recitals.

"Representative" means, with respect to any Person, such Person's Affiliates and the officers, directors, employees, agents, investment bankers, attorneys, financial advisers, accountants, actuaries or other representatives of such Person or any of its Affiliates.

"Required Asset Value" means, as of any date of determination, the amount that would be required to be set forth on the line item labeled "Investments, cash, cash equivalents & accrued inv. Income" in the column labeled "Target Unit Items to be transferred" on a Closing Statement prepared as of such date. For the avoidance of doubt, "Required Asset Value" shall not include any assets required to support any new interest maintenance reserve that will be required to be established upon the transfer of Investment Assets from AHLIC to the Ceding Company in connection with the Pre-Closing Commutation.

"Restricted Entities" has the meaning given to such term in Section 5.13.

"Restricted Period" has the meaning given to such term in Section 5.13.

"Retained Books and Records" has the meaning given to such term in Section 5.05(a).

"Review Period" has the meaning given to such term in Section 2.09(b).

"SAP" means, as to any regulated insurance company, the statutory accounting practices prescribed or permitted by the Governmental Authority responsible for the regulation of insurance companies in the jurisdiction in which such company is domiciled.

"Section 409A" has the meaning given to such term in Section 3.10(e).

"Selection Waterfall" has the meaning given to such term in Section 5.11(a)(iii).

"Seller" has the meaning given to such term in the Preamble.

"Seller 401(k) Plan" has the meaning given to such term in Section 6.01(g).

"Seller Confidentiality Agreement" has the meaning given to such term in Section 5.04(d).

"Seller Disclosure Schedule" has the meaning given to such term in Article III.

"Seller Forfeited Equity Award" has the meaning given to such term in Section 6.01(m).

"Seller FSA" has the meaning given to such term in Section 6.01(k).

"Seller Indemnified Persons" has the meaning given to such term in Section 10.02(b).

"Seller Retention Bonus Liabilities" has the meaning given to such term in Section 6.01(q).

"Seller Specified Representations" means the representations and warranties made in Section 3.01 , Section 3.02 and Section 3.20.

"Seller Trademarks" has the meaning given to such term in Section 5.10(b).

"Shared Service Functions and Assets" means the shared service functions and assets listed on Section 1.01(c) of the Seller Disclosure Schedule.

"Software" means all computer software, including but not limited to application software, system software, firmware, middleware, mobile digital applications, assemblers, applets, compilers and binary libraries, including all source code and object code versions of any and all of the foregoing, in any and all forms and media, and all related documentation.

"South Portland Sublease" has the meaning given to such term in Section 2.08(a)(xii).

"Specified Portfolio" has the meaning given to such term in Section 2.07(c)(ii).

"Statutory Statements" has the meaning given to such term in Section 3.18(a).

"Straddle Period" means a Tax period that begins on or before the Closing Date and ends after the Closing Date, provided that in the case of any Straddle Period, Taxes allocable to the Pre-Closing Period shall equal: (i) in the case of Taxes imposed on a periodic basis (such as real or personal property Taxes), the product of the amount of such Taxes for the Straddle Period and a fraction, the numerator of which is the number of calendar days in the Straddle Period that elapsed through the date hereof and the denominator of which is the number of calendar days in the entire Straddle Period, and (ii) in the case of Taxes not described in clause (i), the amount computed as if such taxable period ended as of the close of business on the date hereof.

"Subleases" means the South Portland Sublease, the Plantation Sublease and the Omaha Sublease.

"Subsidiary" of any Person at the time in question means another Person (other than a joint venture formed with health care providers) more than 50% of the total combined voting power of all classes of capital stock or other voting interests of which, or more than 50% of the equity securities of which, is at such time owned directly or indirectly by such first Person.

"Tax" or " Taxes" means any and all federal, state, provincial, foreign or local income, gross receipts, premium, capital stock, franchise, profits, withholding, social security, Medicare, unemployment, disability, real property, ad valorem/personal property, stamp, goods and services, harmonized sales, excise, occupation, sales, use, transfer, value added, alternative minimum, estimated or other tax, fee, duty, levy, custom, tariff, impost, assessment or charge of the same or of a similar nature to any of the foregoing, including any interest, penalty or addition thereto.

"Tax Authority" means, with respect to any Tax, any government or political subdivision thereof that imposes such Tax, and any agency charged with the collection, assessment, determination or administration of such Tax for such government or subdivision.

"Tax Contest" has the meaning given to such term in Section 7.03.

"Tax Return" means any return, report, declaration, claim for refund or other return or statement, including any schedule or attachment thereto, and any amendment thereof, required to be filed or furnished in connection with the determination, assessment or collection of any Tax.

"Third Party Claim" has the meaning given to such term in Section 10.04(v).

"Threshold Amount" has the meaning given to such term in Section 10.03(a).

"Trademark License Agreement" has the meaning given to such term in Section 5.10(a).

"Trademarks" means trademarks, service marks, Internet domain names, trade dress, trade names, logos, slogans, social media identifiers, handles and tags, and any other indicia of origin, registrations and applications with respect to the foregoing, and the goodwill associated therewith and symbolized thereby.

"Trade Secrets" means all confidential information deriving economic value from not being generally known or readily ascertainable, and that is the subject of reasonable efforts to maintain confidentiality, including, as applicable, inventions, processes, designs, formulae, models, tools, algorithms, Software architectures, trade secrets, know-how, ideas, research and development, data and databases and confidential information.

"Transaction Accounting Principles" means the methodologies, procedures, judgments, practices, principles and estimates used to compute and prepare the Reference Closing Statement and described in Schedule V.

"Transaction Agreements" means this Agreement, the Reinsurance Agreement, the Trust Agreement, the Administrative Services Agreement, the Transition Services Agreement, the Bill of Sale and Assignment and Assumption Agreement, the Intellectual Property Agreement, the Distribution Agreement, the Trademark License Agreement, the Commutation Agreement, the Portland Location Assignment Agreement, the Plantation Sublease, the South Portland Sublease, the Omaha Sublease, the Employee Leasing Agreement and the Data Processing Side Letter.

"Transfer Date" has the meaning given to such term in Section 6.01(c).

"Transfer Offers" has the meaning given to such term in Section 6.01(a).

"Transfer Taxes" has the meaning given to such term in Section 7.02.

"Transferred Assets" has the meaning given to such term in Section 2.01.

"Transferred Employee" has the meaning given to such term in Section 6.01(c).

"Transferred Intellectual Property" has the meaning given to such term in Section 2.01.

"Transferred Portfolio" has the meaning give to such term in Section 2.07(d)(ii).

"Transition Services Agreement" has the meaning given to such term in the Recitals.

"Triggering Event" has the meaning given to such term in the form of the Reinsurance Agreement attached hereto as Exhibit B.

"True-Up Amount" means an amount (which may be positive or negative) equal to (i) the final Accounting Value of the Transferred Portfolio as set forth in the Final Asset Value Statement minus (ii) the Final Closing Required Asset Value.

"Trust Account" has the meaning given to such term in the Recitals.

"Trust Agreement" has the meaning given to such term in the Recitals.

"Trustee" means a U.S. bank or other financial institution or another Person mutually agreed upon by Seller and Purchaser.

"WARN Act" has the meaning given to such term in Section 6.01(e).

"Workability" means the integrated leave, disability and premium life waiver administration Software platform for the Business that includes One Common Solution, as well as the following functionality: (a) absence management, (b) web portal, (c) mobile and claims payment systems, (d) tax reporting, and (e) data analytics.

ARTICLE II.

TRANSFER AND ACQUISITION OF ASSETS

Section 2.01. Purchase and Sale of the Transferred Assets. Upon the terms and subject to the conditions set forth in this Agreement, at the Closing (except with respect to the Business Employee Benefit Plans and the Assigned Lease (subject to the terms of Section 2.08(d)), at the date of termination of the Employee Lease Term), Seller shall, and shall cause its Affiliates to, sell, convey, assign, transfer and deliver to Purchaser, free and clear of all Liens other than Permitted Liens, and Purchaser shall purchase, acquire, assume and accept from Seller and its Affiliates, pursuant to agreements, notifications, or other instruments in such form, reasonably satisfactory to Purchaser, all of Seller's and each such Affiliate's right, title and interest in and to the following assets, properties, rights and contracts (other than the Excluded Assets and excluding, for the avoidance of doubt, any cash or Investment Assets that are transferred to Purchaser or to the Trust Account in connection with the transactions contemplated by the Reinsurance Agreement or pursuant to the terms of Sections 2.07 , 2.09 and 2.10), in each case that exist as of the Closing Date (such assets, properties, rights and contracts to be purchased, acquired, assumed and accepted by Purchaser being referred to herein as the " Transferred Assets"):

(a) the Assigned Contracts;

(b) (i) the Intellectual Property (other than intellectual property rights embodied in Software, and the Trademarks and domain names licensed to Purchaser pursuant to the Trademark License Agreement) owned by Seller or any of its Affiliates and primarily used in the Business, including the Intellectual Property listed on Schedule II(b);

(ii) Workability, including the Intellectual Property embodied therein, other than Software that is generally commercially available and set forth on Section 2.01(b)(ii) of the Seller Disclosure Schedule; and

(iii) all other Software that is necessary to operate Workability, in each case other than (A) Software that is generally commercially available, (B) Open Source Software, and (C) the Seller Software licensed to Purchaser pursuant to the Intellectual Property Agreement ((i), (ii) and (iii) collectively, the " Transferred Intellectual Property");

(c) all furniture, fixtures, equipment (including computer hardware), supplies and other tangible personal property of the Business, in each case to the extent listed on Schedule II(c);

(d) the Books and Records, the transfer of which shall be subject to Section 5.05;

(e) all advertising, marketing, sales and promotional materials relating directly and primarily to the Business;

(f) all rights and claims under any and all warranties extended by suppliers, vendors, contractors, manufacturers and licensors to the extent in relation to any of the Transferred Intellectual Property and hardware assets included in the Transferred Assets;

(g) subject to the terms of Section 2.08(d) , the real estate lease listed on Schedule II(g) (the " Assigned Lease") and all installations, fixtures, improvements and benefits in connection therewith;

(h) the phone numbers listed on Schedule II(h); and

(i) all other assets of the Business listed on Schedule II(i).

Section 2.02. Excluded Assets. Notwithstanding anything contained in this Agreement (including Section 2.01) to the contrary and except to the extent of rights expressly provided in certain Transaction Agreements, neither Seller nor any of its Affiliates is selling, transferring, conveying or delivering (or causing to be sold, transferred, conveyed or delivered), and Purchaser is not purchasing, assuming or accepting any assets, properties, rights and contracts of Seller or any of its Affiliates, or any interests therein, other than the Transferred Assets (all such assets, properties, rights and contracts of Seller or any of its Affiliates, or any interests therein, other than the Transferred Assets being referred to herein as the " Excluded Assets"). Without limiting the generality of the foregoing, all of the following shall constitute Excluded Assets:

(a) all cash and cash equivalents, including checking accounts, bank accounts, certificates of deposit and securities, of Seller or any of its Affiliates;

(b) all intercompany receivables and other amounts due from Seller or its Affiliates;

(c) all contracts to which Seller or any Affiliate thereof is a party or is otherwise bound other than the Assigned Contracts;

(d) any real estate leases, real estate title, or any installations, fixtures, and other improvements at Seller's or any of its Affiliates' leased real estate, whether or not used for the benefit of the Business, in each case other than the Assigned Lease or as contemplated by Section 2.01(g) ;

(e) all furniture, fixtures, equipment (including computer hardware), machinery and other tangible personal property of Seller or any of its Affiliates that are not listed on Schedule II(c);

(f) all Permits of Seller or its Affiliates;

(g) Seller's or any of its Affiliates' rights under any policies of insurance or any benefits, proceeds, or premium refunds payable or paid thereunder or with respect thereto;

(h) all rights of Seller or any of its Affiliates to file for or receive any refunds, credits or similar benefits for Taxes levied and imposed upon, or in connection with, the Transferred Assets or the conduct or operation of the Business allocable to any Pre-Closing Period or to the portion of the Straddle Period ending on the Closing Date;

(i) the Excluded Books and Records;

(j) all rights of Seller or any of its Affiliates under the Transaction Agreements;

(k) all rights of Seller or any of its Affiliates to indemnification from any Person with respect to any of the Excluded Liabilities;

(l) all prepaid Taxes allocable to taxable periods or portions thereof ending on or before the Closing Date;

(m) all Intellectual Property owned by Seller or any of its Affiliates (including all rights in and to the Seller Trademarks), other than the Transferred Intellectual Property;

(n) all Intellectual Property licensed to Seller or any of its Affiliates, other than Intellectual Property licensed pursuant to an Assigned Contract;

(o) all of Seller's or any of its Affiliates' e-mail addresses, URLs, websites, website content, and telephone numbers, other than as contemplated by Section 2.01(h);

(p) all bank accounts and lockboxes used in the Business;

(q) all assets in respect of any Employee Benefit Plan;

(r) any assets arising out of, and any associated claims arising out of, the Excluded Liabilities;

(s) any legal or beneficial interest in the capital stock and other equity interests of Seller or its Affiliates;

(t) the accounts and notes receivable not included in the Transferred Assets;

(u) any assets transferred or otherwise disposed of by Seller or any of its Affiliates (other than any intercompany transfers or sales) in compliance with Section 5.01(a) prior to the Closing;

(v) all accounting systems owned or used by Seller or any of its Affiliates, whether or not used in connection with the operation of the Business, including those that comprise the Shared Service Functions and Assets;

(w) any assets utilized by Seller or any of its Affiliates in connection with businesses other than the Business, including those that comprise the Shared Service Functions and Assets; and

(x) the Shared Service Functions and Assets.

Section 2.03. Procedures for Assets Not Transferrable.

(a) Notwithstanding anything to the contrary contained in this Agreement, if any asset, property, right or contract intended to be included in the Transferred Assets (other than with respect to the Assigned Lease, which is addressed in Section 5.12) is not assignable, transferable or able to be subleased or licensed (as applicable) (each a " Non-Assignable Asset") to Purchaser without the consent or waiver of any Person (other than Seller, Purchaser or any of their respective Affiliates or Governmental Authority), and such consent or waiver has not been obtained on or prior to the Closing Date, this Agreement and the other Transaction Agreements shall not constitute an assignment, transfer, sublease or license (as applicable) thereof unless and until such consent is obtained; provided , that this Section 2.03(a) shall not affect whether any such asset, property, right or contract will be deemed a "Transferred Asset" or "Assigned Contract" under this Agreement. In each such case, Seller shall, and shall cause its Affiliates to, use commercially reasonable efforts to obtain, prior to the Closing, any consent or waiver from any third party (other than a Governmental Authority) that is required for Seller or its applicable Affiliates to sell, transfer, assign, convey and deliver the Transferred Assets and Assigned Contracts to Purchaser or to provide the services to be provided under the Transition Services Agreement. Purchaser shall, and shall cause each of its Affiliates to, cooperate with Seller and its Affiliates at Seller's request to assist Seller and its Affiliates in obtaining such consents or waivers. Each of Seller and Purchaser shall bear its own and its Affiliates' internal costs to obtain such consents and waivers, and the costs payable to third parties for obtaining such consents and waivers (which, for the avoidance of doubt, shall not include any increased fees under the terms of any Assigned Contract from and after the Closing) shall be borne equally by Seller and Purchaser.

(b) If any such consent or waiver referred to in Section 2.03(a) cannot be obtained prior to the Closing, then, to the extent permitted by Applicable Law and the terms of any relevant contracts with third parties, Seller shall, and shall cause its applicable Affiliates to, until the earlier of (i) the time at which such consent or waiver is obtained, and (ii) the expiration or termination of the term or duration of any such Non-Assignable Asset (the length of such term or duration being as it exists as of the Closing): (A) hold the Non-Assignable Assets, from and after the Closing, in trust for the benefit of Purchaser, and all benefits and obligations existing thereunder shall be for Purchaser's account; and (B) take or cause to be taken such actions in its name or otherwise as Purchaser may reasonably request so as to provide Purchaser with the benefits of such Non-Assignable Assets, to enforce (for the benefit of Purchaser or one its Affiliates and to the extent it is commercially reasonable to do so) any of Seller's or Seller's Affiliates' respective rights relating to such Non-Assignable Assets and to effect the collection of

money or other consideration that becomes due and payable under such Non-Assignable Asset, and shall promptly pay over to Purchaser all money or other consideration received by it in respect of such Non-Assignable Asset, provided that Purchaser shall indemnify Seller and Seller's Affiliates for any Liabilities arising out of any action or omission by Purchaser relating to such Non-Assignable Asset (other than any such action or omission by Purchaser at the request or direction of Seller). Purchaser shall timely pay, perform or otherwise discharge (in accordance with the respective terms and subject to the respective conditions thereof, and in the name of Seller or its applicable Affiliate) all of the covenants and obligations of Seller or its applicable Affiliate incurred after the Closing with respect to such Non-Assignable Asset (including, for the avoidance of doubt, any increases in fees, costs or expenses required to be paid by Seller under the terms thereof), provided that Seller shall indemnify Purchaser for any Liabilities arising out of any action or omission by Seller relating to such Non-Assignable Asset (other than any such action or omission by Seller at the request or direction of Purchaser). Purchaser and Seller shall mutually cooperate to provide any other reasonable alternative arrangements as may be reasonably required to implement the purpose and intent of this Agreement and the other Transaction Agreements so that Purchaser and its Affiliates will have access to the rights and benefits contemplated by such Non-Assignable Asset from and after the Closing. Upon obtaining the requisite consent of any applicable Person, any previously Non-Assignable Asset and any Leases that were not assigned, transferred, subleased or licensed (as applicable) at the Closing (in accordance with the first sentence of this Section 2.03(a)) shall be promptly transferred, assigned, subleased or licensed (as applicable) by the Seller or its applicable Affiliate(s) to Purchaser for no additional consideration.

Section 2.04. Assumption of the Assumed Liabilities. Upon the terms and subject to the conditions set forth in this Agreement, at the Closing, Seller shall, and shall cause its Affiliates to, assign to Purchaser, and Purchaser shall assume, satisfy and discharge when due, any and all Liabilities of Seller or any of its Affiliates relating to the Transferred Assets (other than the Excluded Liabilities and excluding, for the avoidance of doubt, (i) all Reinsured Liabilities reinsured by Purchaser under and pursuant to the Reinsurance Agreement, which will be governed by the terms of the Reinsurance Agreement, to the extent arising on or after the Closing Date, (ii) any Liabilities that result from a breach by Seller or its Affiliates of any Assigned Contract arising out of an action or omission occurring prior to the Closing) (all such Liabilities to be so assumed, satisfied or discharged being referred to herein as the " Assumed Liabilities"), including the following: (a) all Liabilities arising under the Assigned Contracts; (b) all Liabilities for Taxes relating to the Transferred Assets other than Excluded Taxes; (c) all Liabilities assumed by Purchaser pursuant to Articles VI and VII; and (d) all Liabilities listed on Schedule III. Notwithstanding the foregoing, the Liabilities of Seller or any of its Affiliates relating to the Business Employee Benefit Plans and the Assigned Lease shall not be assumed or assigned to Purchaser until the termination of the Employee Lease Term, after which time Purchaser shall (with respect to the Assigned Lease, subject to the terms of Section 2.08(d)) assume, satisfy and discharge when due, any and all Liabilities of Seller or any of its Affiliates thereunder.

Section 2.05. Excluded Liabilities. Notwithstanding anything to the contrary contained in this Agreement, Purchaser will not assume or be liable for, and Seller and its applicable Affiliates will retain and remain responsible for, all of Seller's and such Affiliates' Liabilities (fixed or contingent, known or unknown) (other than the Assumed Liabilities and excluding, for

the avoidance of doubt, all Reinsured Liabilities reinsured by Purchaser under and pursuant to the Reinsurance Agreement, which will be governed by the terms of the Reinsurance Agreement), regardless of when asserted (collectively, the " Excluded Liabilities"). Without limiting the foregoing, the Excluded Liabilities include the following:

(a) all of Seller's and its Affiliates' Liabilities under the Transaction Agreements;

(b) the Excluded Benefits Liabilities;

(c) any Liability for or in respect of the payment of all Taxes of Seller or any of its Affiliates, and of any Taxes arising out of or relating to the ownership or use of the Transferred Assets or the conduct of the Business for a Pre-Closing Period, other than as provided in Section 7.02 and Taxes arising out of or relating to actions that Purchaser requests Seller to take prior to Closing (the " Excluded Taxes");

(d) all Liabilities arising out of, in connection with or under contracts to which Seller or any of its Affiliates is a party other than Liabilities relating to periods (or portions thereof) beginning from or after the Closing under the Assigned Contracts, the Assigned Lease and any other contracts included in the Transferred Assets (which such Liabilities shall be Assumed Liabilities);

(e) Seller Retention Bonus Liabilities; and

(f) Liabilities of Seller or any of its Affiliates related to any Permitted Liens on the Transferred Assets.

Section 2.06. Place and Date of Closing. Unless another date, time or place is agreed to in writing by the parties hereto, the closing of the transactions contemplated by this Agreement (the " Closing") shall take place at the offices of Willkie Farr & Gallagher LLP, 787 Seventh Avenue, New York, New York 10019, at 10:00 a.m., New York City time, on the third Business Day after the date on which the last of the conditions set forth in Article VIII to be satisfied or waived (other than those conditions that by their terms are to be satisfied at the Closing, but subject to the satisfaction or waiver of such conditions at the Closing) shall have been so satisfied or waived in accordance with this Agreement (the " Condition Satisfaction"); provided , however , that if the Condition Satisfaction occurs less than ten Business Days prior to the first Business Day of the next calendar month, then the Closing shall take place on the first Business Day of the calendar month immediately following the calendar month in which the Condition Satisfaction occurs. The Closing shall be deemed effective as of the Effective Time. For purposes of preparing the Estimated Closing Statement, Estimated Asset Value Statement, Initial Closing Statement, Initial Asset Value Statement, Final Closing Statement and Final Asset Value Statement and calculating any amounts required to be calculated therefrom, such statements shall be prepared as of the close of the last calendar day of the month immediately preceding the month in which the Closing occurs (the " Accounting Date"). The actual date and time at which the Closing occurs is referred to herein as the " Closing Date. "

Section 2.07. Consideration.

(a) The consideration with respect to the transactions contemplated by this Agreement will be an aggregate amount in cash equal to $1,450,000,000 (the " Purchase Price"), comprised of:

(i) $1,382,000,000, constituting the ceding commission to be paid to the Ceding Company in connection with the Reinsurance Agreement (the "Ceding Commission"), which amount shall constitute consideration for the reinsurance arrangements contemplated by the Reinsurance Agreement; and

(ii) $68,000,000 (the "Asset Consideration") representing the aggregate purchase price for the Transferred Assets.

(b) At the Closing, Purchaser shall pay to Seller or an Affiliate of Seller (as designated by Seller), by wire transfer of immediately available funds to such account or accounts of Seller or its Affiliates as Seller may designate in writing at least two Business Days prior to the Closing Date, an amount equal to the Asset Consideration.

(c) Reference and Estimated Closing Statement; Specified Portfolio.

(i) Section 2.07(c)(i) of the Seller Disclosure Schedule contains, for illustrative purposes, a pro forma Closing Statement assuming, for this purpose, that the Closing occurred, and the Reinsurance Agreement became effective, as of the Reference Date (the "Reference Closing Statement").

(ii) Section 2.07(c)(ii) of the Seller Disclosure Schedule contains a schedule of cash and Investment Assets held by the Ceding Company or AHLIC in respect of the Business as of the Reference Date (such portfolio, as it may have been or will be adjusted or changed between the Reference Date and the Closing Date in accordance with Sections 3.19 and 5.11 , the "Specified Portfolio"), which portfolio had an aggregate Accounting Value as of the Reference Date equal to the Required Asset Value as of the Reference Date.

(iii) Not less than five Business Days prior to the anticipated Closing Date, Seller shall prepare and deliver to Purchaser an estimated Closing Statement as of the anticipated Accounting Date (the "Estimated Closing Statement"). The Estimated Closing Statement shall be prepared in accordance with the Transaction Accounting Principles applied in a manner consistent with the preparation of the Reference Closing Statement and be in the same format as the Reference Closing Statement.

(d) Determination of Transferred Portfolio.

(i) Not less than two Business Days prior to the anticipated Closing Date, Seller shall prepare and deliver to Purchaser a calculation of the Closing Required Asset Value, which calculation will be based on the Required Asset Value reflected in the Estimated Closing Statement and will take into account all Capital Gain or Loss Adjustments and all Reallocated Asset Value Adjustments required pursuant to Section 5.11 or Section 3.19(b) through the Closing Date (the "Estimated Closing Required Asset Value").

(ii) The "Transferred Portfolio" will be determined as follows:

(A) if the Accounting Value of the Specified Portfolio as of the Closing Date equals the Closing Required Asset Value, the Transferred Portfolio will comprise all, and only, the cash and Investment Assets in the Specified Portfolio as of immediately prior to the Closing;

(B) if the Accounting Value of the Specified Portfolio as of the Closing Date is less than the Closing Required Asset Value, the Transferred Portfolio will comprise (x) all of the cash and Investment Assets in the Specified Portfolio as of immediately prior to the Closing and (y) cash or other Investment Assets selected by Seller in accordance with the Pre-Closing Investment Guidelines that have an aggregate Fair Market Value equal to the amount of such shortfall; and

(C) if the Accounting Value of the Specified Portfolio as of the Closing Date is greater than the Closing Required Asset Value, Seller will select for removal from the Specified Portfolio cash or Investment Assets that have an aggregate Accounting Value equal to such excess in accordance with the Selection Waterfall. The cash and Investment Assets remaining in the Specified Portfolio after such removal will be the Transferred Portfolio.

(iii) Concurrently with the delivery by Seller to Purchaser of the calculation of the Estimated Closing Required Asset Value pursuant to clause (i) of this Section 2.07(d) , Seller will also deliver to Purchaser (A) a schedule showing the cash and Investment Assets in the Transferred Portfolio and its estimated calculation of the aggregate Accounting Value of the cash and Investment Assets in the Transferred Portfolio as of immediately prior to the Closing (the "Estimated Asset Value Statement"), and (B) a calculation of Seller's estimate of the Required Balance (as defined in the Reinsurance Agreement) as of the Closing Date based on amounts set forth on the Estimated Closing Statement and calculated using the aggregate FMV-Ex Accrued and the aggregate Book Value of the Transferred Portfolio (the "Estimated Required Balance").

(e) Payment of Ceding Commissions and Initial Transfer Amounts. At the Closing, upon the terms set forth in this Agreement and the Reinsurance Agreement:

(i) in addition to the payment Purchaser is required to make to Seller pursuant to Section 2.07(b) above, Purchaser shall pay to Seller, by wire transfer of immediately available funds to an account or accounts designated in writing to Purchaser by Seller at least two Business Days prior to the Closing Date, an amount equal to the Ceding Commission; and

(ii) Seller shall cause the Ceding Company (or AHLIC on behalf of the Ceding Company) to deposit into the Trust Account, on behalf of Purchaser, the cash and Investment Assets in the Transferred Portfolio; provided that:

(A) if on the Closing Date the aggregate Fair Market Value of the cash and Investment Assets in the Transferred Portfolio exceeds the Estimated Required Balance, then Seller shall cause the Ceding Company (or AHLIC on behalf of the Ceding Company) to transfer to Purchaser cash or Investment Assets from the Transferred Portfolio selected by Purchaser with a Fair Market Value equal to such excess and shall cause the Ceding Company (or AHLIC on behalf of the Ceding Company) to transfer the remainder of the cash and Investment Assets in the Transferred Portfolio to the Trust Account; and

(B) if on the Closing Date the aggregate Fair Market Value of the cash and Investment Assets in the Transferred Portfolio is less than the Estimated Required Balance, Purchaser shall, at the Closing, transfer to the Trust Account Authorized Investments (as defined in the Trust Agreement) having a Fair Market Value as of the Closing Date equal to such shortfall.

Section 2.08. Closing Deliveries.

(a) Upon the terms and subject to the conditions set forth in this Agreement, at the Closing, in addition to the payments contemplated by Section 2.07 above, Seller shall, and shall cause its applicable Affiliates to, enter into and deliver to Purchaser:

(i) a copy of the Commutation Agreement duly executed by the Ceding Company and AHLIC;

(ii) a counterpart to the Reinsurance Agreement duly executed by the Ceding Company;

(iii) a counterpart to the Trust Agreement duly executed by the Ceding Company;

(iv) a counterpart to the Administrative Services Agreement duly executed by the Ceding Company;

(v) a counterpart to the Transition Services Agreement duly executed by the Ceding Company;

(vi) a counterpart to the Intellectual Property Agreement duly executed by Seller and the Ceding Company;

(vii) a counterpart to the Distribution Agreement duly executed by each of the Ceding Company and Carefree Insurance Services, Inc.;

(viii) a counterpart to the Bill of Sale and Assignment and Assumption Agreement duly executed by Seller and the Ceding Company;

(ix) a counterpart to the Trademark License Agreement duly executed by Seller and the Ceding Company;

(x) a counterpart to the Portland Location Assignment Agreement, duly executed by the Ceding Company;

(xi) a counterpart to the sublease in the form attached hereto as Exhibit K-1 (the "Plantation Sublease"), duly executed by the Ceding Company;

(xii) a counterpart to the sublease in the form attached hereto as Exhibit K-2 (the "South Portland Sublease"), duly executed by the Ceding Company;

(xiii) a counterpart to the sublease in the form attached hereto as Exhibit K-3 (the "Omaha Sublease"), duly executed by Aetna Health Management, LLC;

(xiv) a counterpart to the license agreement in the form attached hereto as Exhibit L (the "Hartford License Agreement"), duly executed by the Ceding Company;

(xv) a counterpart to the Employee Leasing Agreement in the form attached hereto as Exhibit M (the "Employee Leasing Agreement"), duly executed by Seller;

(xvi) a counterpart to the Data Processing Side Letter duly executed by the Ceding Company;

(xvii) a certificate of Seller duly executed by an authorized officer of Seller, dated as of the Closing Date, certifying as to Seller's compliance with the conditions set forth in Section 8.02(a) and Section 8.02(b); and

(xviii) such other agreements, instruments and documents as are contemplated by this Agreement or the other Transaction Agreements to be executed and delivered by Seller or any of its Affiliates on the Closing Date.

(b) Upon the terms and subject to the conditions set forth in this Agreement, at the Closing, in addition to the payments contemplated by Section 2.07 above, Purchaser shall, and shall cause its applicable Affiliates to, enter into and deliver to Seller:

(i) a counterpart to the Reinsurance Agreement duly executed by Purchaser;

(ii) a counterpart to the Trust Agreement duly executed by Purchaser;

(iii) a counterpart to the Administrative Services Agreement duly executed by Purchaser;

(iv) a counterpart to the Transition Services Agreement duly executed by Purchaser;

(v) a counterpart to the Intellectual Property Agreement duly executed by Hartford Fire;

(vi) a counterpart to the Distribution Agreement duly executed by Purchaser;

(vii) a counterpart to the Bill of Sale and Assignment and Assumption Agreement duly executed Purchaser;

(viii) a counterpart to the Trademark License Agreement duly executed by Hartford Fire;

(ix) a counterpart to a side letter in the form attached hereto as Exhibit N (the "Data Processing Side Letter"), duly executed by Purchaser, acknowledging that the Ceding Company, its Affiliates (as defined in the Transition Services Agreement) and their respective subcontractors have processed, and will continue to process, data relating to the Business in Alaska, Hawaii, India and the Philippines;

(x) a counterpart to the Portland Location Assignment Agreement, duly executed by Hartford Fire;

(xi) a counterpart to the Plantation Sublease, duly executed by Hartford Fire;

(xii) a counterpart to the South Portland Sublease, duly executed by Hartford Fire;

(xiii) a counterpart to the Omaha Sublease, duly executed by Hartford Fire;

(xiv) a counterpart to the Hartford License Agreement, duly executed by Hartford Fire;

(xv) a counterpart to the Employee Leasing Agreement, duly executed by Purchaser;

(xvi) a certificate of Purchaser duly executed by an authorized officer of Purchaser, dated as of the Closing Date, certifying as to Purchaser's compliance with the conditions set forth in Section 8.03(a) , Section 8.03(b) and 8.03(c); and

(xvii) such other agreements, instruments and documents as are contemplated by this Agreement or the other Transaction Agreements to be executed and delivered by Seller or any of its Affiliates on the Closing Date.

(c) Purchaser and Seller shall each use their reasonable best efforts to obtain, at or prior to the Closing, a counterpart to the Trust Agreement duly executed by the Trustee.

(d) Notwithstanding the delivery by Seller or Purchaser of any counterpart to the Portland Location Assignment Agreement or any Sublease pursuant to Section 2.08(a) or Section 2.08(b) , as applicable, such counterparts shall not be effective at the Closing but shall instead be held in escrow and not become effective with respect to such agreement unless and until, and shall become effective with respect to such agreement only if (i) the applicable Lease Consent is obtained on or prior to December 31, 2017 and (ii) the Employee Lease Term has expired or been terminated. If the foregoing conditions to the effectiveness of the counterparts to the Portland Location Assignment Agreement or any such Sublease are not satisfied, then, upon the expiration or termination of the Employee Lease Term, the applicable agreement to which such counterparts relate shall be deemed not to have been executed by the parties thereto and shall be void and have no force or effect. If the Portland Location Assignment Agreement is deemed not to have been executed in accordance with the prior sentence, then: (i) the Assigned Lease shall be deemed not to be a Transferred Asset or Assigned Contract hereunder; (ii) Seller shall have no Liability to any Purchaser Indemnified Person by virtue of the fact that the Assigned Lease is not a Transferred Asset or Assigned Contract hereunder; and (iii) the Liabilities of Seller and its Affiliates under the Assigned Lease shall not be Assumed Liabilities hereunder; provided , that the foregoing shall not affect either party's obligations under Article V , including Section 5.12 , or any rights to indemnification under Article X arising out of any breach by the other party of its obligations under Article V.

Section 2.09. Adjustment to Initial Transfer Amount after Closing.

(a) Within 90 days following the Closing Date, Seller shall prepare and deliver to Purchaser: (i) a Closing Statement as of the Accounting Date (the " Initial Closing Statement"), which shall be prepared in accordance with the Transaction Accounting Principles applied consistently with their application in connection with the preparation of the Reference Closing Statement and be in the same format as the Reference Closing Statement; (ii) Seller's determination of the Accounting Value of the Transferred Portfolio as of the Accounting Date (the " Initial Asset Value Statement"); and (iii) Seller's calculation of the Closing Required Asset Value based on the amounts set forth on the Initial Closing Statement and the Initial Asset Value Statement and taking into account all Capital Gain or Loss Adjustments and all Reallocated Asset Value Adjustments required from the Reference Date through the Closing Date (the

"Initial Closing Required Asset Value Statement"). Each of the Initial Closing Statement, Initial Asset Value Statement and the Initial Closing Required Asset Value Statement will be accompanied by reasonably detailed supporting documentation relating to the amounts and calculations therein. Each of the amounts set forth on the Estimated Closing Statement, the Initial Closing Statement and the Final Closing Statement shall not include any interest maintenance reserve related to the transfer of Investment Assets from AHLIC to the Ceding Company in connection with the Pre-Closing Commutation; provided , that the foregoing shall not affect the inclusion of such amounts in the calculation of the "Closing Date IMR Amount" under the Reinsurance Agreement.

(b) During the 60 days immediately following Purchaser's receipt of the Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement (the " Review Period"), Purchaser and its Representatives shall be permitted to review Sellers's working papers and any working papers of Seller's independent accountants directly relating to the preparation of the Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement, as well as all of the Books and Records and other relevant information or documents relating to the operations and finances of the Business with respect to the period up to and including the Closing Date, and Seller shall make available the individuals in its or its Affiliates' employ who are responsible for and knowledgeable about the information used in, and the preparation or calculation (as applicable) of, the Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement in order to respond to the inquiries of Purchaser; provided , however , that the independent accountants of Seller shall not be obligated to make any working papers available to Purchaser unless and until Purchaser has signed a customary confidentiality and hold harmless agreement relating to such access to working papers in form and substance reasonably acceptable to such independent accountants.

(c) If Purchaser disagrees with the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement (including any amount or computation set forth therein) in any respect and on any basis (including that the representations and warranties in Section 3.18(d) or the covenants in Section 5.11 were breached), Purchaser may, on or prior to the last day of the Review Period, deliver a notice to Seller setting forth, in reasonable detail, each disputed item or amount and the basis for Purchaser's disagreement therewith (the " Notice of Disagreement"). The Notice of Disagreement shall set forth, with respect to each disputed item, Purchaser's position as to the correct amount or computation that should have been included in the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement. If Purchaser does not deliver a Notice of Disagreement with respect to the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement to Seller by the end of the Review Period, the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement, as applicable, shall become final and binding on the parties.

(d) During the 20 Business Days immediately following the delivery of a Notice of Disagreement, Seller and Purchaser shall seek in good faith to resolve any disagreement that they may have with respect to the matters specified in the Notice of Disagreement.

(e) If, at the end of such 20 Business Day period, Seller and Purchaser have been unable to resolve all disagreements that they may have with respect to the matters specified in the Notice of Disagreement, then Seller and Purchaser shall submit all matters that remain in dispute with respect to the Notice of Disagreement (along with a copy of the applicable Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement marked to indicate those line items that are in dispute) to PricewaterhouseCoopers LLP or, if PricewaterhouseCoopers LLP is unwilling or unable to serve, another independent certified public accounting firm in the United States of international recognition mutually agreeable to Seller and Purchaser and that is not the auditor or independent accounting firm of any of the parties (the " Independent Accountant"), to make a determination with respect to all matters in dispute.

(f) Seller and Purchaser shall use commercially reasonable efforts to cause the Independent Accountant to render a determination within 30 days after the submission of such matters to the Independent Accountant or as soon as practicable thereafter. Seller, on the one hand, and Purchaser, on the other hand, shall promptly (and in any event within five Business Days) after the Independent Accountant's engagement, each submit to the Independent Accountant their respective computations of the disputed items identified in the Notice of Disagreement and information, arguments and support for their respective positions, and shall concurrently deliver a copy of such materials to the other party. Each party shall then be given an opportunity to supplement the information, arguments and support included in its initial submission with one additional submission to respond to any arguments or positions taken by the other party in such other party's initial submission, which supplemental information shall be submitted to the Independent Accountant (with a copy thereof to the other party) within 10 Business Days after the first date on which both parties have submitted their respective initial submissions to the Independent Accountant. The Independent Accountant shall thereafter be permitted to request additional or clarifying information from the parties, and each of the parties shall cooperate and shall cause their Representatives to cooperate with such requests of the Independent Accountant. The Independent Accountant shall determine, based solely on the materials so presented by the parties and upon information received in response to such requests for additional or clarifying information and not by independent review, only those issues in dispute specifically set forth in the Notice of Disagreement and shall render a written report to Seller and Purchaser in which the Independent Accountant shall, after considering all matters set forth in the Notice of Disagreement, determine what adjustments, if any, should be made to the amounts and computations set forth in the Initial Closing Statement, Initial Asset Value Statement and the Initial Closing Required Asset Value Statement solely as to the disputed items. Such written report shall set forth, in reasonable detail, the determination of the Independent Accountant with respect to each of the disputed line items specified in the Notice of Disagreement and the revisions, if any, to be made to the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement resulting therefrom, together with supporting calculations. With respect to each disputed line item, such determination shall be made in accordance with the Transaction Accounting Principles and the terms of this Agreement and, if not in accordance with the position of either Seller or Purchaser, shall not be in excess of the highest amount proposed by either party, nor less than the lowest amount proposed by either party, in the Notice of Disagreement, the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement with respect to such disputed line item. For the avoidance of doubt, the Independent Accountant shall

not review any line items or make any determination with respect to any matter other than those matters in the Notice of Disagreement that remain in dispute. The Independent Accountant's final written determination shall, absent fraud or manifest error, be conclusive and binding upon Seller and Purchaser, shall not be subject to review by a court or other tribunal and shall have the same force and effect as an arbitration award governed by the Federal Arbitration Act, 9 U.S.C. §1 et. seq. The " Final Closing Statement" means the Initial Closing Statement as made final and binding either pursuant to Section 2.09(c) or after it has been modified to reflect any revisions thereto made through the mutual agreement of Purchaser and Seller or through the determination of the Independent Accountant pursuant to this Section 2.09(f). The " Final Asset Value Statement" means the Initial Asset Value Statement as made final and binding either pursuant to Section 2.09(c) or after it has been modified to reflect any revisions thereto made through the mutual agreement of Purchaser and Seller or through the determination of the Independent Accountant pursuant to this Section 2.09(f). The " Final Closing Required Asset Value Statement" means the Initial Closing Required Asset Value Statement as made final and binding either pursuant to Section 2.09(c) or after it has been modified to reflect any revisions thereto made through mutual agreement of Purchaser and Seller or through the determination of the Independent Accountant pursuant to this Section 2.09(f) , and the " Final Closing Required Asset Value" is the Closing Required Asset Value as set forth on the Final Closing Required Asset Value Statement.

(g) The cost of the Independent Accountant's review and determination shall be shared equally by Seller and Purchaser. During the review by the Independent Accountant, Seller and Purchaser shall each make available to the Independent Accountant such individuals and such information, books, records and work papers, as may be reasonably required by the Independent Accountant to fulfill its obligations under Sections 2.09(e) and 2.09(f); provided , however , that the independent accountants of Seller or Purchaser shall not be obligated to make any working papers available to the Independent Accountant unless and until the Independent Accountant has signed a customary confidentiality and hold harmless agreement relating to such access to working papers in form and substance reasonably acceptable to such independent accountants. In acting under this Agreement, the Independent Accountant shall be entitled to the privileges and immunities of an arbitrator. Notwithstanding anything to the contrary contained in this Agreement, the provisions of this Section 2.09 represent the sole and exclusive method for determining the Final Closing Statement, the Final Asset Value Statement, the Final Closing Required Asset Value Statement and the Final Closing Required Asset Value.

(h) Seller shall, following the Closing through the date that the Final Closing Statement, the Final Asset Value Statement and the Final Closing Required Asset Value Statement become final and binding on the parties in accordance with the last three sentences of Section 2.09(f) , take all actions necessary to maintain and preserve all accounting books, records, policies and procedures on which the Initial Closing Statement, Initial Asset Value Statement and Initial Closing Required Asset Value Statement are based or on which the Final Closing Statement, Final Asset Value Statement or Final Closing Required Asset Value Statement are to be based so as not to impede or delay the final determination of the amounts set forth therein.

Section 2.10. Post-Closing Adjustments.

(a) The following adjustments will be made based on the amounts set forth on the Final Closing Statement, Final Asset Value Statement and Final Closing Required Asset Value Statement:

(i) Purchaser shall pay to the Ceding Company the True-Up Amount, if positive; or

(ii) Seller shall cause the Ceding Company to pay into the Trust Account the absolute value of the True-Up Amount, if negative.

(b) Payment of any amounts due under Section 2.10(a) shall be made within five Business Days after the date on which all three of the Final Closing Statement, the Final Asset Value Statement and Final Closing Required Asset Value Statement have become such in accordance with the last three sentences of Section 2.09(f) by wire transfer of immediately available funds.

ARTICLE III.

REPRESENTATIONS AND WARRANTIES OF SELLER

Except as set forth in the corresponding sections or subsections of the disclosure schedule delivered to Purchaser by Seller concurrently with the execution and delivery of this Agreement (the " Seller Disclosure Schedule") (it being understood and agreed by the parties hereto that disclosure of any item in any section or subsection of the Seller Disclosure Schedule shall be deemed disclosure with respect to any other section or subsection of the Seller Disclosure Schedule to which the relevance of such item is reasonably apparent, notwithstanding the omission of a reference or cross-reference thereto), Seller hereby makes the following representations and warranties to Purchaser, as of the date hereof and as of the Closing Date, as follows:

Section 3.01. Organization; Standing and Authority.

(a) Seller is a corporation duly incorporated, validly existing and in good standing under the laws of the Commonwealth of Pennsylvania. The Ceding Company is an insurance company duly organized, validly existing and in good standing under the laws of the State of Connecticut. AHLIC is an insurance company duly organized, validly existing and in good standing under the laws of the State of Connecticut.

(b) Each of Seller, the Ceding Company and AHLIC (i) have all corporate or other applicable organizational power and authority to carry on the activities it currently conducts in connection with the Business as it is now being conducted and to own, lease and operate its properties and assets and (ii) is duly qualified to do business as a foreign or alien corporation or other legal entity, as the case may be, in good standing in each jurisdiction in which the conduct of the Business makes such qualification necessary, except, in the case of clause (ii), where the failure to be so qualified, would not, individually or in the aggregate, reasonably be expected to

have a Material Adverse Effect. This Section 3.01(b) does not relate to Permits from Insurance Regulators and Operating Permits, which are addressed in Section 3.11.

Section 3.02. Authorization. Seller or the applicable Affiliate of Seller (as applicable) has all requisite corporate or other applicable organizational power to enter into, consummate the transactions contemplated by and carry out its obligations under, each of the Transaction Agreements to which it is or is contemplated to become a party. The execution and delivery by Seller or the applicable Affiliate of Seller (as applicable) of each of the Transaction Agreements to which it is or is contemplated to become a party, and the consummation by Seller or the applicable Affiliate of Seller (as applicable) of the transactions contemplated by each of the Transaction Agreements to which it is or is contemplated to become a party, have been duly authorized by all requisite corporate or other similar organizational action on the part of Seller or the applicable Affiliate of Seller (as applicable). Each of the Transaction Agreements to which Seller or the applicable Affiliate of Seller (as applicable) is or is contemplated to become a party has been, or upon execution and delivery thereof will be, duly executed and delivered by Seller or the applicable Affiliate of Seller (as applicable). Assuming due authorization, execution and delivery by the other parties hereto or thereto, each of the Transaction Agreements to which Seller or the applicable Affiliate of Seller (as applicable) is or is contemplated to become a party constitutes, or upon execution and delivery thereof will constitute, the legal, valid and binding obligation of Seller or the applicable Affiliate of Seller (as applicable), enforceable against it in accordance with its terms, subject in each case to the effect of any applicable bankruptcy, reorganization, insolvency, moratorium, rehabilitation, liquidation, fraudulent conveyance, preferential transfer or similar laws now or hereafter in effect relating to or affecting creditors' rights and remedies generally and subject, as to enforceability, to the effect of general equitable principles (regardless of whether enforcement is sought in a proceeding in equity or at law) (the " Enforceability Exceptions").

Section 3.03. Sufficiency of Assets. Except as set forth in Section 3.03 of the Seller Disclosure Schedule and subject to the receipt of all Governmental Approvals, the assets, rights, properties, Employees, Intellectual Property and services transferred or made available to Purchaser and its Affiliates pursuant to this Agreement, the other Transaction Agreements and the Assigned Contracts will, as of the Closing, comprise assets, rights, properties, Employees, Intellectual Property and services that are sufficient to permit Purchaser to operate the Business immediately following the Closing Date in substantially the same manner as the Business is being operated as of the date hereof. This Section 3.03 does not address any Permit needed for the Purchaser to write new or renewal insurance policies with respect to the Business after the Closing Date.

Section 3.04. No Conflict or Violation. Provided that all consents, approvals, authorizations and other actions described in Section 3.05 of the Seller Disclosure Schedule have been obtained or taken, the execution and delivery by Seller or the applicable Affiliate of Seller (as applicable) of, and the consummation by Seller or the applicable Affiliate of Seller (as applicable) of the transactions contemplated by, the Transaction Agreements to which Seller or the applicable Affiliate of Seller (as applicable) is or is contemplated to become a party do not and will not (a) violate or conflict with the organizational documents of Seller or the applicable Affiliate of Seller (as applicable), (b) subject to the Governmental Approvals referred to in Section 3.05 , conflict with or violate any Applicable Law or Governmental Order applicable to

Seller or the applicable Affiliate of Seller (as applicable) or by which any of them or any of their respective properties, assets or rights is bound or subject, (c) result in any breach of, or constitute a default (or event which, with the giving of notice or lapse of time or both, would constitute a default) under, or give to any Person any rights of termination, acceleration or cancellation of, or result in the creation of any Lien (other than Permitted Liens) on any of the assets, properties or rights of Seller or the applicable Affiliate of Seller (as applicable) pursuant to, any contract, or any note, bond, loan or credit agreement, mortgage or indenture to which Seller or such applicable Affiliate of Seller is a party or by which any of them or any of their respective properties, assets or rights is bound or subject or (d) result in a breach or violation of any of the terms or conditions of, result in a default under, or otherwise cause an impairment or revocation of, any material Permit used in the Business, except, in the case of clauses (b), (c) and (d) of this Section 3.04 , for any such conflicts, violations, breaches, defaults, terminations, accelerations, cancellations or creations that, individually or in the aggregate, would not reasonably be expected to have a Material Adverse Effect.

Section 3.05. Consents and Approvals. Except in connection, or in compliance, with the approvals, filings and notifications required by Applicable Laws that are set forth in Section 3.05 of the Seller Disclosure Schedule, the execution and delivery by Seller or the applicable Affiliate of Seller (as applicable) of the Transaction Agreements to which it is or is contemplated to become a party do not and will not, and the consummation by Seller or the applicable Affiliate of Seller (as applicable) of the transactions contemplated by the Transaction Agreements to which it is or is contemplated to become a party will not, require any consent, approval, license, permit, order, qualification or authorization of, or registration with or other action by, or any filing with or notification to, any Governmental Authority (each, a " Governmental Approval") to be obtained or made by or with respect to Seller or such applicable Affiliate of Seller (as applicable), except for any Governmental Approvals the failure to obtain or make which, individually or in the aggregate, would not reasonably be expected to have a Material Adverse Effect.

Section 3.06. Certain Contracts.

(a) Section 3.06(a) of the Seller Disclosure Schedule lists each Material Contract to which Seller or any of its Affiliates is a party or by which it is bound as of the date hereof. The term " Material Contract" means all of the following types of contracts (other than any Ceded Reinsurance Contract or any Group Contract) in effect on the date hereof:

(i) the Assigned Contracts;

(ii) any contract that (A) contains a restriction on the ability of the Business to solicit specified customers or prospective customers for the purchase, renewal, lapse or amendment of any Group Contract or (B) limits in any way the ability of the Business to compete or engage in the conduct of the Business or in the marketing, selling and administration of any Group Contract, in each case, that would be legally binding on Purchaser or any of its Affiliates following the consummation of the transactions contemplated hereby;

(iii) mortgages, indentures, loan or credit agreements, security agreements and other agreements and instruments relating to the borrowing of money or extension of credit directly by or to Seller or an Affiliate thereof in respect of the Business or the direct or indirect guarantee by Seller or an Affiliate thereof for the benefit of the Business of any obligation for borrowed money of any other Person, in each case other than Investment Assets held in the ordinary course of business consistent with the Investment Guidelines;

(iv) any retention agreements providing for payments to any Employee;

(v) any contract restricting or granting rights to use or practice rights under the Transferred Intellectual Property;

(vi) any contract that is primarily related to the Business but is not an Assigned Contract (each, a "Primary Contract") pursuant to which any third Person provides support, maintenance or other services for IT Systems;

(vii) any Primary Contract pursuant to which any material operational function of the Business is outsourced to or otherwise performed by a third Person;

(viii) any Primary Contract pursuant to which one or more independent contractors provides services to the Business;

(ix) any contract that relates to the acquisition or disposition of any business or operation included in the Business, or any other contract that includes an ongoing material indemnification obligation or guarantee of the Ceding Company in respect of the Business, but in either case only where any such contract contains any material obligation of Seller or any of its Affiliates that remains unperformed (other than any obligation to indemnify the buyer thereunder for breaches of provisions that have expired or which are not subject to any survival period); or

(x) any other Primary Contract.

(b) Section 3.06(b) of the Seller Disclosure Schedule lists each vendor with which, as of the date hereof, there is a direct contractual or other relationship to provide rights, services, functions or goods, as applicable, directly to the Business or which charge the Business directly for such rights, services, functions or goods, as applicable (each such vendor, a " Vendor"). For the avoidance of doubt, Section 3.06(b) of the Seller Disclosure Schedule does not list vendors for which the Business is allocated a share of the cost as part of a corporate or enterprise cost allocation.

(c) True and complete copies in all material respects of each of the Material Contracts, including in each case all amendments and addenda thereto, have been made available to Purchaser on the Project DeLorean Intralinks site or by email prior to the date hereof. Each of the Material Contracts is in full force and effect and is the valid and binding obligation of Seller and each Affiliate of Seller party thereto, and, to the Knowledge of Seller as of the date hereof,

each other party thereto, subject to the Enforceability Exceptions. None of Seller or any Affiliate of Seller that is party thereto, nor, to the Knowledge of Seller as of the date hereof, any other Person that is a party thereto, is (or, with the giving of notice or the lapse of time or both, will be), in any material respect, in violation or breach of or default under any of the Material Contracts. None of Seller or any Affiliate of Seller that is party thereto has received written or, to the Knowledge of Seller, oral notice of cancellation of any Material Contract.

Section 3.07. Title to Assets. Seller or one of its Affiliates is the record and beneficial owner of, and holder of good and valid title to, all of the Transferred Assets, free and clear of all Liens other than Permitted Liens. Purchaser will acquire good and valid title to the Transferred Assets, free and clear of Liens, except for Permitted Liens or any Liens arising from acts of Purchaser (other than entering into any Transaction Agreement), (a) in the case of Transferred Assets other than the Business Employee Benefit Plans and the Assigned Lease, at the Closing, and (b) in the case of the Business Employee Benefit Plans, upon the termination of the Employee Lease Term, and (c) in the case of the Assigned Lease, upon the termination of the Employee Lease Term and the effectiveness of the Portland Location Assignment Agreement.

Section 3.08. Absence of Litigation. Except as disclosed in Section 3.08 of the Seller Disclosure Schedule, as of the date hereof, there are no Actions relating to the Business (other than claims under or in connection with Group Contracts in the ordinary course of business) pending or, to the Knowledge of Seller, threatened in writing against (i) the Ceding Company or (ii) Seller or any of its other Affiliates with respect to the Business that, individually or in the aggregate, would reasonably be expected to have a Material Adverse Effect.

Section 3.09. Compliance With Laws.

(a) Except as disclosed in Section 3.09(a)(i) of the Seller Disclosure Schedule, Seller and its Affiliates (solely with respect to, and to the extent related to, the Business) are, and since December 31, 2014 have been, in compliance in all respects with all Applicable Laws, including Privacy and Data Security Laws, except for such instances of non-compliance that would not, individually or in the aggregate, have a material adverse impact on the Business. Except as set forth in Section 3.09(a)(ii) of the Seller Disclosure Schedule, as of the date hereof, since December 31, 2014, none of Seller or any of its Affiliates (solely with respect to, and to the extent related to, the Business) has received any written notice or other written or, to the Knowledge of Seller, oral communication from any Governmental Authority or has paid or incurred any penalty or fine imposed by a Governmental Authority, in each case, regarding any actual or alleged violation of, or failure to comply with, Applicable Law in connection with the Business (other than actual or alleged violations which have been resolved).

(b) Except as set forth in Section 3.09(b) of the Seller Disclosure Schedule, as of the date hereof, all material deficiencies or violations with respect to the Business in all reports of examinations of the affairs of the Ceding Company or AHLIC (including financial, market conduct and similar examinations) issued by any Insurance Regulator to the Ceding Company or AHLIC for any period ending on or after December 31, 2014, have been resolved to the reasonable satisfaction of the Insurance Regulator that noted such deficiencies or violations.

(c) Except as set forth in Section 3.09(c) of the Seller Disclosure Schedule, as of the date hereof, there are no Governmental Orders in effect against or involving Seller or any of its Affiliates under which Seller or any of its Affiliates has any continuing obligation relating to the Business and none of Seller or any of its Affiliates (solely with respect to, and to the extent related to, the Business) is a party to any material contract with any Governmental Authority (other than any Group Contract with respect to which a Governmental Authority is a policyholder or contractholder) in each case to the extent relating to the Business.

(d) Except as set forth in Section 3.09(d) of the Seller Disclosure Schedule, since December 31, 2014, Seller or an Affiliate thereof has filed all material reports, statements, documents, registrations, filings or submissions required to be filed with any Governmental Authority (solely with respect to, and to the extent related to, the Business). All such registrations, filings and submissions were in compliance in all material respects with Applicable Law when filed or as amended or supplemented, and, as of the date hereof, no material deficiencies have been asserted by any Governmental Authority with respect to such registrations, filings or submissions that have not been satisfied.

Section 3.10. Employee Matters.

(a) Section 3.10(a) of the Seller Disclosure Schedule sets forth a list of all material written Employee Benefit Plans as of the date hereof and a description of any material Employee Benefit Plan that is not in written form.

(b) Section 3.10(b) of the Seller Disclosure Schedule sets forth a list of all Business Employee Benefit Plans as of the date hereof. As of the date hereof, there are no material claims or disputes pending, or to the Knowledge of Seller, threatened with respect to any Business Employee Benefit Plan, other than routine claims for benefits in the ordinary course of business.

(c) No Business Employee Benefit Plan and, except as set forth on Section 3.10(c) of the Seller Disclosure Schedule, none of the Employee Benefit Plans is subject to Title IV of ERISA and no Employee participates or is eligible to participate in an Employee Benefit Plan or Business Employee Benefit Plan that is subject to Title IV of ERISA. None of the Employee Benefit Plans or Business Employee Benefit Plans is a "multiemployer plan" (as defined in section 3(37) of ERISA) and no Employee participates or is eligible to participate in an Employee Benefit Plan or Business Employee Benefit Plan that is a multiemployer plan. Purchaser shall have no Liabilities in respect of any Employee Benefit Plan, except as expressly set forth in Section 6.01(j) below.

(d) No Business Employee Benefit Plan and, except as disclosed in Section 3.10(d) of the Disclosure Schedule, no Employee Benefit Plan provides medical, dental, or life insurance coverage or any other welfare benefits after termination of employment.

(e) Each Employee Benefit Plan (i) complies in form in all material respects with all requirements of Applicable Laws and has been administered in all material respects in accordance with its terms and all Applicable Laws, and (ii) is otherwise in compliance in all material respects with all Applicable Laws. Each Business Employee Benefit Plan (i) complies in form in all material respects with all requirements of Applicable Laws and has been

administered in all material respects in accordance with its terms and all Applicable Laws, and (ii) is otherwise in compliance in all material respects with all Applicable Laws. With respect to each Employee Benefit Plan that is intended to be qualified under Section 401(a) of the Code, such plan, and its related trust, has received a determination letter (or opinion letters in the case of any prototype plans) from the IRS that it is so qualified and that its trust is exempt from tax under Section 501(a) of the Code and, to the Knowledge of the Seller, no event has occurred which will or could reasonably be expected to cause any such Employee Benefit Plan to fail to comply with such requirements. Each Employee Benefit Plan and Business Employee Benefit Plan is either (i) exempt from Section 409A of the Code (" Section 409A") or (ii) has, in all material respects, been maintained and operated in documentary and operational compliance in accordance with Section 409A and the regulations and guidance issued thereunder.

(f) Except as set forth on Section 3.10(f) of the Seller Disclosure Schedule, neither consummation of the transactions contemplated by this Agreement nor this Agreement (whether separately or together with any other action) will accelerate the time of vesting or the time of payment, or increase the amount, of compensation due to any Employee. None of the payments contemplated by the Employee Benefit Plans or any Business Employee Benefit Plan to or with respect to Employees would, in the aggregate, constitute excess parachute payments (as defined in section 280G of the Code (without regard to subsection (b)(4) thereof)). As of the date hereof, each of Seller and its Affiliates is in compliance, in all material respects, with all Applicable Laws regarding employment, labor and wage and hour matters, disability, immigration, health and safety, harassment, non-discrimination in employment, workers' compensation, and unemployment compensation (solely with respect to, and to the extent related to, the Business). To the Knowledge of the Seller, each independent contractor and consultant, in each case, providing personal services to the Seller and its Affiliates (solely with respect to, and to the extent related to, the Business) has been properly classified as an independent contractor for purposes of and consistent with good faith interpretations of, all Applicable Laws, including Applicable Laws with respect to employee benefits, and to the Knowledge of the Seller, each Employee has been properly classified consistent with good faith interpretations under the Fair Labor Standards Act (solely with respect to, and to the extent related to, the Employees). The Seller and its Affiliates are not a party to, bound by or in the process of negotiating any collective bargaining agreement or similar labor-related contract (solely with respect to, and to the extent related to, the Business). As of the date hereof, no labor organization or group of current Employees has made a pending demand (solely with respect to, and to the extent related to, the Business) for recognition or certification, and there are no representation or certification proceedings or petitions seeking a representation proceeding presently pending or, to the Knowledge of the Seller, threatened to be brought or filed with the National Labor Relations Board or any other labor relations tribunal or authority (in each case solely with respect to, and to the extent related to, the Business). To the Knowledge of the Seller, as of the date hereof, there are no material organizing activities, strikes, work stoppages, slowdowns, lockouts, arbitrations or grievances, or other material labor disputes, pending or threatened against or involving any Employees (solely with respect to, and to the extent related to, the Business).

(g) Each Employee Benefit Plan that is a "group health plan" as defined in Section 733(a)(1) of ERISA (a " Health Plan") (i) is currently in compliance in all material respects with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (" PPACA"), the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (" HCERA"), and the

regulations and guidance issued thereunder (collectively, with PPACA and HCERA, the "Healthcare Reform Laws"), and (ii) has been in compliance in all material respects with all applicable Healthcare Reform Laws since January 1, 2015.

(h) Neither Seller nor any of its Affiliates is a party to any employment agreement with any Employee, other than retention agreements that are listed in Section 3.06(a)(iv) of the Disclosure Schedule and offer letters.

(i) Section 3.10(i) of the Seller Disclosure Schedule sets forth a list of all individual independent contractors providing personal services to the Business as of the date hereof.

(j) Except as set forth on Section 3.10(j) of the Seller Disclosure Schedule, none of the Employees is a foreign national is in the United States pursuant to a United States H1-B visa or similar employer-sponsored work permit.

(k) Seller has performed a criminal background check on each Employee in a reasonable manner consistent with prudent hiring practices. Seller requires each Employee to annually complete an attestation regarding criminal conduct. To the Knowledge of Seller, none of the Employees are disqualified from performing services for the Business by reason of a criminal conviction.

Section 3.11. Permits.

(a) (i) The Ceding Company and AHLIC holds all Permits from all Insurance Regulators that are necessary for the current operation and conduct of the Business; and (ii) each of Seller and its Affiliates (solely with respect to, and to the extent related to, the Business) holds all other material Permits from all other Governmental Authorities that are necessary for the current operation and conduct of the Business and to own or use its assets and properties to the extent relating to the Business (collectively, the " Operating Permits"), except where the failure to hold an Operating Permit would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. Except as would not be reasonably likely to have a Material Adverse Effect, all such Operating Permits are valid and in full force and effect in accordance with their terms. Each of the Ceding Company and AHLIC is, and since December 31, 2014 has been, in compliance in all material respects with all such Operating Permits.

(b) As of the date hereof, since December 31, 2014, Seller and its Affiliates have not received any written notice, or, to the Knowledge of Seller, oral communication from any Governmental Authority regarding any actual, alleged, or potential material violation of, or failure to comply with, the terms or requirements of any such Operating Permit (solely with respect to, and to the extent related to, the Business). As of the date hereof, none of Seller or any of its Affiliates is the subject of any pending or, to the Knowledge of Seller, threatened action seeking the revocation, withdrawal, suspension, termination, cancellation, nonrenewal, modification or impairment of any such Operating Permit (solely with respect to, and to the extent related to, the Business).

Section 3.12. Intellectual Property.

(a) Section 3.12(a) of the Seller Disclosure Schedule sets forth, as of the date hereof, a true, complete and correct list of (i) all Transferred Intellectual Property that is Registered, indicating for each item: (A) the current owner; (B) the jurisdiction where the application or registration is located; and (C) the application or registration number, and (ii) proprietary Software and material unregistered Trademarks that are Transferred Intellectual Property.

(b) Seller or an Affiliate thereof are the exclusive owners of the Transferred Intellectual Property free and clear of all Liens other than Permitted Liens. As of the Closing Date, Purchaser or its designee will be the exclusive owners of the Transferred Intellectual Property, free and clear of all Liens other than Permitted Liens.

(c) Except as set forth in Section 3.12(c) of the Seller Disclosure Schedule (i) to the Knowledge of Seller, the operation of the Business has not been and is not infringing, violating or misappropriating the Intellectual Property of any third party, (ii) no third party has asserted in a writing received by Seller or any of its Affiliates, or to the Knowledge of Seller asserted orally, that its conduct of the Business has infringed, violated or misappropriated the Intellectual Property of any third party and there are no such claims pending or, to the Knowledge of Seller , threatened, (iii) and, to the Knowledge of Seller, as of the date hereof, no third party has infringed, violated or misappropriated or is now infringing, violating or misappropriating any Transferred Intellectual Property. Notwithstanding anything to the contrary set forth in this Agreement, this Section 3.12(c) contains all of the representations and warranties provided by Seller with respect to the non-infringement, non-violation and non-misappropriation of Intellectual Property.

(d) Seller and its Affiliates have taken commercially reasonable actions to maintain the enforceability of the Transferred Intellectual Property under all Applicable Law (including (i) making and maintaining in full force and effect all necessary filings, registrations and issuances and (ii) maintaining the secrecy of all Trade Secrets).

(e) Seller has maintained and currently maintains complete source code for all current and the immediately prior (i.e., n-1) versions and releases of all Software developed by or for Seller and included within the Transferred Intellectual Property (" Developed Software"). All Developed Software is designed and documented in a reasonable manner, consistent with accepted industry practices. Except as would not be material to the Business, no Developed Software contains any viruses, worms, back doors, spyware, adware, malware, time-bombs or key-locks (as such terms are commonly understood in the software industry).

(f) Except as set forth on Section 3.12(f) of the Seller Disclosure Schedule, no Transferred Intellectual Property that is Software contains any Open Source Software, including any software governed by an "open source" license that may (i) require, as a condition to the use of such Software, that Seller disclose, license or distribute to third parties any of the source code for such Software, (ii) requires derivative works of such Software to be licensed under the same "open source" license as the original work or otherwise requires its licensing thereof for the purpose of making derivative works, (iii) imposes any restriction on the consideration to be charged for the distribution of such Software, or (iv) creates, or purports to create, obligations for

Seller with respect to the Intellectual Property rights owned by Seller or grants, or purports to grant, to any third party any rights or immunities under Intellectual Property rights owned by Seller.

Section 3.13. Insurance Business.

(a) Except as set forth in Section 3.13 of the Seller Disclosure Schedule, since December 31, 2014 any application, form of insurance policy, certificates of insurance, riders, endorsements, advertising material, rate, rule or producer compensation utilized by the Seller and its Affiliates (solely with respect to, and to the extent related to, the Business), the use or issuance of which requires filing or approval, has been appropriately filed, and, if required, approved by the Insurance Regulator of any state in which such application forms, forms of insurance policies, advertising materials and rates and rules are required to be filed and (as applicable) approved or not objected to by such authorities within the period provided for approval or objection, except for failures to effect such filings or secure such approvals, which would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. All such application forms, forms of insurance policies, advertising materials and rates or rules are utilized in compliance in all material respects with all Applicable Laws and within the scope of the approvals (if any) received with respect thereto. No material deficiencies have been asserted by any Governmental Authority with respect to any such filings or compliance with the filings or approvals issued by the Insurance Regulators which have not been cured or otherwise resolved.

(b) The underwriting standards and ratings applied by the Ceding Company since such date with respect to Group Contracts have conformed in all material respects to those contained in the underwriting manuals utilized by the Ceding Company, as in effect at the times such Group Contracts were underwritten.

(c) Since December 31, 2014, Seller and any applicable Affiliates have timely paid in all material respects all guaranty fund assessments that have been due, claimed or asserted by, or are the subject of any voluntary contribution commitment to, any state guaranty fund or association or any Insurance Regulator in any jurisdiction in which Seller or any applicable Affiliate operates the Business arising out of or resulting from such operation of the Business by Seller and its Affiliates. Except for regular periodic assessments in the ordinary course of business or assessments based on developments that are publicly known within the insurance industry, no material claim or assessment is pending or, to the Knowledge of Seller, threatened against Seller or any Affiliate with respect to the Business by any state insurance guaranty association in connection with such association's fund relating to insolvent insurers.

(d) The Business does not include (i) any policies issued to a plan sponsor located outside the United States and its territories, or (ii) any policies issued to plan sponsors located in the United States to cover primarily employees located outside the United States.

Section 3.14. Producers; Sale Practices.

(a) Except as set forth in Section 3.14(a) of the Seller Disclosure Schedule, to the Knowledge of Seller, from December 31, 2014 to the date hereof, each Producer, at any time that

it wrote, sold or produced Group Insurance Contracts for Seller or any of its Affiliates, was duly licensed, authorized and appointed (for the Group Insurance Contract written, sold or produced by such Producer) in the particular jurisdiction in which such Producer wrote, sold or produced such Group Insurance Contract and, to the Knowledge of Seller, from December 31, 2014 to the date hereof, no such Producer violated any term or provision of Applicable Law relating to the writing, sale or production of Group Insurance Contracts, in each case except as would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

(b) Except as set forth in Section 3.14(b) of the Seller Disclosure Schedule, since December 31, 2014, none of Seller or the Ceding Company has received any written notice or communication from any Governmental Authority that a Producer is in material violation of any Applicable Law applicable to the writing, sale, production or marketing of any Group Insurance Contract.

Section 3.15. Real Property. The Transferred Assets do not include any real property other than the real property that is leased pursuant to the Assigned Lease. Section 3.15 of the Seller Disclosure Schedule lists, as of the date hereof, all real property, including the real property located at 222 SW Columbia Street, Portland, Oregon (the " Portland Location"), (a) which are owned by Seller or an Affiliate of Seller or (b) in which Seller or an Affiliate of Seller has a leasehold interest and, in each case, in which Seller intends will be occupied by Purchaser or an Affiliate thereof from and after the day immediately following the expiration or termination of the Employee Lease Term (such leases in subclause (b) of this Section 3.15 (but expressly excluding the Assigned Lease) are collectively referred to as the " Non-Assigned Leases" ; together with the Assigned Lease, collectively, the " Leases"). True and complete copies in all material respects of each of the Leases, including in each case all amendments and addenda thereto, have been made available to Purchaser on the Project DeLorean Intralinks site or by email prior to the date hereof. Seller or an Affiliate thereof has a valid and enforceable leasehold interest under the Leases, subject to Permitted Liens and to the Enforceability Exceptions and neither Seller nor any such Affiliate has received any written notice of any default under the Leases, and, to the Knowledge of Seller, no event has occurred and no condition exists that, with notice or lapse of time or both, would constitute a default by Seller or any such Affiliate under the Leases, except, in each case, for such invalidity, unenforceability or defaults that, individually or in the aggregate, would not reasonably be expected to have a Material Adverse Effect.

Section 3.16. Ceded Reinsurance Contracts.

(a) Section 3.16(a) of the Seller Disclosure Schedule lists each reinsurance agreement to which the Ceding Company or AHLIC is a party and under which the Ceding Company or AHLIC reinsured or retroceded risk under any of the Group Insurance Contracts that were in effect as of the date hereof (the " Ceded Reinsurance Contracts").

(b) Each of the Ceded Reinsurance Contracts constitutes a valid and binding obligation of the Ceding Company or AHLIC and, to the Knowledge of Seller, each other party thereto, enforceable against the Ceding Company or AHLIC and, to the Knowledge of Seller, each other party thereto in accordance with its terms, subject to the Enforceability Exceptions. Except as set forth in Section 3.16(b) of the Seller Disclosure Schedule, as of the date hereof,

neither the Ceding Company nor AHLIC has delivered notice or received written or, to the Knowledge of Seller, oral notice of early termination of any such Ceded Reinsurance Contract. There exists no material breach or event of default with respect to any Ceded Reinsurance Contract on the part of the Ceding Company or AHLIC or, to the Knowledge of Seller, as of the date hereof, any other party thereto, in each case that would, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

(c) Since December 31, 2014, there has not been any dispute with respect to any material amounts recoverable or payable by the Ceding Company pursuant to any Ceded Reinsurance Contract. All amounts owed under any Ceded Reinsurance Contracts have been timely paid in accordance with their terms.

Section 3.17. Tax.

(a) There are no outstanding audits or other administrative or judicial actions by any Governmental Authority with regard to, or related to, the Tax treatment of the Business or the Transferred Assets, nor to the Knowledge of Seller, as of the date hereof, is any such audit or other administrative or judicial action pending or threatened.

(b) Seller and its Affiliates have timely paid all material Taxes which will have been required to be paid on or prior to the date hereof in respect of the Business or the ownership of the Transferred Assets.

(c) All material Taxes required to have been withheld, collected or remitted with respect to the Business or the Transferred Assets have been withheld, collected or remitted, as applicable, to the applicable Governmental Authority in accordance with Applicable Law.

(d) Seller and its Affiliates have materially complied with all Tax reporting, withholding, and disclosure requirements applicable to the Ceded Insurance Contracts under the Code, Treasury Regulations, and forms issued by the Internal Revenue Service and under any corresponding or similar provision of state or local law.

(e) Seller and its Affiliates have duly and timely (including any applicable extensions) filed all material Tax Returns required to have been filed by them in respect of the Business or the ownership of the Transferred Assets, and all such Tax Returns are accurate and complete in all material respects as they relate to the Business or the Transferred Assets.

(f) All material deficiencies asserted in writing or assessments made in writing with respect to the Business or the ownership of the Transferred Assets by a Tax authority have been paid in full, except to the extent they are being contested in good faith through appropriate proceedings.

(g) There are no material Liens for Taxes (other than Permitted Liens) upon the Transferred Assets.

(h) Seller and each of its Affiliates are not and have not been a party to any "reportable transaction" within the meaning of Treasury Regulation Section 1.6011-4 with respect to the Business or the Transferred Assets.

(i) There is no written claim pending from any Tax authority in any jurisdiction where the Seller does not file Tax Returns in respect of the Business that the Business is or may be subject to taxation by that jurisdiction.

(j) The reserves reflected with respect to the Ceded Insurance Contracts on the consolidated federal income Tax Return filed by the affiliated group of which Seller is a member for the year ending December 31, 2014, and since such date, have been determined in all material respects in the manner required by the Code and other Applicable Law, and to the extent relevant to the determination and maintenance thereof, have been determined and maintained in all material respects in accordance with SAP.

(k) The Tax treatment of each Ceded Insurance Contract is not, and, since the time of issuance, has not been, materially less favorable to the purchaser, policyholder or intended beneficiaries thereof, than the Tax treatment and purported to qualify for at the time of issuance.

Section 3.18. Financial Statements; Books and Records.

(a) Seller has previously delivered to Purchaser true, correct and complete copies of (i) the audited annual statutory financial statements of each of the Ceding Company and AHLIC, together with the report of each such company's independent auditors thereon, as of and for the years ended December 31, 2015 and December 31, 2016 and (ii) the unaudited statutory financial statements of each of the Ceding Company and AHLIC as of and for the quarter ended June 30, 2017 (collectively, the " Statutory Statements"), in each case, as filed with the Insurance Regulator of such entity's jurisdiction of domicile. The Statutory Statements were prepared in accordance with applicable SAP consistently applied throughout all such periods and, except as set forth in Section 3.18(a) of the Seller Disclosure Schedule, fairly present in all material respects the financial position, admitted assets, liabilities, capital, and surplus of the Ceding Company and AHLIC (as applicable) at December 31, 2015, December 31, 2016 and June 30, 2017, and the results of operations, changes in surplus, and cash flows of the Ceding Company and AHLIC (as applicable) for the periods covered thereby, subject, in the case of the quarterly Statutory Statements as of and for the quarter ended June 30, 2017, to normal yearend adjustments and the absence of full footnote disclosures and other presentation items. Section 3.18(a) of the Seller Disclosure Schedule sets forth a complete list of all permitted practices used by each such company in the preparation of the Statutory Statements.

(b) The reserves, including incurred but not reported (IBNR), for payment of benefits, losses, claims, expenses, and other similar purposes (including claims litigation) with respect to the Group Contracts reflected in the Statutory Statements, the Reference Closing Statement, and the Pro Forma Financial Statements, as of their respective dates: (a) were computed in all material respects in accordance with generally accepted actuarial standards, consistently applied and developed by the Ceding Company applying consistent practices, assumptions and methodologies used as of their respective dates; (b) met the requirements of SAP and other Applicable Law; and (c) were based on actuarial information and data and inventories and policies and contracts that were accurate in all material respects; provided that this Section 3.18(b) shall not be deemed to be a representation or warranty of Seller that the reserves of the Ceding Company or AHLIC (to the extent relating to the Business) are or will be adequate or sufficient for the purposes for which they were established.

(c) Seller has previously delivered to Purchaser a true, correct and complete copy of the unaudited pro forma balance sheets of the Business as of December 31, 2015 and December 31, 2016 and an unaudited pro forma statement of profits and losses for the annual period ended December 31, 2016 (" Pro Forma Financial Statements"). The Pro Forma Financial Statements were prepared in good faith from the Books and Records using methodologies, estimates and adjustments to give effect to assumptions that provide a reasonable basis for presenting the financial position, direct profits and direct losses of the Business in accordance with GAAP, applied consistently with the historical practices of Seller, as of December 31, 2015 and December 31, 2016.

(d) The Reference Closing Statement was prepared in accordance with the Transaction Accounting Principles and fairly presents, in all material respects in accordance with the Transaction Accounting Principles, the assets and liabilities of the Business as of the Reference Date.

(e) The Books and Records (i) have been maintained in all material respects in accordance with Applicable Law and (ii) are in material compliance with any and all record keeping maintenance requirements in applicable Group Contracts. No Board Materials relating to the Business exist except those certain Board Materials identified and made available by Seller for inspection and review by Purchaser prior to the date hereof.

(f) Seller and the Ceding Company maintain a system of internal control over financial reporting sufficient to provide reasonable assurance regarding the reliability of the financial reporting of the Ceding Company with respect to the Business and the preparation of financial statements for external purposes in accordance with GAAP, applied consistently with the historical practices of Seller, or SAP, as applicable. There are no material weaknesses or significant deficiencies in the internal controls over financial reporting of Seller or the Ceding Company with respect to the Business.

Section 3.19. Specified Portfolio.

(a) During the period from the Reference Date to the date hereof, (i) no Investment Assets that were in the Specified Portfolio as of the Reference Date have been sold except: (A) sales of Investment Assets that were determined by Seller (in accordance with SAP and Seller's and its Affiliates' past practices), to have become, or to be reasonably likely to become, impaired, all of which sales are set forth on Section 3.19(a)(i)(A) of the Seller Disclosure Schedule; and (B) sales of Investment Assets set forth in Section 3.19(a)(i)(B) of the Seller Disclosure Schedule, which collectively did not exceed the Discretionary Turnover Allowance; and (ii) all additions to the Specified Portfolio were made in accordance with the Pre-Closing Investment Guidelines.

(b) Section 3.19(b)(i) of the Seller Disclosure Schedule sets forth, as of the date hereof, the Capital Gain or Loss Adjustments for each of the sales of Investment Assets set forth in Section 3.19(a)(i)(B) of the Seller Disclosure Schedule. Section 3.19(b)(ii) of the Seller Disclosure Schedule sets forth a list of each of the Reallocated Investment Assets that were added to the Specified Portfolio between the Reference Date and the date of this Agreement, and the Reallocated Asset Value Adjustments, if any, that were required with respect to such

Reallocated Investment Assets during such period. The representations and warranties in this Section 3.19 have been made assuming, for this purpose, that the terms of Section 5.11 (other than the definition of "Selection Waterfall" included therein) applied with respect to the period between the Reference Date and the date of this Agreement.

Section 3.20. No Undisclosed Liabilities. The Business has no Liabilities required to be disclosed or reserved for on a balance sheet of the Ceding Company prepared in accordance with applicable SAP, except (i) Liabilities set forth in Section 3.20 of the Seller Disclosure Schedule, (ii) Liabilities disclosed or reserved for in the Statutory Statements and (iii) Liabilities that (x) were incurred after December 31, 2016 in the ordinary course of business consistent with past practice and (y) have not had and would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

Section 3.21. Actuarial Report. Seller has delivered to Purchaser true, complete and correct copies of the actuarial report, dated as of June 7, 2017 (as adjusted by a memorandum dated August 28, 2017) prepared by Milliman Inc. (" Milliman") with respect to the Business as of December 16, 2016 (the " Actuarial Report"). The information and factual data furnished by Seller and its Affiliates in writing to Milliman with respect to the Business in connection with the preparation of the Actuarial Report (and any supplements or addenda thereto) were (a) obtained from the Books and Records, (b) generated from the same underlying sources and systems that were utilized by Seller or its applicable Affiliates to prepare the Pro Forma Statements to the extent applicable and (c) to the Knowledge of Seller, did not include any material Data Input Inaccuracies. As of the date hereof, Milliman has not issued to Seller or its Affiliates any new or revised report with respect to the Business or any errata with respect to the Actuarial Report nor has it notified Seller or any of its Affiliates that the Actuarial Report is inaccurate in any material respect.

Section 3.22. Absence of Certain Changes or Events. Except as expressly contemplated or required by this Agreement or as set forth in Section 3.22 of the Seller Disclosure Schedule, since December 31, 2016 (a) Seller and its Affiliates have operated and conducted the Business in all material respects in the ordinary course of business; (b) there has not been any event, occurrence, condition or change that has had, or would reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect; and (c) neither Seller nor any of its Affiliates has taken any action or failed to take any action that, if taken or failed to have been taken after the date hereof, would violate Section 5.01.

Section 3.23. Brokers and Finders. Except for Barclays Capital Inc. and one or more of its Affiliates, whose fees will be paid by Seller, no broker, investment banker, financial adviser or other person is entitled to any broker's, finder's, financial adviser's or other similar fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of Seller or any of its Affiliates.

Section 3.24. Data Protection and Privacy; IT Systems.

(a) Since December 31, 2014, Seller and its Affiliates with respect to the Business have been and are in compliance in all material respects with any and all contractual requirements, including applicable terms of use and privacy policies, pertaining to the protection,

privacy, security, collection, storage, use, disclosure, disposal, maintenance and transmission of Personal Data.

(b Since December 31, 2014, to the Knowledge of Seller, none of Seller and its Affiliates, or any third Person working on behalf of any of them, has experienced an incident of unauthorized access, disclosure, use, destruction or loss of any Personal Data that Seller or its Affiliates (or a third Person on behalf of any of them) collects, stores, uses or transmits in the conduct of the Business that required the delivery of notice to affected individuals pursuant to Privacy and Data Security Laws.

(c) Section 3.24(c) of the Seller Disclosure Schedule identifies (i) all IT Systems that are included in the Transferred Assets and (ii) all Vendors that provide "cloud", support, hosting, servicing, interfacing, connectivity, security, and redundancy services to the Business. All IT Systems that are included in the Transferred Assets or access to which will be provided pursuant to the Transition Services Agreement (x) are in good repair and operating condition and in all material respects adequate and suitable for the purposes for which they are being used or held for use, and (y) have not, since December 31, 2014, experienced bugs, failures, breakdowns, unauthorized access or use, or substandard performance, malfunction or failure of any unplanned downtime that caused any material disruption or interruption in or to the operation of the Business, and (z) to the Knowledge of Seller, do not contain any "malware" that would reasonably be expected to interfere with the ability of the Purchaser to conduct the Business. Seller and its Affiliates have implemented, currently maintain, and comply with commercially reasonable business continuity and backup and disaster recovery plans and procedures with respect to the IT Systems that are included in the Transferred Assets or access to which will be provided pursuant to the Transition Services Agreement.

Section 3.25. Distribution of Group Insurance Contracts.

(a) Seller hereby represents and warrants that (a) the Service Standards which are attached to the Distribution Agreement as Exhibit A are based upon and are consistent in all material respect with the Ceding Company's service standards generally applicable on an individual plan basis to specified services provided to plans in connection with large Group Insurance Contracts, except (i) as modified to reflect that the Service Standards are applicable to specified categories of Group Insurance Contracts in the aggregate, rather than on an individual plan basis; or (ii) as expressly agreed by the Parties to apply solely to Group Insurance Contracts administered on Purchaser's systems; and (b) since December 31, 2015 all Group Insurance Contracts issued by Seller or its Affiliates, in the aggregate, have been administered in material compliance with the service standards upon which such Service Standards are based.

(b) Seller hereby represents and warrants that Seller and its Affiliates calculated the compensation payable by Seller or its Affiliates to the Sales Force (as such term is defined in the Form of Distribution Agreement) in respect of the distribution of Group Insurance Contracts during the calendar year 2017 in a manner consistent with the terms of Exhibit D to the attached Form of Distribution Agreement, except in such instances as would not, individually or in the aggregate, have a material adverse impact on the Business.

Section 3.26. Administration of the Subject Contracts. The Service Standards that are attached to the form of Administrative Services Agreement as Exhibit II are based upon and are consistent in all material respects with the Ceding Company's service standards generally applicable on an individual plan basis to specified services provided to plans in connection with the Subject Contracts (as such term is defined in the form of Administrative Services Agreement attached hereto as Exhibit D). Since December 31, 2015, Seller and its Affiliates in the aggregate have administered the Subject Contracts in material compliance with the service standards upon which such Service Standards are based. In addition, since December 31, 2015, Seller and its Affiliates have administered the Subject Contracts in material compliance with all agreements with customers who purchased the Subject Contracts, including requirements to maintain the administration of the Subject Contracts in the United States.

ARTICLE IV.

REPRESENTATIONS AND WARRANTIES OF PURCHASER

Except as set forth in the corresponding sections or subsections of the disclosure schedule delivered to Seller by Purchaser concurrently with the execution and delivery of this Agreement (the " Purchaser Disclosure Schedule") (it being understood and agreed by the parties hereto that disclosure of any item in any section or subsection of the Purchaser Disclosure Schedule shall be deemed disclosure with respect to any other section or subsection of the Purchaser Disclosure Schedule to which the relevance of such item is reasonably apparent, notwithstanding the omission of a reference or cross-reference thereto), Purchaser hereby makes the following representations and warranties to Seller, as of the date hereof and as of the Closing Date as follows:

Section 4.01. Organization, Standing. Purchaser is an insurance company duly incorporated, validly existing and in good standing under the laws of Connecticut.

Section 4.02. Authorization. Purchaser or the applicable Affiliate of Purchaser (as applicable) has all requisite corporate or other applicable organizational power to enter into, consummate the transactions contemplated by and carry out its obligations under, each of the Transaction Agreements to which it is or is contemplated to become a party. The execution and delivery by Purchaser or the applicable Affiliate of Purchaser (as applicable) of each of the Transaction Agreements to which it is or is contemplated to become a party and the consummation by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the transactions contemplated by each of the Transaction Agreements to which it is or is contemplated to become a party have been duly authorized by all requisite corporate or other similar organizational action on the part of Purchaser or the applicable Affiliate of Purchaser (as applicable). Each of the Transaction Agreements to which Purchaser or the applicable Affiliate of Purchaser (as applicable) is or is contemplated to become a party has been, or upon execution and delivery thereof will be, duly executed and delivered by Purchaser or the applicable Affiliate of Purchaser (as applicable). Assuming due authorization, execution and delivery by the other parties hereto or thereto, each of the Transaction Agreements to which Purchaser or the applicable Affiliate of Purchaser (as applicable) is or is contemplated to become a party constitutes, or upon execution and delivery thereof will constitute, the legal, valid and binding

obligation of Purchaser or the applicable Affiliate of Purchaser (as applicable), enforceable against it in accordance with its terms, subject in each case to the Enforceability Exceptions.

Section 4.03. No Conflict or Violation. Provided that all consents, approvals, authorizations and other actions described in Section 4.04 have been obtained or taken, the execution and delivery by Purchaser or the applicable Affiliate of Purchaser (as applicable) of, and the consummation by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the transactions contemplated by, the Transaction Agreements to which Purchaser or the applicable Affiliate of Purchaser (as applicable) is or is contemplated to become a party do not and will not (a) violate or conflict with the organizational documents of Purchaser or the applicable Affiliate of Purchaser (as applicable), (b) subject to the Governmental Approvals referred to in Section 4.04 , conflict with or violate any Applicable Law or Governmental Order applicable to Purchaser or the applicable Affiliate of Purchaser (as applicable) or by which any of them or any of their respective properties, assets or rights is bound or subject to, (c) result in any breach of, or constitute a default (or event which, with the giving of notice or lapse of time or both, would constitute a default) under, or give to any Person any rights of termination, acceleration or cancellation of or result in the creation of any Lien (other than Permitted Liens) on any of the assets, properties or rights of Purchaser or any of its Affiliates pursuant to, any contract or any note, bond, loan or credit agreement, mortgage or indenture to which Purchaser or any of its Affiliates is a party or by which any of them or any of their respective properties or assets is bound or subject, or (d) result in a breach or violation of any of the terms or conditions of, result in a default under, or otherwise cause an impairment or revocation of, any material Permit of Purchaser or its Affiliates; except, in the case of clauses (b), (c) and (d) of this Section 4.03 , for any such conflicts, violations, breaches, defaults, terminations, accelerations, cancellations or creations that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.04. Consents and Approvals. The execution and delivery by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the Transaction Agreements to which it is or is contemplated to become a party do not, and the consummation by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the transactions contemplated by the Transaction Agreements to which it is or is contemplated to become a party will not, require any Governmental Approval to be obtained or made by or with respect to Purchaser or the applicable Affiliate of Purchaser (as applicable), except for any Governmental Approvals the failure to obtain or make which, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.05. Absence of Litigation. There are no Actions pending or, to the Knowledge of Purchaser, threatened in writing against Purchaser or any of its Affiliates or any of their respective assets, properties or businesses that (i) question the legality of the transactions contemplated by any of the Transaction Agreements or (ii) as of the date hereof, individually or in the aggregate, would reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.06. Compliance With Laws.

(a) Purchaser and its Affiliates are not in violation of any Applicable Laws (including any Applicable Laws regulating the insurance business) or Governmental Orders applicable to

them or their respective assets, properties or businesses, except for violations that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

(b) All material deficiencies or violations with respect to the respective insurance businesses of Purchaser and its Affiliates that are party to any Transaction Agreement in all reports of examinations of the affairs of Purchaser or any such Affiliate with respect to such businesses (including financial, market conduct and similar examinations) issued by any Insurance Regulator for any period ending on a date on or after December 31, 2014, have been resolved to the reasonable satisfaction of the Insurance Regulator that noted such deficiencies or violations, except as would not reasonably be expected to have a Purchaser Material Adverse Effect.

(c) Neither Purchaser nor its Affiliates, nor any of their respective properties, assets or rights, is a party to, or bound by, any Governmental Order, except for those Governmental Orders that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

(d) Purchaser and each Affiliate of Purchaser that is party to a Transaction Agreement has filed all reports, statements, documents, registrations, filings or submissions required to be filed by Purchaser or such Affiliate with any Governmental Authority to the extent they relate to their respective insurance businesses, except for any failures to file that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect. All such registrations, filings and submissions were in compliance in all material respects with Applicable Law when filed or as amended or supplemented, and no deficiencies have been asserted by any Governmental Authority with respect to such registrations, filings or submissions that have not been satisfied, except for any non-compliance or failures to file that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.07. Financial Ability.

(a) Purchaser has, and will have at the Closing, all funds necessary to: (i) pay all amounts required to be paid or deposited by Purchaser and its Affiliates pursuant to Article II; and (ii) consummate the transactions contemplated by this Agreement and the other Transaction Agreements.

(b) Purchaser has previously delivered to Seller copies of (i) the audited annual statutory financial statements of Purchaser as of and for the years ended December 31, 2015 and December 31, 2016 and (ii) the unaudited interim statutory financial statements of the Purchaser as of and for the six-month period ending June 30, 2017. The foregoing statutory financial statements were prepared in all material respects in accordance with SAP and fairly present, in all material respects in accordance therewith, the admitted assets, liabilities and capital and surplus of Purchaser at their respective dates and the results of operations, changes in surplus and cash flows of Purchaser at and for the periods indicated, subject, in the case of the financial statements referenced in clause (ii) above, to normal year-end adjustments.

Section 4.08. Permits.

(a) Purchaser and each of its Affiliates executing any Transaction Agreement holds, or as of the Closing Date will hold, all registrations, filings, licenses, permits, approvals or authorizations issued or granted by Governmental Authorities that are necessary to consummate the transactions contemplated by the Reinsurance Agreement, for the current operation and conduct of the Business and to own or use its assets and properties to the extent relating to the Business (collectively, the " Purchaser Permits") except for such failure to hold Purchaser Permits as would not reasonably be expected to have, individually or in the aggregate, a Purchaser Material Adverse Effect.

(b) Since December 31, 2014, none of Purchaser or any of its Affiliates executing any Transaction Agreement has received any written notice or communication from any Governmental Authority regarding any actual, alleged, or potential violation of, or failure to comply with, the terms or requirements of any such Purchaser Permit, except as would not reasonably be expected to have, individually or in the aggregate, a Purchaser Material Adverse Effect. As of the date hereof, none of Purchaser or any of its Affiliates executing any Transaction Agreement is the subject of any pending or, to the Knowledge of Purchaser, threatened action seeking the revocation, withdrawal, suspension, termination, cancellation, nonrenewal, modification or impairment of any such Purchaser Permit except as would not reasonably be expected to have, individually or in the aggregate, a Purchaser Material Adverse Effect.

Section 4.09. Brokers and Finders. Except for Merrill Lynch, Pierce, Fenner & Smith Inc., whose fees will be paid by Purchaser, no broker, investment banker, financial adviser or other person is entitled to any broker's, finder's, financial adviser's or other similar fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of Purchaser or any of its Affiliates.

Section 4.10. Absence of Triggering Event. As of the date hereof and assuming, for this purpose, that the Reinsurance Agreement became effective immediately prior to the date hereof, to the Knowledge of Purchaser, no Triggering Event (as defined in the Reinsurance Agreement) shall have occurred thereunder.

ARTICLE V.

COVENANTS

Section 5.01. Conduct of Business. Between the date hereof and the Closing Date, and, with respect to Section 5.01(c)-(h) , between the date hereof and the end of the Employee Lease Term, subject to the terms of the Employee Leasing Agreement, except (a) as required under any Applicable Law, (b) as otherwise contemplated by or necessary to effectuate the Transaction Agreements (including compliance with Sections 5.06(a) and 5.11), (c) for matters identified in Section 5.01 of the Seller Disclosure Schedule or (d) with the consent of Purchaser (which consent may not be unreasonably withheld, delayed or conditioned), Seller shall, and shall cause its Affiliates to, in each case solely with respect to, and to the extent relating to, the Business, use commercially reasonable efforts to (x) conduct the Business in the ordinary course of business,

(y) maintain current significant business relationships and goodwill with policyholders, customers, suppliers and service providers of and to the Business, and with the Governmental Authorities with jurisdiction over the Business, and (z) not do any of the following:

(a) other than in the ordinary course of business and other than with respect to Investment Assets, sell, voluntarily terminate, transfer, assign, lease, sublease, license or otherwise dispose of any Transferred Assets;

(b) sell, terminate, transfer or otherwise dispose of any of the cash or Investment Assets in the Specified Portfolio other than as contemplated by Section 5.11;

(c) increase the base salary (or wages), target cash incentive compensation opportunity, benefits (including severance benefits) paid or payable to any Employee, except for annual salary or wage adjustment increases in the ordinary course of business and consistent with increases applicable to similarly situated employees of the Seller and its Affiliates or as required by the terms of any Employee Benefit Plan in existence as of the date hereof;

(d) (A) establish or adopt, enter into, change, terminate, or amend in any material respect any Employee Benefit Plan or any retention or severance agreement with respect to any Employee, (B) take any action to accelerate any material rights or benefits under any Employee Benefit Plan with respect to any Employee (except to the extent required as of the date hereof by any such plan), or (C) grant any new equity or equity-based awards to any Employee;

(e) establish, adopt, enter into, change or amend any Business Employee Benefit Plan or take any action to accelerate any material rights or benefits under any Business Employee Benefit Plan;

(f) hire or engage any Employee or independent contractor providing personal services with respect to the Business, in each case, who will earn annual base salary in excess of $150,000;

(g) terminate, other than for cause, the employment or engagement of any Employee or independent contractor providing personal services with respect to the Business;

(h) transfer or reallocate, or permit the transfer or reallocation of, the employment or services of any employee or independent contractor providing personal services to Seller or its Affiliates into or out of the Business;

(i) enter into, amend in any material respect, waive any rights under, or assign or transfer any Assigned Contract or Material Contract;

(j) make any material change in the accounting, actuarial, investment, reserving, underwriting or claims administration policies, practices, or principles of (and solely to the extent relating to) the Business, except as may be required by GAAP, SAP, Applicable Law or internal accounting policies existing as at December 31, 2016;

(k) make or change any material Tax election in respect of the Business, adopt or materially change any accounting method in respect of the Business, file any material amended

Tax Return in respect of the Business, or materially modify the method by which Seller and its Affiliates determine reserves with respect to the Ceded Insurance Contracts;

(l) voluntarily grant any Lien (other than Permitted Liens) on any Transferred Assets;

(m) abandon, modify, waive, terminate or allow to lapse any material Permit of Seller or the Ceding Company to the extent relating to the Business; or

(n) enter into a binding agreement to take any of the foregoing actions.

Section 5.02. Pre-Closing Access to Information.

(a) Between the date of this Agreement and the Closing Date, subject to Applicable Law and subject to the rules applicable to visitors at Seller's offices generally, Seller shall afford to Purchaser and its Representatives reasonable access, upon reasonable advance notice and during normal business hours, to such contracts, documents and information of or relating to the assets, liabilities, business, operations and other aspects of the Business as Purchaser may reasonably request; provided , however , that Seller shall not be obligated to provide such access or information if Seller determines, in its reasonable judgment, that doing so would violate Applicable Law or a contract, agreement or obligation of confidentiality owing to a third party, jeopardize the protection of an attorney-client privilege, or expose Seller or any of its Affiliates to risk of liability for disclosure of sensitive or personal information; provided, further , that Seller shall not be obligated to provide such access to its offices if Seller determines, in its reasonable judgment, that such contracts, documents and information can be provided electronically or in another reasonably accessible location. Purchaser agrees that it will hold, and will cause its Representatives to hold, any information so obtained in confidence to the extent required by, and in accordance with, the provisions of the Confidentiality Agreement and Section 5.04. Notwithstanding anything to the contrary set forth herein, none of Seller, its Affiliates or their respective Representatives shall be required to disclose or provide access to Excluded Books and Records to Purchaser or, prior to the Closing Date, any of its Representatives or any information that Seller reasonably determines to be competitively sensitive.

(b) Without limiting the foregoing, from the date hereof until the Closing, Seller shall deliver to Purchaser complete copies of the audited or unaudited statutory financial statements of the Ceding Company, together with any notes, exhibits or schedules thereto, that are filed with the Insurance Regulator for the applicable company's jurisdiction of domicile between the date hereof and the Closing, as promptly as practicable after the filing of such statements with such Insurance Regulator.

Section 5.03. Post-Closing Access to Information.

(a) For a period of five years following the Closing Date, Seller shall: (i) allow Purchaser, upon reasonable prior notice and during normal business hours, through its Representatives, the right, at Purchaser's expense, to examine and make copies of any Excluded Books and Records which were retained by Seller or its Affiliates pursuant to this Section 5.03; and (ii) allow Purchaser to interview Seller's and its Affiliates' Representatives for any reasonable business purpose relating to the Business, including in connection with Seller's pre-

Closing employment of the Transferred Employees or Purchaser's preparation or examination of regulatory and statutory filings and financial statements and the conduct of any litigation relating to the Business (other than any litigation or dispute between Seller or its Affiliates, on the one hand, and Purchaser or its Affiliates, on the other hand), or the conduct of any regulatory authority, policyholder, reinsurer or other dispute resolution or any other Third Party Claim (whether or not such Third Party Claim is the subject of an indemnification claim by a Purchaser Indemnified Person or Seller Indemnified Person), whether pending or threatened; provided , however , that Seller shall not be obligated to provide such access to its offices if Seller determines, in its reasonable judgment, that such Excluded Books and Records can be provided electronically or in another reasonably accessible location. Access to such Representatives and Excluded Books and Records shall be at Purchaser's expense and shall not unreasonably interfere with Seller's or its Affiliates' or any of their respective successor companies' business operations.

(b) For a period of five years following the Closing Date, Purchaser shall: (i) allow Seller, upon reasonable prior notice and during normal business hours, through its Representatives, the right, at Seller's expense, to examine and make copies, at Seller's expense, of any Books and Records which were transferred to Purchaser or its Affiliates at or after the Closing and of which neither Seller nor any of its Affiliates retained a copy; and (ii) allow Seller to interview Purchaser's Representatives, upon reasonable prior notice and during normal business hours, for any reasonable business purpose relating to the Business, including in connection with Seller's preparation or examination of regulatory and statutory filings and financial statements, and the conduct of any litigation relating to the Business (other than any litigation or dispute between Seller or its Affiliates, on the one hand, and Purchaser or its Affiliates, on the other hand), or the conduct of any regulatory, contract holder, reinsurer or other dispute resolution or any other Third Party Claim (whether or not such Third Party Claim is the subject of an indemnification claim by a Purchaser Indemnified Person or Seller Indemnified Person), whether pending or threatened; provided , however , that Purchaser shall not be obligated to provide such access to its offices if Purchaser determines, in its reasonable judgment, that such Books and Records can be provided electronically or in another reasonably accessible location. Access to such Representatives and Books and Records shall be at Seller's expense and shall not unreasonably interfere with the business operations of Purchaser or its Affiliates.

(c) Except as otherwise prohibited by Applicable Law and subject to clause (d) and (e) below, Purchaser shall, with respect to the Books and Records, and Seller and its Affiliates shall, with respect to the Excluded Books and Records and the Retained Books and Records, in each case, to which the other party is entitled to access pursuant to the foregoing provisions of this Section 5.03(a) and (b) and Section 5.05 : (i) comply in all material respects with all Applicable Laws relating to the preservation and retention of records; (ii) apply preservation and retention policies that are no less stringent than those generally applied by such party; and (iii) without limitation to the foregoing, for at least five years after the Closing Date, preserve and retain all original Books and Records, Retained Books and Records, and Excluded Books and Records, as the case may be, and thereafter dispose of such originals only after it shall have given the other party 90 days' prior written notice of such disposition and the opportunity (at such other party's expense) to remove and retain such information.

(d) Notwithstanding any other provision of this Agreement, a party hereto shall not be obligated to provide such access to any Books and Records, Retained Books and Records, or Excluded Books and Records or information if such party determines, in its reasonable judgment, that doing so would violate Applicable Law (except that copies thereof shall be furnished to the requesting party or its Representatives to the extent permitted under Applicable Law) or a contract, agreement or obligation of confidentiality owing to a third party, or jeopardize the protection of an attorney-client privilege; provided, that the party contemplated to provide access shall use commercially reasonable efforts to obtain waivers or make other arrangements (including redacting information or entering into joint defense agreements) that would enable otherwise required disclosure to the other party or its Representatives to occur without so jeopardizing privilege or contravening such Applicable Law, contract or obligation of confidentiality.

(e) Notwithstanding any other provision of this Agreement to the contrary, Purchaser shall, and shall cause its Affiliates to, retain and preserve all Books and Records (in whatever form maintained) transferred to Purchaser that are subject to a Legal Hold in effect as of the Closing, until such time as Seller notifies Purchaser in writing that such Books and Records may be destroyed. Seller shall use commercially reasonable efforts to notify Purchaser within 30 days of the termination of any applicable Legal Hold. Purchaser shall provide Seller and its Affiliates with access to any Books and Records subject to this Section 5.03(e); provided that access to Books and Records subject to Legal Holds shall be limited in time only by the terms of the applicable Legal Hold; provided , however , that Purchaser shall not be obligated to provide access to its offices for such purposes if Purchaser determines, in its reasonable judgment, that such Books and Records can be provided electronically or in another reasonably accessible location.

Section 5.04. Confidentiality.

(a) The terms of the confidentiality agreement, dated June 12, 2017 (the " Confidentiality Agreement"), between Seller and The Hartford Financial Services Group Inc. shall continue in full force and effect until the Closing, at which time the confidentiality obligations under the Confidentiality Agreement shall terminate.

(b) Notwithstanding the foregoing, nothing in the Confidentiality Agreement shall restrict, prohibit or delay the ability of Seller or Purchaser to exercise its rights or perform its obligations under the Transaction Agreements. If, for any reason, the transactions contemplated by this Agreement are not consummated, the Confidentiality Agreement shall nonetheless continue in full force and effect in accordance with its terms.

(c) From and after the Closing: (i) Seller shall, and shall cause its Representatives to, maintain in confidence any written, oral or other information to the extent relating to the Business obtained by virtue of Seller's ownership of the Business prior to the Closing, including the Retained Books and Records; and (ii) Purchaser shall, and shall cause its Representatives to, maintain in confidence any written, oral or other information of or relating to Seller or its Affiliates (other than information relating to the Business) obtained by virtue of its ownership of the Business from and after the Closing, except, in each case, to the extent that the applicable party is required to disclose such information by judicial or administrative process or pursuant to

Applicable Law (provided that, except in connection with any required disclosure pursuant to any Applicable Law relating to Taxes and any filings required by the applicable securities laws, such party has given the other party written notice of such potential disclosure and, to the extent reasonably requested by such other party, cooperated with such other party in seeking an appropriate order or other remedy protecting such information from disclosure) or such information can be shown to have been in the public domain through no fault of the applicable party.

(d) Effective as of the Closing, Seller shall (i) enforce, on behalf of and at the request of Purchaser, Seller's rights, powers and privileges under any in-force confidentiality agreements with third Persons other than Purchaser regarding the potential sale of the Business executed prior to the date hereof (each, a " Seller Confidentiality Agreement") in connection with any material breach thereof by such third persons, provided that Purchaser shall reimburse Seller for its costs and expenses (including reasonable legal fees and expenses) incurred in connection with such enforcement, and (ii) submit written requests to all third Persons who executed a Seller Confidentiality Agreement that such other Persons promptly deliver to Purchaser or otherwise destroy all proprietary or confidential material furnished to such Person by or on behalf of Seller or its Affiliates in accordance with the terms of such Seller Confidentiality Agreement.

Section 5.05. Maintenance and Transfer of Books and Records.

(a) Through the Closing Date, Seller shall, and shall cause its Affiliates to, maintain the Books and Records in all material respects in the same manner and with the same care that the Books and Records have been maintained for the 12-month period prior to the execution of this Agreement. Books and Records of the type identified in Section 5.05(a) of the Seller Disclosure Schedule, including, for the avoidance of doubt, Books and Records that (i) are necessary for Seller to provide services under the Transition Services Agreement (to the extent that such Books and Records cannot reasonably be duplicated and a copy retained by Seller or its applicable Affiliate(s)); or (ii) are not permitted to be disclosed or transferred under applicable Law (such Books and Records, the " Retained Books and Records"), shall not be transferred at the Closing but will instead be made available by Seller to Purchaser, at Seller's expense, from and after the Closing in accordance with the guidelines set forth in Section 5.05(a) of the Seller Disclosure Schedule. Notwithstanding anything to the contrary in this Agreement, Seller and its Affiliates shall not be required to transfer the Retained Books and Records at the Closing or on the Closing Date, and Seller and its Affiliates shall be entitled to retain copies of any Books and Records transferred to Purchaser at the Closing or on the Closing Date. Seller shall, and shall cause its Affiliates to, provide Purchaser and its Representatives reasonable access to such Retained Books and Records, and once any Retained Books and Records are no longer necessary for the provision of services under the Transition Services Agreement or are permitted to be transferred, as applicable, Seller shall cause such Retained Books and Records to be delivered to Purchaser (or a Person designated by Purchaser) or, at Purchaser's option, to be destroyed.

(b) At the Closing, Seller shall cause all Books and Records (except the Retained Books and Records) in the possession or control of Seller or any of its Affiliates to be delivered to Purchaser (or a Person designated by Purchaser) in accordance with the requirements and guidelines set forth in Section 5.05(b) of the Seller Disclosure Schedule.

Section 5.06. Consents, Approvals and Filings.

(a) Subject to the terms and conditions hereof, Seller and Purchaser shall each use their reasonable best efforts, and shall cooperate fully with each other, (i) to comply as promptly as practicable with all requirements of Governmental Authorities applicable to the transactions contemplated by the Transaction Agreements and (ii) to obtain as promptly as practicable all Governmental Approvals necessary in connection with the consummation of the transactions contemplated by the Transaction Agreements; provided that, Purchaser shall be responsible for the costs (including any license or other fees and expenses) associated with Seller, Purchaser or any of their respective Affiliates obtaining any such Governmental Approvals. In connection therewith, Seller and Purchaser shall make and cause their respective Affiliates to make all legally required filings as promptly as practicable in order to facilitate prompt consummation of the transactions contemplated by the Transaction Agreements, shall provide and shall cause their respective Affiliates to provide such information and communications to Governmental Authorities as such Governmental Authorities may request, shall take and shall cause their respective Affiliates to take all steps that are necessary, proper, or advisable to avoid any Action by any Governmental Authority with respect to the transactions contemplated by the Transaction Agreements, shall defend or contest in good faith any Action by any third party (including any Governmental Authority), whether judicial or administrative, challenging any of the Transaction Agreements or the transactions contemplated thereby, or that could otherwise prevent, impede, interfere with, hinder, or delay in any material respect the consummation of the transactions contemplated thereby, including by using their reasonable best efforts to have vacated or reversed any stay or temporary restraining order entered with respect to the transactions contemplated by any of the Transaction Agreements by any Governmental Authority, and shall consent to and comply with any condition imposed by any Governmental Authority on its grant of any such permit, order, consent, approval, or authorization, other than any Burdensome Condition. Each of the parties shall provide to the other party copies of all applications or other communications to Governmental Authorities in connection with this Agreement in advance of the filing or submission thereof.

(b) Without limiting the generality of the foregoing, as promptly as practicable after the date hereof, each of Purchaser and Seller shall file with all applicable Insurance Regulators all required requests for approval of the transactions contemplated by the Transaction Agreements, which requests shall include all required exhibits. A reasonable time prior to furnishing any written materials to any Insurance Regulator in connection with the transactions contemplated by the Transaction Agreements, the furnishing party shall provide the other party with a copy thereof, and the other party shall have a reasonable opportunity to provide comments thereon, which comments shall be considered by the furnishing party in good faith. Each party shall give to the other party prompt written notice if it receives any notice or other communication from any Insurance Regulator or other Governmental Authority in connection with the transactions contemplated by the Transaction Agreements and, in the case of any such notice or communication that is in writing, shall promptly furnish the other party with a copy thereof. If any Governmental Authority requires that a hearing be held in connection with any such approval, each party shall use its reasonable best efforts to arrange for such hearing to be held promptly after the notice that such hearing is required has been received by such party. Each party shall give to the other party reasonable prior written notice of the time and place when any meetings, telephone calls, or other conferences may be held by it with any

Governmental Authority in connection with the transactions contemplated by the Transaction Agreements, and the other party shall have the right to have a representative or representatives attend or otherwise participate in any such meeting, telephone call, or other conference unless prohibited by Applicable Law.

(c) Notwithstanding anything herein to the contrary, neither Purchaser nor Seller shall be obligated to take or refrain from taking or to agree to it, its Affiliates or any of their respective Representatives taking or refraining from taking any action or to permit or suffer to exist any restriction, condition, limitation or requirement which, individually or together with all other such actions, restrictions, conditions, limitations or requirements, would constitute a Burdensome Condition. As used in this Agreement, " Burdensome Condition" means any arrangement, condition or restriction (i) in the case of Purchaser, (A) to sell or hold separate or agree to sell, divest or discontinue, before or after the Closing Date, any properties, assets, businesses or licenses of Purchaser or its Affiliates that are material to Purchaser and its Affiliates, taken as a whole, or to the Business, as applicable, or (B) that otherwise is reasonably likely to have a Material Adverse Effect or a material adverse effect on the business, financial condition, operations or results of operations of Purchaser and its Affiliates, taken as a whole; and (ii) in the case of Seller, would require Seller or any of its Affiliates to provide any guarantee or incur any liability with respect to the Business or the Transferred Assets after the Closing Date, or restrict the ability of Seller or any of its Affiliates to conduct their respective businesses after the Closing Date.

Section 5.07. Further Assurances.

(a) Subject to the terms and conditions herein provided, including Section 5.06 , each of the parties hereto shall, and shall cause its Affiliates to, execute such documents and other papers and perform such further acts as may be reasonably required to carry out the provisions hereof and the transactions contemplated hereby and by the other Transaction Agreements. Each such party shall, at or prior to the Closing Date, use its reasonable best efforts to fulfill or obtain the fulfillment of the conditions precedent to the consummation of the transactions contemplated hereby and by the other Transaction Agreements, including the execution and delivery of any documents, certificates, instruments or other papers and the taking of any other actions that are reasonably necessary for the consummation of the transactions contemplated hereby and by the other Transaction Agreements.

(b) Subject to the terms and conditions of this Agreement, on and after the Closing Date, Seller and Purchaser shall, and shall cause their respective Affiliates to, take all reasonable actions and execute any additional documents, instruments or conveyances of any kind which may be reasonably necessary to put Purchaser and its Affiliates in full possession and operating control of the Business and to effect fully the separation of the Business from Seller and its Affiliates.

Section 5.08. Privacy and Data Security Compliance; Use of Information. Notwithstanding any other provision of this Agreement or any Transaction Agreement to the contrary, none of Seller, Purchaser or any of their respective Affiliates shall be required to take any action that would violate or conflict with, and each such Person shall comply with, all Privacy and Data Security Laws. Notwithstanding any other provision of this Agreement, Seller

and Purchaser shall use their respective reasonable best efforts to ensure that all Personal Data about individual insureds and employees on leaves of absence under Group Contracts or other individuals is used, shared, accessed, stored, transmitted, disclosed, or otherwise processed in a manner (including the scope of information) that complies with, and facilitates each party's compliance with, Privacy and Data Security Laws. For the avoidance of doubt, any Personal Data relating to individual insureds and employees on leaves of absence under Group Contracts accessed by or disclosed to Purchaser or any of its Affiliates pursuant to this Agreement shall be subject to Purchaser's confidentiality obligations under Section 5.04 and under the Administrative Services Agreement.

Section 5.09. Non-Solicitation of Employees.

(a) For a period of 24 months following the Closing Date, without the prior written consent of Purchaser, neither Seller nor any of its Affiliates shall, whether directly or indirectly, solicit for employment or employ any Transferred Employee or any employee of the Purchaser whose name is set forth on Section 5.09(a) of the Purchaser Disclosure Schedule; provided , that nothing in this Section 5.09(a) shall prohibit Seller or any of its Affiliates from engaging in general solicitations not directed at such Persons (including general media advertisements and the use of a search firm not directed to target Transferred Employees) or from soliciting or employing any such Person whose employment with or engagement by Purchaser or any of its Affiliates has been terminated by Purchaser or its applicable Affiliate at least three months prior to the first such solicitation or employment.

(b) For a period of 24 months following the Closing Date, without the prior written consent of Seller, neither Purchaser nor any of its Affiliates shall, whether directly or indirectly, solicit for employment or employ any employee of the Seller whose name is set forth on Section 5.09(b) of the Seller Disclosure Schedule; provided , that nothing in this Section 5.09(b) shall prohibit Purchaser or any of its Affiliates from engaging in general solicitations not directed at such Persons (including general media advertisements and the use of a search firm not directed to target such Persons) or from soliciting or employing any such Person whose employment with or engagement by Seller or any of its Affiliates has been terminated by Seller or its applicable Affiliate at least three months prior to the first such solicitation or employment.

(c) For a period of 24 months following the Closing Date (including during the Employee Lease Term), without the prior written consent of Purchaser, neither Seller nor any of its Affiliates shall, whether directly or indirectly, interfere with Purchaser's obligations under Section 6.01(a) or attempt to retain for employment or rehire any Employee set forth on Section 6.01(a)(i) of the Seller Disclosure Schedule who does not become a Transferred Employee; provided , that nothing in this Section 5.09(c) shall prohibit Seller or any of its Affiliates from engaging in general solicitations not directed at such Persons (including general media advertisements and the use of a search firm not directed to target such Persons).

Section 5.10. Use of Names.

(a) At the Closing, Seller shall enter into a royalty-free license agreement with Purchaser substantially in the form attached hereto as Exhibit I (the " Trademark License Agreement"), among other things, permitting Purchaser to use the "Aetna" name and related

Trademarks on a transitional basis in connection with the operation of the Business in the United States in accordance with the terms thereof.

(b) Except as otherwise contemplated by the Administrative Services Agreement, the Distribution Agreement, the Transition Services Agreement and the Trademark License Agreement in accordance with the terms thereof: (i) following the Closing Date (including in connection with the operation of the Business and the Transferred Assets), Purchaser shall not, and shall cause its Affiliates not to, use any of the names or Trademarks set forth in Section 5.10 of the Seller Disclosure Schedule, any other Trademarks of Seller's Affiliates that include the name "Aetna," or any name, Trademark, or acronym that is confusingly similar to, or is based on or incorporates, any of such names or Trademarks (collectively, the " Seller Trademarks") whether or not in combination with other words, symbols, or other distinctive or non-distinctive elements, and all trade, corporate or business names, trademarks, tag-lines, identifying logos, trade dress, monograms, slogans, service marks, domain names, brand names, and other name or source identifiers that are derivations, translations, adaptations, combinations or variations of the Seller Trademarks or Trademarks of Seller's Affiliates, or embodying any of the foregoing, whether or not in combination with other words, symbols, or other distinctive or non-distinctive elements; and (ii) Purchaser, for itself and its Affiliates, agrees that any and all rights arising out of the Transferred Assets to the Seller Trademarks or Trademarks of Seller's Affiliates, whether written or oral, with Seller or its Affiliates, shall terminate on the Closing Date without recourse by Purchaser or any of its Affiliates. Neither Purchaser nor any of its Affiliates shall seek to register in any jurisdiction any trade, corporate, or business name, trademark, tag-line, identifying logo, trade dress, monogram, slogan, service mark, domain name, brand name, or other name or source identifier that is a derivation, translation, adaptation, combination, or variation of the Seller Trademarks or Trademarks of Seller's Affiliates.

Section 5.11. Pre-Closing Management of Specified Portfolio.

(a) Monthly Asset Value Statements and Related Adjustments.

(i) After the end of each calendar month that occurs between the date hereof and the Closing Date, Seller shall estimate in good faith the Adjusted Required Asset Value and the Accounting Value of the Specified Portfolio as of the end of such month and deliver to Purchaser a statement (each, a "Monthly Asset Value Statement") specifying such Adjusted Required Asset Value and Accounting Value as of the end of such month, provided that no such Monthly Asset Value Statement shall be so prepared or delivered with respect to the month preceding the month in which the Closing occurs.

(ii) If the Accounting Value of the Specified Portfolio set forth in a Monthly Asset Value Statement is less than the Adjusted Required Asset Value set forth in such Monthly Asset Value Statement, Seller shall (or shall cause the Ceding Company or AHLIC to), promptly following the delivery of such Monthly Asset Value Statement to Purchaser pursuant to Section 5.11(a)(i) , acquire or, subject to Section 5.11(c) below, designate for

inclusion in the Specified Portfolio additional cash or Investment Assets with an aggregate Fair Market Value equal to the amount of such shortfall.

(iii) If the Accounting Value of the Specified Portfolio set forth in a Monthly Asset Value Statement is greater than the Adjusted Required Asset Value set forth in such Monthly Asset Value Statement, Seller may, at its option and in its sole discretion, select for removal from the Specified Portfolio cash or Investment Assets that have an aggregate Accounting Value equal to such excess as follows (clauses (A) and (B) below, the "Selection Waterfall"):

(A) cash and cash equivalents in the Specified Portfolio will be selected first; and

(B) otherwise, Investment Assets will be selected in an order of shortest stated maturity to longest stated maturity, determined in each case in good faith by Seller.

(iv) Notwithstanding anything to the contrary in this Agreement, Seller may (and may cause the Ceding Company or AHLIC to) sell any Investment Asset in the Specified Portfolio if Seller determines in good faith that such Investment Asset has become, or is reasonably likely to become, impaired. In the event of any such sale of an impaired asset, Seller shall (or shall cause the Ceding Company or AHLIC to), as promptly as practicable following such sale (with a target of within one Business Day), acquire or designate for inclusion in the Specified Portfolio cash or replacement Investment Assets with an aggregate Fair Market Value equal to the Accounting Value of the Investment Asset sold in such sale, determined prior to any adjustment as a result of the impairment. For the avoidance of doubt, the Capital Gain or Loss Adjustment (as defined in clause (b) below) does not apply to sales of Investment Asset pursuant to this Section 5.11(a)(iv) , but the Reallocated Asset Value Adjustment (as defined in Section 5.11(c) below) does apply to any Reallocated Investment Asset that replaces such an Investment Asset.

(v) Any changes to the Specified Portfolio contemplated by this Section 5.11(a) will be effected in accordance with Pre-Closing Investment Guidelines.

(b) Discretionary Turnover Allowance.

(i) Between the date hereof and the Closing Date, Seller may, at its option and in its sole discretion, sell:

(A) any bond in the Specified Portfolio that has an option adjusted duration of 3.00 years or less as of the close of business on the Business Day immediately prior to the date on which it is sold, determined in accordance with the OAD model provided by

Bloomberg L.P.'s Portfolio & Risk Analytics solution (PORT); and

(B) an additional (x) 5% of the aggregate Specified Portfolio (where such percentage is determined by reference to the Accounting Value of the Specified Portfolio as of the Reference Date and sales are measured by Accounting Value of the sold Investment Assets as of the applicable sale dates) during the period between the Reference Date through December 31, 2017; and (y) if the Closing has not occurred on or prior to December 31, 2017, 1% of the Specified Portfolio (where such percentage is determined by reference to the Accounting Value of the Specified Portfolio as of the beginning of each applicable month and sales are measured by Accounting Value of the sold Investment Assets as of the applicable sale dates) during each calendar month, or portion thereof, that between December 31, 2017 and the Closing (this Section 5.11(b)(i) collectively, the "Discretionary Turnover Allowance");

provided , however , that the sales described in (A) and (B) above may not, in the aggregate, exceed 10% of the Specified Portfolio through November 30, 2017, plus 2% of the Specified Portfolio for every calendar month after November 2017.

(ii) On the date that any Investment Asset in the Specified Portfolio is sold pursuant to this Section 5.11(b) , the Adjusted Required Asset Value as of such date will, in addition to any adjustment to the Required Asset Value required under the Transaction Accounting Principles to account for any change in the interest maintenance reserve of the Ceding Company or AHLIC, as applicable, resulting from such sale, be adjusted as set forth below (each of the adjustments described in (A) and (B) below, a "Capital Gain or Loss Adjustment"):

(A) if the sale of the Investment Asset generates a (statutory basis) capital gain (calculated as the excess, if any, of the FMV Ex-Accrued of such Investment Asset as of the applicable date of sale over the Book Value of such Investment Asset as of such date), the Adjusted Required Asset Value as of such date will be increased by the amount of such capital gain, less the amount of any interest maintenance reserve of the Ceding Company or AHLIC, as applicable, generated by the sale of such asset in accordance with the Transaction Accounting Principles; and

(B) if the sale of the Investment Asset generates a (statutory basis) capital loss (calculated as the excess, if any, of the Book Value of such Investment Asset as of the applicable date of sale over the FMV Ex-Accrued of such Investment Asset as of such date), the

Adjusted Required Asset Value as of such date will be decreased by an amount equal to (A) the absolute value of such capital loss minus (B) the absolute value of any decrease in interest maintenance reserve of the Ceding Company or AHLIC, as applicable, resulting from the sale of such asset in accordance with the Transaction Accounting Principles.

(iii) In the event that Seller elects to sell any Investment Asset pursuant to this Section 5.11(b) , Seller shall, as promptly as reasonably practicable (with a target of within one Business Day) reinvest the gross proceeds it receives from such sale (less the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset) in the Specified Portfolio by either acquiring one or more new Investment Assets or, subject to Section 5.11(c) below, selecting for inclusion in the Specified Portfolio one or more Reallocated Investment Assets, in each case that have an aggregate FMV Ex-Accrued equal to the amount of such gross proceeds (less the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset).

(iv) Any changes to the Specified Portfolio contemplated by this Section 5.11(b) will be effected in accordance with the Pre-Closing Investment Guidelines.

(c) Reallocated Investment Assets. If, between the date of this Agreement and the Closing Date, any Reallocated Investment Asset is designated for inclusion in the Specified Portfolio pursuant to Section 5.11(a) or Section 5.11(b) , then the following adjustment shall be made to the Adjusted Required Asset Value as of the date of such designation (each of the adjustments described in (i) and (ii) below, a " Reallocated Asset Value Adjustment"):

(i) if the FMV Ex-Accrued of the Reallocated Investment Asset as of such date exceeds the Book Value of such Reallocated Investment Assets as of such date, the Adjusted Required Asset Value shall be decreased by the amount of such excess; and

(ii) if the FMV Ex-Accrued of the Reallocated Investment Asset as of such date is less than the Book Value of such Reallocated Investment Asset as of such date, the Adjusted Required Asset Value shall be increased by the amount of such shortfall.

Section 5.12. Properties.

(a) Schedule VI hereto sets forth all real property at which Employees of the Business use space for the current operation and conduct of the Business (collectively, the " Properties"). The Properties are separated on Schedule VI into the following two (2) categories: (1) the Properties that Seller intends, and agrees to cooperate as required in Section 5.12(b) to enable, Purchaser and such Employees to have the right to occupy or use (in the case of the Subleases, on a co-location basis with Seller, its Affiliates and their respective employees)

from and after the day immediately following the expiration or termination of the Employee Lease Term pursuant to the Portland Location Assignment Agreement, the Subleases and the Hartford License Agreement (collectively, the " Occupied Properties"); and (2) the Properties that Purchaser and such Employees will not have the right to occupy or use from and after the day immediately following the expiration of the Employee Lease Term (collectively, the " Non-Occupied Properties"). Purchaser acknowledges and agrees that all Employees at the Non-Occupied Properties shall vacate the Non-Occupied Properties from and after the day immediately following the expiration of the Employee Lease Term and Purchaser shall cause such Employees' job location to either be a home-office or an alternative real estate solution other than the Non-Occupied Properties. The Employees' job location between the Closing Date and the expiration of the Employee Lease Term shall remain at the Properties pursuant to the Employee Leasing Agreement.

(b) Seller and Purchaser shall, and shall cause their respective Affiliates to, use commercially reasonable efforts to obtain, on or prior to December 31, 2017, the required consent of (i) the landlord of the Portland Location to the assignment of the Assigned Lease pursuant to the Portland Location Assignment Agreement and (ii) the respective landlords of the other Occupied Properties to the subleasing of such locations to Purchaser pursuant to the Subleases, in each case, on the terms and subject to the conditions set forth herein and therein (collectively, the " Lease Consents"). Seller and Purchaser shall cooperate with each other as may be reasonably required to obtain the Lease Consents.

(c) If any such Lease Consent is not obtained on or prior to December 31, 2017, then, (i) the Portland Location Assignment Agreement and/or any applicable Sublease to which such Lease Consent was not obtained shall not become effective as of the expiration or termination of the Employee Lease Term and (ii) Purchaser shall, and shall cause its Affiliates to, obtain alternative office space, at its sole cost and expense, and vacate the applicable Occupied Properties for which a Lease Consent has not been obtained prior to the expiration of the Employee Lease Term for such applicable Occupied Properties as provided for in this Section 5.12(c).

Section 5.13. Non-Competition. During the period beginning on the Closing Date and ending on the date that is three years and six months after the Closing Date (the " Restricted Period"), Seller shall not, and shall cause its Affiliates (together with Seller, the " Restricted Entities") not to, directly or indirectly, issue or sell in any state or jurisdiction within the United States, any products or services of a type that comprises part of the Business as of the date hereof and that was underwritten, issued, sold, renewed or serviced as part of the Business during the two years prior to the date hereof (the " Competing Businesses"); provided , however , that this Section 5.13 shall not prohibit or in any way prevent or restrict:

(a) any Restricted Entity from operating any business other than the Business (including the business described in the proviso included in the definition of "Business") or from operating the Business from and after the time at which the Business or any portion thereof is recaptured under any coinsurance agreement;

(b) any Restricted Entity from providing (i) provider network access or network management services; (ii) medical management, case management, or cost containment services;

or (iii) administrative services for short-term disability plans that are provided in conjunction with a self-funded plan sponsor's medical benefits coverage or plan that is administered or serviced by a Restricted Entity.

(c) any Restricted Entity from performing any act or conducting any business expressly required by this Agreement or any other Transaction Agreement;

(d) any Restricted Entity from entering into a reinsurance agreement or similar arrangement primarily reinsuring the Competing Business of a ceding company that is not a Restricted Entity, so long as none of the Restricted Entities engages in the issuing, underwriting, selling, distributing, marketing, delivering, cancelling or administering of such underlying reinsured business;

(e) any Restricted Entity from (A) making any investment or providing advisory services (or activities related thereto) in a fiduciary or agency capacity and carried out on behalf of clients or other third party beneficiaries in the ordinary course of business, or (B) making passive investments for general insurance accounts or investment management, proprietary investing or trading activities in the ordinary course of its businesses; provided that in no event shall the aggregate ownership interest held by Restricted Entities in any Person engaged in a Competing Business, whether directly or indirectly, equal or exceed 20% of the aggregate voting power or issued and outstanding equity securities of such Person, subject to Sections 5.13(f) and (g) below;

(f) the ownership of, any affiliation with, or the conduct of any other activity with respect to, a Person that conducts, either directly or indirectly, a Competing Business (any such person, together with all of its Affiliates, a " Competing Person") that is the result of (A) the merger, consolidation, share exchange, sale or purchase of assets, scheme of arrangement or similar business combination involving any Restricted Entity with any Competing Person or (B) the acquisition of 20% or more of the voting power or outstanding equity interests in any Competing Person by any Restricted Entity, if, in the case of either (A) or (B), at least 66 2/3% of the total consolidated revenues of such Competing Person in the calendar year prior to such ownership or affiliation was derived from activities that do not constitute Competing Business; provided , however , that such Restricted Entity may proceed with such acquisition of a Competing Person that derived in excess of 33 1/3% of its total consolidated revenues in its most recent fiscal year from activities that constitute Competing Business only if such Restricted Entity divests, within 24 months of its acquisition, a sufficient portion of such Competing Person such that the total consolidated revenues from activities that constitute Competing Business that remain with any such Competing Person after such divestment over the last four full fiscal quarters prior to such acquisition are not greater than 33 1/3% of its consolidated revenues for such period; or

(g) subject to the foregoing clause (f), any Restricted Entity from foreclosing on collateral of or acquiring any of the outstanding capital stock or other interests in any person that has outstanding indebtedness to any Restricted Entity, or engaging in any activities otherwise prohibited by this Section 5.13 in connection with any such Person as a result of the acquisition of such capital stock or other interests in connection with a debt previously contracted.

ARTICLE VI.

EMPLOYEE MATTERS

Section 6.01. Employee Matters.

(a) Except as set forth in Section 6.01(b), Purchaser or its Affiliate shall, not more than 30 Business Days following the Closing Date, extend offers of employment ("Transfer Offers") to all then-current Employees. Section 6.01(a)(i) of the Seller Disclosure Schedule sets forth, as of the date hereof, a list of then-current Employees, together with such Employees' (i) current base salary (or wages), (ii) current target incentive compensation opportunities by component, including (1) target annual cash bonus opportunity, (2) commission opportunity, and (3) target long-term incentive opportunity, (iii) recognized years of service, (iv) current work address, (v) remote work arrangement, if any, (vi) exempt or non-exempt status, (vii) hourly or salaried status, (viii) annual paid time off accrual rate, (ix) paid time off carryover amount, (x) current job title and career level, (xi) date of hire, (xii) valid work email address, and (xiii) status as active or on leave. Seller shall promptly update Section 6.01(a)(i) of the Seller Disclosure Schedule between the date hereof and the expiration of the Employee Lease Term to reflect any new hires, transfers, resignations and other employment additions and terminations of Employees which may have occurred subsequent to the date hereof in the ordinary course of business of the Business and shall deliver to Purchaser (A) a Closing version of Section 6.01(a)(i) of the Seller Disclosure Schedule no later than two days prior to the Closing Date, and (B) a final version of Section 6.01(a)(i) of the Seller Disclosure Schedule no later than 10 Business Days prior to the expiration of the Employee Lease Term. Notwithstanding anything to the contrary herein, to the extent an individual is hired or otherwise retained at the direction of Purchaser and added to Section 6.01(a)(i) of the Seller Disclosure Schedule after the date hereof, Purchaser or its Affiliate shall extend a Transfer Offer to such Employee as soon as reasonably practicable following such addition, but not more than the later to occur of (x) 30 Business Days following the Closing Date, and (y) ten Business Days following such addition. Section 6.01(a)(ii) of the Seller Disclosure Schedule sets forth, as of the date hereof, a list of then current Business Employees on a no-name basis by each Business Employee's current job title.

(b) With respect to any Employee identified on Section 6.01(a) of the Seller Disclosure Schedule hereto who is not actively at work upon the expiration of the Employee Lease Term as a result of a leave of absence (including temporary leave for purposes of jury or military duty, maternity or paternity leave, leave under the Family Medical Leave Act of 1993, approved personal leave or disability or medical leave) (each, a "Leave Recipient"), Purchaser shall make an offer of employment in the manner required by this Section 6.01, contingent on such Leave Recipient's return to active status within six months following the expiration of the Employee Lease Term or such longer period as required by Applicable Law; provided that, notwithstanding anything in this Agreement to the contrary, Purchaser shall not be required to make an offer of employment to any such Employee (and shall have no obligation of any nature to hire or employ any such Employee) who is receiving long-term disability benefits. When a Leave Recipient who has accepted the offer returns to active status pursuant to the terms hereof and commences active employment with Purchaser or its Affiliates, such Leave Recipient shall be considered a Transferred Employee. Purchaser shall take, or cause its Affiliates to take, all reasonably necessary steps to sponsor or transfer sponsorship of, the work permits for all

Employees who are foreign nationals listed in Section 3.10(j) of the Seller Disclosure Schedule on or after the expiration of the Employee Lease Term. Seller shall cooperate as reasonably necessary to effect Purchaser's or its Affiliates' sponsorship or transfer of sponsorship of all such foreign national Employees, in each case, to the extent permitted by Applicable Law. Each such foreign national Employee who accepted an offer of employment from Purchaser or an Affiliate pursuant to the terms hereof shall be considered a Transferred Employee on the later of the Transfer Date or the date such Employee obtains the necessary authorization to work for Purchaser and its Affiliates and commences active employment with Purchaser and its Affiliates.

(c) Purchaser or its Affiliate shall set forth in the Transfer Offers the proposed terms of employment (or service) for the Employees and, as of the expiration of the Employee Lease Term and for a period of 12 months immediately following the expiration of the Employee Lease Term (or such earlier date on which such Employee's employment with Purchaser or its Affiliate terminates), Purchaser or its Affiliate shall provide each Transferred Employee with the following terms of employment (or service): (i) base salary (or wages) no less than the base salary (or wages) provided to such Employee by Seller or its Affiliates immediately prior to the Closing Date, or, if later, as of the Employee's date of hire; (ii) annual incentive opportunities no less than those provided by Seller or its Affiliates immediately prior to the Closing Date, or, if later, as of the Employee's date of hire, (iii) a long-term incentive compensation opportunity (whether paid in cash or equity) at a similar range and participation rate to that provided to such Employee by Seller or its Affiliates immediately prior to the Closing Date or, if later, as of the Employee's date of hire; (iv) commission opportunities that are no less than those provided to such Employee by Seller or its Affiliates immediately prior to the Closing Date or, if later, as of the Employee's date of hire, including, with respect to each individual set forth on Section 6.01(c) of the Seller Disclosure Schedule (each, a " Listed Sales Employee"), guaranteed commission opportunities consistent with the terms of the retention letter with each such Listed Sales Employee set forth on Section 3.10(a) of the Seller Disclosure Schedule, but in each case to be paid consistent with Purchaser's or its Affiliate's standard payroll cycle; (iii) employee retirement and welfare (including paid time off) benefits, in each case, substantially similar to those provided to similarly-situated employees of Purchaser or its Affiliate; and (iv) with respect to Employees whose job location is a home-office as of the Closing Date, the ability to continue to work from such home-office, and with respect to all other Employees, a job location that does not increase such Employee's commute by more than 30 miles when compared to the commute from such Employee's residence to the job location to which such Employee reports immediately prior to the expiration of the Closing Date, or if later, as of the Employee's date of hire, or provide the Employee the ability to work from a home-office. Without limiting the foregoing, Purchaser hereby acknowledges and agrees that if the Employee Lease Term extends past Lessee's regularly scheduled long-term incentive grant date in the first quarter of calendar year 2018, Purchaser shall, during the first "open window" trading period following the expiration of the Employee Lease Term, grant an award to each Transferred Employee who is eligible to earn a long-term incentive award for calendar year 2018. Employment or service, as applicable, pursuant to a Transfer Offer shall be contingent upon such Employee (i) being employed by (or providing on-going services with) Seller or any of its Subsidiaries immediately prior to the expiration of the Employee Lease Term, (ii) satisfying required professional licensure requirements (to the extent applicable), (iii) successfully completing a background check, I-9 form/eVerify process, and all applicable Purchaser new hire documentation and (iv) with respect to Employees who are foreign nationals, obtaining the necessary authorization to work for

Purchaser or its Affiliates within six (6) months of the expiration of the Employee Lease Term. All employment offers shall be for employment at-will and nothing in this Article VI shall require Purchaser or any of its Affiliates to continue to employ any Transferred Employee for any specified period of time following the expiration of the Employee Lease Term. Except as set forth in Section 6.01(b) , each Employee who accepts Purchaser's Transfer Offer shall be a " Transferred Employee" at 12:00:01 a.m. on the first day following the expiration of the Employee Lease Term. Effective as of the date they become Transferred Employees (the " Transfer Date"), such Transferred Employees shall cease to be employees of Seller and its Affiliates and shall cease any further participation in (and shall cease to accrue benefits under) Employee Benefit Plans, subject to the terms and conditions of the Employee Benefit Plans and Applicable Law.

(d) As of the expiration of the Employee Lease Term, in no event shall any Employee be entitled to accrue any benefits under the Employee Benefit Plans with respect to services rendered or compensation paid on or after the expiration of the Employee Lease Term, subject to the terms and conditions of the Employee Benefit Plans and Applicable Law.

(e) Notwithstanding anything in this Agreement to the contrary, any Transferred Employee who incurs a termination of employment during the 12-month period immediately following the expiration of the Employee Lease Term shall be entitled to receive severance payments and benefits that are no less favorable than the severance payments and benefits provided to similarly-situated employees of Purchaser or its Affiliates under the Purchaser severance plan as in effect immediately prior to the date hereof and set forth on Section 6.01(e) of the Seller Disclosure Schedule; provided , however, that in lieu of the thirty (30) day paid notice period applicable to similarly-situated employees of Purchaser, Transferred Employees will be entitled to a nine (9) week paid non-working period with benefits continuation during such period.

(f) Notwithstanding anything in this Agreement to the contrary, Purchaser or its Affiliate shall be solely responsible for all Liabilities arising from, related to or based upon the termination of any Employee who is terminated by Seller or its respective Affiliates on or after the expiration of the Employee Lease Term in the event such employee is not offered employment or service with Purchaser in accordance with the provisions of this Section 6.01. Purchaser or its Affiliate shall be solely responsible for providing all notices required under the Worker Adjustment and Retraining Notification Act, 29 U.S.C. § 2109 *et seq.* , or the regulations promulgated thereunder (the " WARN Act") (including comparable state, local or other Applicable Laws) and for taking all remedial measures, including, without limitation, the payment of all amounts, penalties, liabilities, costs and expenses if such notices are not provided, with respect to any obligations under the WARN Act (including comparable state, local or other Applicable Laws) arising out of or resulting from any termination of employment of any Transferred Employees by Purchaser and its Affiliates on or after the expiration of the Employee Lease Term.

(g) Purchaser shall cause its Affiliate to: (i) permit each Transferred Employee participating in each Employee Benefit Plan that is a defined contribution plan with a qualified cash or deferred arrangement within the meaning of Section 401(k) of the Code (the " Seller 401(k) Plan") to effect, and (ii) cause its defined contribution plan that includes a qualified cash

or deferred arrangement within the meaning of Section 401(k) of the Code (the " Purchaser 401(k) Plan") to accept, in accordance with Applicable Law, a "direct rollover" (within the meaning of Section 401(a)(31) of the Code) of his or her account balances (including earnings thereon through the date of transfer) under the Seller 401(k) Plan if such rollover to the Purchaser 401(k) Plan is elected in accordance with Applicable Law by such Transferred Employee.

(h) Subject to any reimbursement or other obligations of Purchaser or its Affiliates agreed upon pursuant to the Employee Leasing Agreement, Seller shall retain responsibility for all liabilities under and with respect to, and claims incurred under, the Employee Benefit Plans (including those relating to Transferred Employees and their covered dependents). Purchaser or its Affiliate shall be responsible for all liabilities under and with respect to, and claims incurred under, any employee benefit plans, programs, policies and arrangements maintained by Purchaser or its Affiliates (including those relating to Transferred Employees and their covered dependents).

(i) Unless Seller or one of its Affiliates is required under Applicable Law to make a payment in settlement of accrued paid time off of a Transferred Employee, (i) Purchaser or its Affiliate shall assume, recognize and provide each Transferred Employee up to forty (40) hours of the Transferred Employee's earned but unused paid time-off as of the expiration of the Employee Lease Term as determined under Seller's policy in effect as of the expiration of the Employee Lease Term and (ii) Seller or one of its Affiliates shall make a payment in settlement of accrued paid time off of any such Transferred Employee in excess of forty (40) hours in accordance with Seller's paid time off policy and Applicable Law.

(j) Purchaser or its Affiliate shall assume and pay, the accrued but unpaid annual cash bonuses with respect to performance in the calendar year ending December 31, 2017. In respect thereof, the following shall be accrued on the Initial Closing Statement: (i) accruals for ten-twelfths (10/12) of such annual cash bonuses, assuming maximum (140%) performance, and (ii) accruals representing the matching contribution that would have been made under Seller 401(k) Plan with respect to the bonus amounts accrued pursuant to Section 6.01(j)(i). In no event shall the amount of such payment by Purchaser to the Transferred Employees in the aggregate be less than the aggregate amount set forth with respect to such bonuses in the Initial Closing Statement as described in Section 6.01(j)(i).

(k) Purchaser shall, or shall cause one of its Affiliates to, make available to the Transferred Employees a flex spending account plan for medical and dependent care expenses under a new or existing plan established or maintained under Section 125 and Section 129 of the Code (the " Purchaser FSA"), effective as of the expiration of the Employee Lease Term and in accordance with this Section 6.01(k). If the Employee Lease Term ends after December 31, 2017, Purchaser, or one of its Affiliates, shall credit the applicable account under the Purchaser FSA of each Transferred Employee participating in the Seller Employee Benefit Plan maintained pursuant to Section 125 and Section 129 of the Code (the " Seller FSA" *)* with an amount equal to the balance of such Transferred Employee's account under the Seller FSA immediately prior to the expiration of the Employee Lease Term, in accordance with the following:

(i) If the aggregate amount withheld from Transferred Employees' compensation under the Seller FSA for 2018 exceeds the aggregate amount of reimbursements paid to Transferred Employees prior to the expiration of the Employee Lease Term under the Seller FSA for claims incurred in 2018, Seller shall transfer (or cause to be transferred) to Purchaser within 30 days after the expiration of the Employee Lease Term a cash payment equal to such excess, if any.

(ii) If the aggregate amount of reimbursements paid to Transferred Employees prior to the expiration of the Employee Lease Term under the Seller FSA for claims incurred in 2018 exceeds the aggregate amount withheld from Transferred Employees' compensation under the Seller FSA for 2018 prior to the expiration of the Employee Lease Term, Purchaser shall transfer (or cause to be transferred) to Seller within 30 days after the expiration of the Employee Lease Term a cash payment equal to such excess, if any.

(iii) In each case, Purchaser shall assume and be solely responsible for all claims for reimbursement by Transferred Employees for 2018 that have not been paid in full as of the expiration of the Employee Lease Term, which claims shall be paid pursuant to and under the terms of the Purchaser FSA, and Purchaser shall indemnify and hold harmless Seller and its Affiliates from any and all claims by or with respect to Transferred Employees for reimbursement under the Seller FSA that have not been paid in full as of the expiration of the Employee Lease Term; provided, however, that the foregoing indemnification shall not apply to any claims that were adjudicated under the terms of the Seller FSA on or prior to the expiration of the Employee Lease Term. Purchaser agrees to cause the Purchaser FSA to honor through the end of the calendar year in which the Employee Lease Term expires the elections made by each Transferred Employee under the Seller FSA in respect of the flexible spending reimbursement accounts under the Purchaser FSA that are in effect immediately prior to the expiration of the Employee Lease Term, subject to each Transferred Employee's ability to adjust such elections pursuant to the terms of the Purchaser FSA. For the avoidance of doubt, except as provided herein, (A) in no event shall Seller or any of its Affiliates have any liability or obligation under the Purchaser FSA, and (B) any Transferred Employee who elects coverage under a high deductible health plan may be ineligible to make continuing elections under the Purchaser health care FSA pursuant to the terms of such plans.

For the avoidance of doubt, if the Employee Lease Term ends on December 31, 2017, Purchaser shall have no obligation to provide credits as described in this Section 6.01(k).

(l) In respect of each Employee who becomes a Transferred Employee, Seller and Purchaser shall adopt the "standard procedure" for preparing and filing IRS Forms W-2 (Wage

and Tax Statements), as described in Revenue Procedure 2004-53. Under this procedure, Purchaser, as successor employer, shall provide, as applicable, all required Forms W-2 to all Employees who become Transferred Employees reflecting only wages paid and Taxes withheld by Purchaser and its Affiliates as the successor employer. In addition, Seller and Purchaser shall adopt the "standard procedure" of Revenue Procedure 2004-53 for purposes of filing IRS Forms W-4 (Employee's Withholding Allowance Certificate) and W-5 (Earned Income Credit Advance Payment Certificate).

(m) Purchaser or one of its Affiliates shall grant during the first "open window" trading period following the expiration of the Employee Lease Term new awards, payable in cash or in stock (each, a " New Award"), vesting over two (2) years, to each Transferred Employee who, as a result of the transactions contemplated by this Agreement, forfeits restricted share units, performance share units or stock appreciation rights that were granted pursuant to any Employee Benefit Plan prior to the date hereof and are not vested as of the expiration of the Employee Lease Term (each, a " Seller Forfeited Equity Award"). The value of the New Awards will be no less than the value of the Seller Forfeited Equity Awards, both individually and in the aggregate. Seller shall provide Purchaser with a schedule of the value of each Seller Forfeited Equity Award as soon as practicable following the termination of the Employee Lease Term.

(n) Purchaser agrees to cause its Affiliate to (i) provide coverage for the Transferred Employees under its employee benefit plans as of the applicable Transfer Date, (ii) waive any preexisting conditions, waiting periods and actively at work requirements under such plans and (iii) cause such plans to honor any expenses incurred by the Transferred Employees and their beneficiaries under similar Employee Benefit Plans during the portion of the calendar year in which the Transfer Date occurs for purposes of satisfying applicable deductible, co-insurance and maximum out-of-pocket expenses. Transferred Employees shall be given credit under each employee benefit plan, program, policy or arrangement of Purchaser in which the Transferred Employees are eligible to participate for all service with Seller (to the extent such credit was given by the applicable Employee Benefit Plan) for all purposes (except that no benefit accrual will be provided under any defined benefit pension plans), except to the extent it would result in a duplication of benefits.

(o) The parties hereto shall coordinate with each other prior to the Closing Date as to the form and content of any material, broad based communication from Purchaser or any of its Affiliates to the Employees. Seller acknowledges, understands and agrees, on behalf of itself and its Affiliates, that Purchaser shall, from the date hereof, be allowed to approach and meet with all Employees. Seller and its Affiliates shall permit Purchaser reasonable access to all Employees; provided, that such access shall not interfere with the operations of the Business, and that when on Seller premises, Purchaser shall abide by any Seller security protocols. In no event shall Purchaser or any of its employees have access to the systems of Seller.

(p) Seller, Purchaser and their respective Affiliates shall promptly take all steps necessary to fulfill their obligations, and to cause their applicable employee benefit plans to fulfill the obligations that Seller and Purchaser have agreed to pursuant to this Section 6.01. All transfers of information required by this Section 6.01 shall be made at the time and in the manner (including applicable file format) as reasonably requested by Purchaser or its applicable vendor.

In furtherance thereof, Seller shall provide to Purchaser a complete employee data file, in the format and with the elements prescribed by Purchaser, no later than October 23, 2017.

(q) Seller shall be solely responsible for and shall discharge all retention bonuses under Business Employee Benefit Plans that become vested at or prior to the termination of the Employee Lease Term (" Seller Retention Bonus Liabilities").

Section 6.02. No Third Party Beneficiaries. Notwithstanding the provisions of this Article VI , this Article VI is not intended to and shall not (a) create any third party rights, (b) amend any Employee Benefit Plan or Business Employee Benefit Plan, (iii) require Purchaser or any of its Affiliates to continue any Business Employee Benefit Plan beyond the time when it otherwise lawfully could be terminated or modified, or (d) require Purchaser or any of its Affiliates to continue to employ any Transferred Employee for any specified period, or (e) provide any Transferred Employee with any rights to continued employment, severance pay or similar benefits following any termination of employment.

ARTICLE VII.

TAX MATTERS

Section 7.01. Allocation of Consideration. In addition to the allocation of the Purchase Price contemplated by Article II , Seller and Purchaser shall further allocate the Purchase Price, as finally determined pursuant to Article II , and any other applicable consideration (the " Allocable Amount") in accordance with the requirements of Section 1060 of the Code (and the regulations promulgated thereunder) for all Tax purposes; provided that such allocation for Tax purposes shall be consistent with the allocation of the Purchase Price as contemplated by Article II. As soon as practicable following the date on which the Final Closing Statement becomes final and binding on the parties pursuant to Section 2.09(f) , Seller shall prepare a schedule reflecting the allocation of the Allocable Amount and shall submit such allocation to Purchaser for review. Purchaser and Seller shall use commercially reasonable efforts to agree on the amount and proper allocation of the Allocable Amount in accordance with Section 1060 of the Code. If Seller and Purchaser have not agreed on the allocation within 90 calendar days after the date on which the Final Closing Statement become final and binding on the parties pursuant to Section 2.09(f) , then Purchaser and Seller shall each have the right to deliver notice to the other party of its intent to refer the matter for resolution to the Independent Accountant. Purchaser and Seller will each deliver to the other and to the Independent Accountant a notice setting forth in reasonable detail their proposed allocations. Within 30 days after receipt thereof, the Independent Accountant will deliver the allocation schedule and provide a written description of the basis for its determination of the allocations therein (such allocations, whether agreed to by Purchaser and Seller or determined by the Independent Accountant (the " Final Allocation") shall be final, binding and conclusive on Purchaser and Seller and the parties will report, and will cause their respective Affiliates to report, the federal, state, local and other Tax consequences of the transactions, including the filing of Internal Revenue Service Form 8594, in a manner consistent with such Final Allocation). One-half of all fees, costs and expenses of retaining the Independent Accountant shall be borne by Seller and one-half of such fees, costs and expenses of retaining the Independent Accountant shall be borne by Purchaser. Each party will bear the costs of its own counsel, witnesses (if any) and employees.

Section 7.02. Transfer Taxes. Any Transfer Taxes shall be borne fifty percent (50%) by Seller and fifty percent (50%) by Purchaser. Seller and Purchaser shall cooperate in (a) determining the amount of Transfer Taxes, (b) obtaining any relief, exemption or refund of any such Transfer Tax, (c) preparing and timely filing any and all required Tax Returns for or with respect to such Transfer Taxes with any and all appropriate Tax authorities, (d) promptly providing the other party with evidence that such Transfer Taxes have been paid, and (e) promptly reimbursing the other party for fifty percent (50%) of such Transfer Taxes, as applicable. " Transfer Taxes" means any and all sales, use, stamp, documentary, filing, recording, transfer, goods and services, provincial sales, harmonized sales, excise, real estate, stock transfer, intangible property transfer, personal property transfer, gross receipts, registration, securities transactions, conveyance and notarial Taxes, and similar fees, Taxes and governmental charges (together with any interest, penalty, addition to Tax, and additional amount imposed in respect thereof) arising out of or in connection with the transactions contemplated by this Agreement.

Section 7.03. Cooperation and Exchange of Information. Seller and Purchaser shall provide each other with such cooperation and information as either of them or their respective Affiliates may reasonably request of the other in filing any Tax Return, amended Tax Return or claim for Tax refund, determining a liability for Taxes or a right to a Tax refund, or participating in or conducting any contest in respect of Taxes (a " Tax Contest"). Such cooperation and information shall include providing copies of relevant Tax Returns or portions thereof, together with accompanying schedules, related work papers and documents relating to rulings or other determinations by Tax Authorities. Each party and its Affiliates shall make its employees available on a basis mutually convenient to both parties to provide explanations of any documents or information provided hereunder. Each of Seller and Purchaser shall retain all Tax Returns, schedules and work papers, records and other documents in its possession relating to Tax matters of the Business for each Tax period first ending after the Closing Date and for all prior Tax periods until the later of (i) the expiration of the statute of limitations of the Tax period to which such Tax Returns and other documents relate, without regard to extensions except to the extent notified in writing of such extensions for the respective Tax periods, and (ii) three years following the due date (without extension) for such Tax Returns. Any information obtained under this Section 7.03 shall be kept confidential except as otherwise may be necessary in connection with the filing of Tax Returns or claims for Tax refunds or in conducting a contest or as otherwise may be required by Applicable Law or the rules of any stock exchange. Seller shall promptly notify Purchaser if, as a result of the amendment of any Tax Return, any claim or assessment by any Tax authority or any other cause, the Tax reserves in respect of the Ceded Insurance Contracts no longer accurately reflect the reserves maintained by Seller, the Ceding Company of any of its Affiliates as of the Closing Date (immediately prior to the Closing) with respect to the Ceded Insurance Contracts, and shall provide Purchaser updated information of such reserves. Upon receipt of such information, Purchaser shall provide Seller with a revised Purchase Price allocation in accordance with the principles of Section 7.01.

Section 7.04. Miscellaneous. Seller and Purchaser agree to treat all payments (other than interest on a payment) made by either of them to or for the benefit of the other or the other's Affiliates under this Article VII and under other indemnity provisions of this Agreement as adjustments to the Purchase Price for Tax purposes and that such treatment shall govern for purposes hereof to the extent permissible under Applicable Law.

ARTICLE VIII.

CONDITIONS TO CLOSING

Section 8.01. Conditions to Obligations of Each Party.

The respective obligations of each party hereto to consummate the transactions contemplated by this Agreement shall be subject to the fulfillment or waiver, at or prior to the Closing, of each of the following conditions:

(a) Governmental Consents and Approvals. All consents, approvals, or authorizations of, declarations or filings with, or notices to, any Governmental Authority in connection with the transactions contemplated hereby that are set forth in Section 8.01(a) of the Seller Disclosure Schedule shall have been obtained or made and shall be in full force and effect, and all waiting periods required under Applicable Law with respect thereto shall have expired or been terminated, in each case without the imposition of a Burdensome Condition with respect to the party asserting the failure of this condition.

(b) No Injunction or Illegality. There shall be no law or Governmental Order in existence that prohibits the consummation of the transactions contemplated by this Agreement.

(c) Reinsurance Consents. Seller shall have received the Munich Consent and the Hannover Consent.

Section 8.02. Conditions to Obligations of Purchaser.

The obligations of Purchaser under this Agreement are subject to the satisfaction on or prior to the Closing Date of the following conditions, any one or more of which may be waived by Purchaser to the extent permitted by Applicable Law:

(a) Representations and Warranties. (i) Each of the Seller Specified Representations that are qualified by materiality or Material Adverse Effect shall be true and correct in all respects, and each of the other Seller Specified Representations that are not so qualified shall be true and correct in all material respects and (ii) each of the representations and warranties of Seller contained in Article III of this Agreement (other than those referenced in subclause (i) above) shall be true and correct in all respects (without regard to materiality or Material Adverse Effect qualifiers), in each case as of the Closing Date with the same force and effect as though made on and as of the Closing Date (except to the extent that any such representations and warranties are given as of a particular date and relate solely to a particular date or period, which representations and warranties shall be true and correct as of such date or period), except in the case of clause (ii) above where the failure to be true and correct would not have, individually or in the aggregate, a Material Adverse Effect.

(b) Covenants. Seller and its Affiliates shall have performed and complied in all material respects with all covenants and agreements required by this Agreement to be performed or complied with by Seller and its Affiliates on or prior to the Closing Date.

(c) Closing Deliverables. Seller shall have delivered or caused to be delivered to Purchaser each of the documents required to be delivered by Seller pursuant to Section 2.08(a).

Section 8.03. Conditions to Obligations of Seller. The obligations of Seller under this Agreement are subject to the satisfaction on or prior to the Closing Date of the following conditions, any one or more of which may be waived by Seller to the extent permitted by Applicable Law:

(a) Representations and Warranties. (i) Each of the Purchaser Specified Representations that are qualified by materiality or Purchaser Material Adverse Effect shall be true and correct in all respects, and each of the other Purchaser Specified Representations that are not so qualified shall be true and correct in all material respects and (ii) each of the representations and warranties of Purchaser contained in Article IV of this Agreement (other than those referenced in subclause (i) above) shall be true and correct in all respects (without regard to materiality or Purchaser Material Adverse Effect qualifiers), in each case as of the Closing Date with the same force and effect as though made on and as of the Closing Date (except to the extent that any such representations and warranties are given as of a particular date and relate solely to a particular date or period, which representations and warranties shall be true and correct as of such date or period), except in the case of clause (ii) above where the failure to be true and correct would not have, individually or in the aggregate, a Purchaser Material Adverse Effect.

(b) Covenants. Purchaser shall have performed and complied in all material respects with all covenants and agreements required by this Agreement to be performed or complied with by Purchaser on or prior to the Closing Date.

(c) Triggering Event. Assuming for the purposes of this Section 8.03(c) that the Reinsurance Agreement is in full force and effect at all applicable times prior to the Closing, there shall not have been a Triggering Event (as defined in the Reinsurance Agreement) under the Reinsurance Agreement.

(d) Closing Deliverables. Purchaser shall have delivered or caused to be delivered to Seller each of the documents required to be delivered by Purchaser pursuant to Section 2.08(b).

ARTICLE IX.

TERMINATION PRIOR TO CLOSING

Section 9.01. Termination of Agreement. This Agreement may be terminated at any time prior to the Closing:

(a) by Seller or Purchaser in writing, if there shall be any order, injunction or decree of any Governmental Authority which prohibits or restrains the parties from consummating the transactions contemplated hereby, and such order, injunction or decree shall have become final and nonappealable; provided that prior to termination under this Section 9.01(a) , the party seeking to terminate this Agreement shall have used best efforts to have such order, injunction or decree vacated;

(b) by either Seller or Purchaser in writing, if the Closing has not occurred on or before February 1, 2018 (as it may be extended as contemplated below or by Section 11.14 , the " Outside Date"), unless the failure of the Closing to occur is the result of a breach of this Agreement by the party seeking to terminate this Agreement; provided that, if on the Outside Date the condition set forth in Section 8.01(a) has not been satisfied then, upon the written notice of Seller to Purchaser, the Outside Date shall be extended to a date and time that is not later than 5:00 p.m., New York City time, on March 31, 2018;

(c) by either Seller or Purchaser (but only so long as Seller or Purchaser, as applicable, is not in material breach of its obligations under this Agreement) in writing, if a material breach of any provision of this Agreement that has been committed by the other party would cause the failure of any mutual condition to Closing or any condition to Closing for the benefit of the non-breaching party and such breach is not subsequently waived by the non-breaching party or capable of being cured or is not cured within 20 Business Days after the breaching party receives written notice from the non-breaching party that the non-breaching party intends to terminate this Agreement pursuant to this Section 9.01(c);

(d) by Seller if, (i) except for the condition in Section 8.03(c) , all of the conditions set forth in Section 8.01 , Section 8.02 and Section 8.03 have been satisfied or waived (other than those conditions that by their terms are to be satisfied at the Closing, so long as such conditions are capable of being satisfied at the Closing) and (ii) the Closing has not occurred at the then most recent date on which it was otherwise required to occur pursuant to Section 2.06 because the condition set forth in Section 8.03(c) has not been satisfied; or

(e) at any time on or prior to the Closing Date, by mutual written consent of Seller and Purchaser.

Section 9.02. Termination Procedure. In the event of termination by Purchaser or Seller pursuant to Section 9.01 , written notice thereof shall forthwith be given to the other party and the transactions contemplated by this Agreement shall be terminated, without further action by any party. If the transactions contemplated by this Agreement are terminated as provided herein:

(a) Each party shall, and shall cause its Representatives to, return all documents and other material received from the other party and its Affiliates relating to the transactions contemplated hereby, whether so obtained before or after the execution hereof, to the other party; and

(b) all information received by Purchaser or any of its Representatives with respect to the Business shall be treated in accordance with the Confidentiality Agreement and Section 5.04.

Section 9.03. Survival. In the event of the termination of this Agreement as provided in Section 9.01 , this Agreement shall thereafter become null and void as to all parties, and no party hereto shall have any liability to any other party hereto or their respective Representatives, except as set forth in Section 5.04 , this Article IX and Article XI , which shall survive the termination hereof pursuant to this Article IX; provided , however , that nothing in this Agreement shall relieve any party hereto from liability for (x) any willful and material breach of this Agreement prior to such termination or (y) fraud in the event that such party is finally

determined by a court of competent jurisdiction to have willfully and knowingly committed a fraud, with specific intent to deceive and mislead any other party, regarding such party's representations, warranties, covenants or other agreements set forth in this Agreement; provided , further , that any claim for fraud may only be brought against the party that committed such fraud. For purposes hereof, "willful and material breach" means a material breach by a party of the applicable provision of this Agreement as a result of an action or failure to act by such Person that it actually knew would result in a breach of this Agreement.

ARTICLE X.

INDEMNIFICATION

Section 10.01. Survival.

(a) The representations and warranties of Seller and Purchaser contained in this Agreement shall survive the Closing solely for purposes of this Article X and shall terminate and expire on the date that is 18 months following the Closing Date; provided , that the Seller Specified Representations and the Purchaser Specified Representations and the representations and warranties of Seller set forth in Section 3.17 shall survive until the date that is 60 days following the expiration of the applicable statute of limitations and the representations and warranties of Seller set forth in Section 3.18(d) or Section 3.19 will terminate and be of no further force and effect from and after the Closing. Any claim for indemnification in respect of any representation or warranty that is not asserted by notice given as required herein prior to the expiration of the specified period of survival shall not be valid and any right to indemnification is hereby irrevocably waived after the expiration of such period of survival. Any claim properly made for an Indemnifiable Loss in respect of such a breach asserted within such period of survival as herein provided will be timely made for purposes hereof.

(b) To the extent that it is to be performed after the Closing, each covenant in this Agreement will, for purposes of this Article X , survive and remain in effect in accordance with its terms plus a period of six months thereafter, after which no claim for indemnification with respect thereto may be brought hereunder. All covenants in this Agreement that by their terms are required to be fully performed prior to the Closing will, for purposes of this Article X , survive and remain in effect until the date that is 18 months following the Closing Date, after which time no claim for indemnification with respect thereto may be brought hereunder; provided , however , that the covenants set forth in Section 5.11 will terminate and be of no further force and effect from and after the Closing.

Section 10.02. Indemnification.

(a) Seller shall indemnify, defend and hold harmless Purchaser, its Affiliates and their respective directors, officers and employees, successors and, in connection with a sale of all or substantially all of the group benefits business of Purchaser and its Affiliates, assignees (provided , that in the case of any such sale during the 18-month period after the Closing, Seller shall have provided its consent to such assignment) (collectively, the " Purchaser Indemnified Persons") from and against any and all Indemnifiable Losses asserted against, imposed upon or incurred or suffered by any Purchaser Indemnified Person resulting from or arising out of:

(i) any inaccuracy in or breach of any representation or warranty of Seller made in this Agreement;

(ii) any breach or non-fulfillment of any agreement or covenant of Seller under this Agreement; or

(iii) any Excluded Liabilities including Excluded Taxes.

(b) Purchaser shall indemnify, defend and hold harmless Seller, its Affiliates and their respective directors, officers and employees (collectively, the " Seller Indemnified Persons") from and against any and all Indemnifiable Losses asserted against, imposed upon or incurred or suffered by any Seller Indemnified Person resulting from or arising out of:

(i) any inaccuracy in or breach of any representation or warranty of Purchaser made in this Agreement;

(ii) any breach or non-fulfillment of any agreement or covenant of Purchaser under this Agreement;

(iii) any Assumed Liability; or

(iv) the operation of the Business from and after the Closing Date (except to the extent such Indemnifiable Loss is subject to indemnification by Seller of a Purchaser Indemnified Person pursuant to Section 10.02(a)).

(c) For purposes of determining whether any representation and warranty (other than the representations and warranties set forth in Section 3.06(a) and Section 3.22) has any inaccuracy or been breached and the amount of any Indemnifiable Losses under this Article X , each representation and warranty contained in this Agreement shall be read without regard to any materiality or Material Adverse Effect qualifier contained therein.

Section 10.03. Certain Limitations.

(a) Except with respect to Indemnifiable Losses resulting from Excluded Taxes or from any inaccuracy in or breach of a representation or warranty set forth in Section 3.17 , no party shall be obligated to indemnify and hold harmless its respective Indemnitees under Section 10.02(a)(i) (in the case of Seller, and other than with respect to an inaccuracy in or breach of any Seller Specified Representation) or Section 10.02(b)(i) (in the case of Purchaser, and other than with respect to an inaccuracy in or breach of any Purchaser Specified Representation) (i) with respect to any claim or series of claims arising out of substantially similar facts and circumstances, unless such claim or series of claims involves Indemnifiable Losses in excess of $100,000 (the " Threshold Amount") (nor shall any claim that does not exceed the Threshold Amount be applied to or considered for purposes of calculating the amount of Indemnifiable Losses for which the Indemnitor is responsible under clause (ii) below) and (ii) unless and until the aggregate amount of all Indemnifiable Losses of the Indemnitees under Section 10.02(a)(i) or such Section 10.02(b)(i) , as the case may be, exceeds $14,500,000 for all Indemnifiable Losses (the " Deductible"), at which point such Indemnitor shall be liable to its respective Indemnitees for the value of the Indemnitee's claims under Section 10.02(a)(i) (other than with respect to a

breach of any Seller Specified Representation) or Section 10.02(b)(i) (other than with respect to a breach of any Purchaser Specified Representation), as the case may be, that is in excess of the Deductible, subject to the limitations set forth in this Article X; provided , however , that any Indemnifiable Losses of the Purchaser Indemnified Persons resulting from or arising out of any inaccuracy in or breach of any representation or warranty set forth in Section 3.03 shall not be subject to the Deductible, and the Threshold Amount for such Indemnifiable Losses shall be $50,000; provided further that, for the avoidance of doubt, any such Indemnifiable Losses shall be subject to the Threshold Amount and the maximum aggregate liability set forth in the following sentence prior to the proviso set forth therein. The maximum aggregate liability of Seller, on the one hand, and Purchaser on the other hand, to their respective Indemnitees for any and all Indemnifiable Losses under Section 10.02(a)(i) , in the case of Seller (other than with respect to a breach of any Seller Specified Representation), or Sections 10.02(b)(i) , in the case of Purchaser (other than with respect to a breach of any Purchaser Specified Representation), shall be $174,000,000; provided , that the maximum aggregate liability of Seller to all Purchaser Indemnified Persons for any or all Indemnifiable Losses under this Agreement shall not exceed the Purchase Price. The limitations in this Section 10.03(a) shall not apply to claims made under Section 10.02(a)(iii) , Section 10.02(b)(iii) or Section 10.02(b)(iv).

(b) Each Indemnitee shall use commercially reasonable efforts to mitigate all Indemnifiable Losses for which indemnification may be sought hereunder; provided that the costs and expenses of such mitigation shall constitute Indemnifiable Losses hereunder.

(c) Notwithstanding anything to the contrary herein, any Indemnifiable Losses resulting from or arising out of any breach of any representation or warranty of Seller made in this Agreement in respect of Taxes, including under Section 3.17 , shall be limited to Taxes attributable to Pre-Closing Periods.

Section 10.04. Definitions. As used in this Agreement:

(i) "Indemnitee" means any Person entitled to indemnification under this Agreement;

(ii) "Indemnitor" means any Person required to provide indemnification under this Agreement;

(iii) "Indemnifiable Losses" means any and all damages, losses, Liabilities, obligations, costs and expenses (including reasonable attorneys' and other professional fees and expenses); provided , that any Indemnity Payment (x) shall in no event include any amounts constituting consequential or punitive damages, or any damages calculated based on a loss of future revenue, income or profits, relating to the breach or alleged breach of this Agreement; provided , however , that notwithstanding the foregoing or anything to the contrary contained in this Agreement, Indemnifiable Losses shall include recoveries for lost profits (including diminution in value used by a trier of fact in determining lost profits) if and only if (A) such damages for lost profits are recoverable under the laws of the State of New York; (B) the Indemnitee satisfies all elements necessary for proof of

such damages for lost profits under such laws; and (C) such lost profits can be demonstrated by reference to the Actuarial Report and, with respect to the reduction or elimination of any profits contemplated by the Actuarial Report, shall in no event exceed the present value ascribed to any such remaining profits contemplated by the Actuarial Report as of the date of the Indemnifiable Loss giving rise to the related claim, calculated based on the assumptions on which the Actuarial Report was prepared and discounted using a 9% discount rate; provided , further , that the Purchaser Indemnified Persons may recover lost profits only to the extent such lost profits are attributable to the Business; and (y) shall be net of any amounts actually recovered by the Indemnitee for the Indemnifiable Losses for which such Indemnity Payment is made under any insurance policy, reinsurance agreement, warranty or indemnity or otherwise from any Person other than a party hereto (net of any actual costs, expenses or increases in premiums incurred as a result of obtaining such proceeds), and the Indemnitee shall promptly reimburse the Indemnitor for any such amount that is received by it from any such other Person with respect to an Indemnifiable Losses after any indemnification with respect thereto has actually been paid pursuant to this Agreement;

(iv) "Indemnity Payment" means any amount of Indemnifiable Losses required to be paid pursuant to this Agreement; and

(v) "Third Party Claim" means any claim, action, suit, or proceeding made or brought by any Person that is not a party to this Agreement and not an Affiliate of such party to this Agreement.

Section 10.05. Procedures for Third Party Claims.

(a) If any Indemnitee receives notice of assertion or commencement of any Third Party Claim against such Indemnitee in respect of which an Indemnitor may be obligated to provide indemnification under this Agreement, the Indemnitee shall give such Indemnitor reasonably prompt written notice (but in no event later than 30 days after becoming aware of such Third Party Claim) thereof and such notice shall include a reasonable description of the claim based on the facts known at the time and any documents relating to the claim and an estimate of the Indemnifiable Loss and shall reference the specific sections of this Agreement that form the basis of such claim to the extent reasonably ascertainable; provided , that no delay on the part of the Indemnitee in notifying any Indemnitor shall relieve the Indemnitor from any obligation hereunder unless (and then solely to the extent that) the Indemnitor is actually prejudiced by such delay (except that the Indemnitor shall not be liable for any expenses incurred during the period in which the Indemnitee failed to give such notice). Thereafter, the Indemnitee shall deliver to the Indemnitor, within five Business Days after the Indemnitee's receipt thereof, copies of all notices and documents (including court papers) received by the Indemnitee relating to the Third Party Claim.

(b) The Indemnitor shall be entitled to participate in the defense of any Third Party Claim and, if it so chooses, to assume the defense thereof with counsel selected by the

Indemnitor. Should the Indemnitor so elect to assume the defense of a Third Party Claim, the Indemnitor shall not as long as it conducts such defense be liable to the Indemnitee for legal expenses incurred by the Indemnitee in connection with the defense thereof subsequent to the Indemnitor notifying the Indemnitee in writing of its election to assume such defense. If the Indemnitor assumes such defense, the Indemnitee shall have the right to participate in the defense thereof and to employ counsel, at its own expense, separate from the counsel employed by the Indemnitor, it being understood that the Indemnitor shall control such defense. The Indemnitor shall be liable for the reasonable fees and expenses of counsel employed by the Indemnitee (A) for any period during which the Indemnitor has not assumed the defense thereof (other than during any period in which the Indemnitee shall have not yet given notice of the Third Party Claim as provided above) or (B) if the Third Party Claim involves conflicts of interest for the Indemnitee and the Indemnitor (in the reasonable opinion of counsel to the Indemnitee) that would make representation by the same counsel inappropriate, in which event the Indemnitor shall be responsible for only one counsel for the Indemnitee. If the Indemnitor chooses to defend any Third Party Claim, the other party hereto shall cooperate in the defense thereof. Such cooperation shall include the retention and (upon the Indemnitor's request) the provision to the Indemnitor of records and information that are relevant to such Third Party Claim, and making employees available on a mutually convenient basis to provide additional information and explanation of any material provided hereunder; provided , in each case, that such other party shall not be obligated to provide such records, information or access to Indemnitor if doing so would violate Applicable Law or jeopardize the protection of an attorney-client privilege. Whether or not the Indemnitor shall have assumed the defense of a Third Party Claim, the Indemnitee shall not admit any liability with respect to, or pay, settle, compromise or discharge, such Third Party Claim without the Indemnitor's prior written consent (which consent shall not be unreasonably withheld, conditioned or delayed). If the Indemnitor has assumed the defense of a Third Party Claim, the Indemnitor may only pay, settle, compromise or discharge a Third Party Claim with the Indemnitee's prior written consent (which consent shall not be unreasonably withheld, conditioned or delayed); provided , that the Indemnitor may pay, settle, compromise or discharge such a Third Party Claim without the written consent of the Indemnitee if such settlement (i) includes a release of the Indemnitee from all Liability in respect of such Third Party Claim, (ii) does not subject the Indemnitee to any injunctive relief or other equitable remedy, (iii) does not include a statement or admission of fault, culpability or failure to act by or on behalf of the Indemnitee and (iv) does not impose any financial cost on the Indemnitee (other than by application of the limitations set forth in Section 10.03(a)). If the Indemnitor submits to the Indemnitee a bona fide settlement offer with respect to a Third Party Claim that has been accepted by all Persons bringing such Third Party Claim and otherwise satisfies the requirements set forth in the proviso of the immediately preceding sentence and the Indemnitee refuses to consent to such settlement, then thereafter the Indemnitor's liability to the Indemnitee with respect to such Third Party Claim shall not exceed the Indemnitor's portion of the settlement amount included in such settlement offer.

(c) Notwithstanding anything in this Agreement to the contrary, Seller shall have the sole right to represent the interests of the Business and settle all issues in its sole discretion, and to employ counsel of its choice at its expense, in any audit or other examination or administrative or court proceeding relating to Taxes for all taxable periods (or portions thereof) ending on or before the Closing Date; provided , that Seller shall not pay, discharge, settle, compromise, litigate or otherwise dispose of any item subject to such Tax proceedings in a manner that will

adversely affect Purchaser or any of its Affiliates without obtaining the prior written consent of Purchaser, which consent shall not be unreasonably withheld, conditioned or delayed. Notwithstanding the foregoing and subject to Seller's rights set forth in the immediately preceding sentence, Purchaser shall be entitled, at its expense, to participate in the conduct of any Tax audit and any judicial or administrative proceeding relating to any such Tax audit that may adversely affect Purchaser or any of its Affiliates.

Section 10.06. Direct Claims. The Indemnitor will have a period of 30 days within which to respond in writing to any claim by an Indemnitee on account of an Indemnifiable Loss that does not result from a Third Party Claim. If the Indemnitor does not so respond within such 30 day period, the Indemnitor will be deemed to have rejected such claim, in which event the Indemnitee will be entitled to pursue such remedies as may be available to the Indemnitee.

Section 10.07. Sole Remedy. The parties hereto acknowledge and agree that, except as (a) set forth in Section 11.14 , (b) as expressly contemplated by Section 2.09 , (c) for any remedy expressly contemplated by any other Transaction Agreement with respect to a claim made under such Transaction Agreement and (d) under the circumstances described in Section 9.03(y) , if the Closing occurs, their sole and exclusive remedy following the Closing with respect to any and all claims arising out of or related to the transactions contemplated by this Agreement shall be pursuant to the provisions set forth in this Article X.

Section 10.08. Certain Other Matters.

(a) Upon making any Indemnity Payment, Indemnitor will, to the extent of such Indemnity Payment, be subrogated to all rights of Indemnitee against any third Person (other than any Tax Authority) in respect of the Indemnifiable Loss to which the Indemnity Payment related. Without limiting the generality or effect of any other provision hereof, each such Indemnitee and Indemnitor will duly execute upon request all instruments reasonably necessary to evidence and perfect the above-described subrogation rights.

(b) The rights and remedies of any party in respect of any inaccuracy or breach of any representation, warranty, covenant or agreement shall in no way be limited by the fact that the act, omission, occurrence or other state of facts or circumstances upon which any claim of any such inaccuracy or breach is based may also be the subject matter of any other representation, warranty, covenant or agreement as to which there is no inaccuracy or breach. The representations, warranties and covenants of Seller set forth herein (as such representations and warranties are qualified in accordance with the introductory paragraph of Article III), and the Purchaser Indemnified Persons' rights to indemnification with respect thereto, shall not be affected or deemed waived by reason of (and the Purchaser Indemnified Persons shall be deemed to have relied upon such representations and warranties notwithstanding) (i) any investigation made by or on behalf of any of the Purchaser Indemnified Persons (including by any of its Representatives) or by reason of the fact that any of the Purchaser Indemnified Persons or any of such Representatives knew or should have known that any such representation or warranty is, was or might be inaccurate, regardless of whether such investigation was made or such knowledge was obtained before or after the execution and delivery of this Agreement or (ii) Purchaser's waiver of any condition set forth in Article VIII. The representations, warranties and covenants of Purchaser set forth herein (as such representations and warranties are qualified

in accordance with the introductory paragraph of Article IV), and the Seller Indemnified Persons' rights to indemnification with respect thereto, shall not be affected or deemed waived by reason of (and the Seller Indemnified Persons shall be deemed to have relied upon such representations and warranties notwithstanding) (i) any investigation made by or on behalf of any of the Seller Indemnified Persons (including by any of its Representatives) or by reason of the fact that any of the Seller Indemnified Persons or any of such Representatives knew or should have known that any such representation or warranty is, was or might be inaccurate, regardless of whether such investigation was made or such knowledge was obtained before or after the execution and delivery of this Agreement or (ii) Seller's waiver of any condition set forth in Article VIII.

ARTICLE XI.

GENERAL PROVISIONS

Section 11.01. Publicity. Except as may otherwise be required by Applicable Law, regulation or obligation pursuant to any listing agreement with any national securities exchange, no press release or public announcement, including any presentation to the investment community (other than pro forma financial statements and dilution or accretion analyses included in shareholder presentations), concerning this Agreement or the transactions contemplated hereby shall be made by Seller, on the one hand, or Purchaser, on the other hand, prior to the Closing Date without advance approval thereof by the other party, such approval not to be unreasonably withheld. The parties hereto shall cooperate with each other in making any press release or public announcement concerning the Business on or prior to the Closing Date.

Section 11.02. Expenses. Regardless of whether any or all of the transactions contemplated by this Agreement are consummated, and except as otherwise expressly provided herein or in any Transaction Agreement, Purchaser and its Affiliates, on the one hand, and Seller and its Affiliates, on the other hand, shall each bear their respective direct and indirect fees, costs and expenses incurred in connection with the negotiation and preparation of this Agreement, the Transaction Agreements and the consummation of the transactions contemplated hereby or thereby, including all fees and expenses of their respective Representatives.

Section 11.03. Notices. All notices, requests, consents, claims, demands and other communications under this Agreement and the other Transaction Agreements shall be in writing and shall be given or made (and shall be deemed to have been duly given or made upon receipt) by delivery in person, by overnight courier service, by electronic mail (followed by delivery of an original via overnight courier service) or by registered or certified mail (postage prepaid, return receipt requested) to the respective parties hereto at the following respective addresses (or at such other address for a party hereto as shall be specified in a notice given in accordance with this Section 11.03):

(a) If to Purchaser:

Hartford Life and Accident Insurance Company
c/o The Hartford Financial Services Group, Inc.

One Hartford Plaza
Hartford, CT 06155
Attention: Chief Financial Officer, General Counsel
Facsimile: (855) 388-6397
Email address: beth.bombara@thehartford.com,
david.robinson@thehartford.com

With a concurrent copy (which shall not constitute notice) to:

Mayer Brown LLP
1221 Avenue of the Americas
New York, NY 10020
Attention: Stephen G. Rooney, David W. Alberts
Facsimile: (212) 849-5632; (212) 849-5611
Email address: srooney@mayerbrown.com;
dalberts@mayerbrown.com

(b) If to Seller:
Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156
Attention: General Counsel
Facsimile: (212) 457-0301

With a concurrent copy (which shall not constitute notice) to:

Willkie Farr & Gallagher LLP
787 Seventh Avenue
New York, NY 10019
Attention: Michael Groll
Rajab S. Abbassi
Facsimile: (212) 728-8111
Email address: mgroll@willkie.com
rabbassi@willkie.com

Any party may, by notice given in accordance with this Section 11.03 to the other parties, designate another address or person for receipt of notices hereunder, provided that notice of such a change shall be effective upon receipt.

Section 11.04. Entire Agreement. Except as otherwise expressly provided in the Transaction Agreements, this Agreement and the other Transaction Agreements constitute the entire agreement of the parties hereto with respect to the subject matter of the Transaction Agreements and supersede all prior agreements and undertakings, both written and oral, other than the Confidentiality Agreement to the extent not in conflict with this Agreement, between or on behalf of Seller and its Affiliates, on the one hand, and Purchaser and its Affiliates, on the other hand, with respect to the subject matter of the Transaction Agreements.

Section 11.05. Severability. If any term or other provision of this Agreement is invalid, illegal or incapable of being enforced under any Applicable Law or as a matter of public policy, all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect so long as the economic or legal substance of the transactions contemplated by this Agreement is not affected in any manner materially adverse to any party hereto. Upon such determination that any term or other provision is invalid, illegal or incapable of being enforced, the parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the parties hereto as closely as possible in a mutually acceptable manner in order that the transactions contemplated by this Agreement be consummated as originally contemplated to the greatest extent possible. If any provision of this Agreement is determined by a court of competent jurisdiction to be so broad as to be unenforceable, that provision shall be interpreted to be only so broad as it is enforceable.

Section 11.06. Assignment. This Agreement may not be assigned, in whole or in part, by operation of law or otherwise without the prior written consent of the parties hereto. Any attempted assignment in violation of this Section 11.06 shall be void. This Agreement shall be binding upon, shall inure to the benefit of, and shall be enforceable by the parties hereto and their successors and permitted assigns.

Section 11.07. Waivers and Amendments. No provision of this Agreement or any other Transaction Agreements may be amended, supplemented or modified except by a written instrument signed by all of the parties thereto. No provision of this Agreement or any other Transaction Agreements may be waived except by a written instrument signed by the party against whom the waiver is to be effective.

Section 11.08. Disclosure Schedules. Matters reflected in any Section of this Agreement, including any section or subsection of the Seller Disclosure Schedule or Purchaser Disclosure Schedule, are not necessarily limited to matters required by this Agreement to be so reflected. Such additional matters are set forth for informational purposes and do not necessarily include other matters of a similar nature. No reference to or disclosure of any item or other matter in any Section or Schedule of this Agreement, including any section or subsection of the Seller Disclosure Schedule or Purchaser Disclosure Schedule, shall be construed as an admission or indication that such item or other matter is material or that such item or other matter is required to be referred to or disclosed in this Agreement, the Seller Disclosure Schedule or Purchaser Disclosure Schedule. Without limiting the foregoing, no such reference to or disclosure of a possible breach or violation of any contract, Applicable Law or Governmental Order shall be construed as an admission or indication that breach or violation exists or has actually occurred.

Section 11.09. Governing Law; Submission to Jurisdiction; Waiver of Jury Trial.

(a) THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF NEW YORK WITHOUT REGARD TO SUCH STATE'S PRINCIPLES OF CONFLICT OF LAW THAT COULD COMPEL THE APPLICATION OF THE LAWS OF ANOTHER JURISDICTION.

(b) Each party hereto irrevocably and unconditionally submits to the exclusive jurisdiction of any federal court located in New York County in the State of New York, over any

action, suit or proceeding arising out of or relating to this Agreement or the transactions contemplated hereby; provided , however , that, if said court determines that it does not have subject matter jurisdiction, then said action, suit or proceeding may be brought in the Supreme Court of the State of New York for New York County. Each party hereto agrees that service of any process, summons, notice or document by U.S. registered mail addressed to such party shall be effective service of process for any action, suit or proceeding brought against such party in any such court. Purchaser hereby designates the individual listed in Section 11.03(a) to whom notice may be given on behalf of Purchaser as its true and lawful agent upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of Seller. Seller hereby designates the individual listed in Section 11.03(b) to whom notice may be given on behalf of Seller as its true and lawful agent upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of Purchaser. In the event either party decides to change its designation of agent, it shall provide written notice to the other party. Each party hereto irrevocably and unconditionally waives any objection to the laying of venue of any such action, suit or proceeding brought in any such court and any claim that any such action, suit or proceeding brought in any such court has been brought in an inconvenient forum. Each party hereto agrees that any final, nonappealable judgment in any such action, suit or proceeding brought in any such court shall be conclusive and binding upon such party and may be enforced in any other courts to whose jurisdiction such party may be subject, by suit upon such judgment.

(c) EACH OF THE PARTIES HERETO HEREBY WAIVES TO THE FULLEST EXTENT PERMITTED BY LAW ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY WITH RESPECT TO ANY LITIGATION DIRECTLY OR INDIRECTLY ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT. EACH OF THE PARTIES HERETO HEREBY (A) CERTIFIES THAT NO REPRESENTATIVE, AGENT OR ATTORNEY OF THE OTHER PARTY HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT SUCH OTHER PARTY WOULD NOT, IN THE EVENT OF LITIGATION, SEEK TO ENFORCE THE FOREGOING WAIVER, AND (B) ACKNOWLEDGES THAT IT HAS BEEN INDUCED TO ENTER INTO THIS AGREEMENT AND THE TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT, AS APPLICABLE, BY, AMONG OTHER THINGS, THE MUTUAL WAIVERS AND CERTIFICATIONS IN THIS SECTION 11.09.

Section 11.10. Rules of Construction. Interpretation of this Agreement and the other Transaction Agreements (except as specifically provided in any such other Transaction Agreements, in which case such specified rules of construction shall govern with respect to such other Transaction Agreements) shall be governed by the following rules of construction: (a) words in the singular shall be held to include the plural and vice versa, and words of one gender shall be held to include the other gender as the context requires; (b) references to the terms Preamble, Recitals, Article, Section, paragraph, Schedule and Exhibit are references to the Preamble, Recitals, Articles, Sections, paragraphs, Schedules and Exhibits to this Agreement unless otherwise specified; (c) references to "$" mean, and all payments required to be made under this Agreement shall be required to be made in, U.S. dollars; (d) the word "including" and words of similar import means "including without limitation," unless otherwise specified; (e) the word "or" shall not be exclusive; (f) the words "herein," "hereof," "hereunder" or "hereby" and similar terms are to be deemed to refer to this Agreement as a whole and not to any specific Section; (g) the headings are for reference purposes only and shall not affect in any way the

meaning or interpretation of the Transaction Agreements; (h) the Transaction Agreements shall be construed without regard to any presumption or rule requiring construction or interpretation against the party drafting or causing any instrument to be drafted; (i) if a word or phrase is defined, the other grammatical forms of such word or phrase have a corresponding meaning; (j) references to any statute, listing rule, rule, standard, regulation or other law include a reference to the corresponding rules and regulations; (k) references to any section of any statute, listing rule, rule, standard, regulation or other law include any successor or amendment to such section; (l) references to any Person include such Person's predecessors or successors, whether by merger, consolidation, amalgamation, reorganization or otherwise; and (m) references to any contract (including this Agreement) or organizational document are to the contract or organizational document as amended, modified, supplemented or replaced from time to time, unless otherwise stated.

Section 11.11. Certain Limitations.

(a) Notwithstanding anything to the contrary contained in this Agreement, the other Transaction Agreements, the Seller Disclosure Schedule or any of the Schedules or Exhibits hereto or thereto, Purchaser acknowledges and agrees that neither Seller nor any of its Representative makes or has made, and Purchaser has not relied on, any inducement or promise to Purchaser except as specifically made in this Agreement or any representation or warranty to Purchaser, oral or written, express or implied, other than as expressly set forth in Article III. Without limiting the generality of the foregoing, other than as expressly set forth in Article III , no Person has made any representation or warranty to Purchaser with respect to the Business, the Transferred Assets (including the Assigned Contracts), the Assumed Liabilities or any other matter, including with respect to (i) merchantability, suitability or fitness for any particular purpose, (ii) the operation of the Business by Purchaser after the Closing, (iii) the probable success or profitability of the Business after the Closing or (iv) any information, documents or material made available to Purchaser or its Representatives in any "data rooms," information memoranda, management presentations, functional "break-out" discussions or in any other form or forum in connection with the transactions contemplated by this Agreement, including any estimation, valuation, appraisal, projection or forecast with respect to the Business. With respect to any such estimation, valuation, appraisal, projection or forecast (including the confidential information memoranda prepared by or on behalf of Seller in connection with the transactions contemplated by this Agreement or the any actuarial reports provided to Purchaser), Purchaser acknowledges that: (i) there are uncertainties inherent in attempting to make such estimations, valuations, appraisals, projections and forecasts; (ii) it is familiar with such uncertainties; (iii) it is not acting and has not acted in reliance on any such estimation valuation, appraisal, projection or forecast delivered by or on behalf of Seller to Purchaser; (iv) such estimations, valuations, appraisals, projections and forecasts are not and shall not be deemed to be representations or warranties of Seller or any of its Affiliates and (v) it shall have no claim against any Person with respect to any such valuation, appraisal, projection or forecast.

(b) Seller makes no express or implied representation or warranty hereby or otherwise under this Agreement: (i) as to the future experience, success or profitability of the Business, whether or not conducted in a manner similar to the manner in which the Business was conducted prior to the Closing; (ii) that the reserves held by or on behalf of the Business or the assets supporting such reserves have been or will be adequate or sufficient for the purposes for

which they were established; (iii) that the reinsurance recoverables taken into account in determining the amount of such reserves will be collectible or whether such reserves were calculated, established or determined in accordance with any actuarial, statutory or other standard; or (iv) concerning any financial statement "line item" or asset, liability or equity amount that would be affected by any of the foregoing.

(c) Purchaser further acknowledges and agrees that it: (i) has made its own inquiry and investigation into and, based thereon, has formed an independent judgment concerning the Business, the Transferred Assets (including the Assigned Contracts) and the Assumed Liabilities; (ii) has been provided adequate access to such information as it has deemed necessary to enable it to form such independent judgment; (iii) has had such time as it deems necessary and appropriate fully and completely to review and analyze such information, documents and other materials; and (iv) has been provided an opportunity to ask questions of Seller with respect to such information, documents and other materials and has received answers to such questions that it considers satisfactory. Purchaser further acknowledges and agrees that neither Seller nor any of its Affiliates has made any representations or warranties, express or implied, as to the accuracy or completeness of, and that Purchaser and its Affiliates have made their investment decision with respect to the acquisition of the Transferred Assets without reliance upon, such information, documents and other materials other than the representations and warranties expressly set forth in this Agreement.

Section 11.12. No Third Party Beneficiaries. Nothing in this Agreement is intended or shall be construed to give any Person (including the employees of Seller or Purchaser or any Affiliate of Seller or Purchaser), other than the parties hereto, their successors and permitted assigns, any legal or equitable right, remedy or claim under or in respect of this Agreement or any provision contained herein.

Section 11.13. Execution in Counterparts. This Agreement may be executed by the parties hereto in separate counterparts, each of which when so executed and delivered shall be an original, but all such counterparts shall together constitute one and the same instrument. Delivery of an executed counterpart of a signature page to any Transaction Agreement by facsimile or other means of electronic transmission utilizing reasonable image scan technology shall be as effective as delivery of a manually executed counterpart of any such Agreement.

Section 11.14. Equitable Remedies. The parties hereto agree that irreparable damage would occur in the event that any of the provisions of this Agreement were not performed in accordance with their specific terms or were otherwise breached. It is accordingly agreed that, without the necessity of posting bond or other undertaking, the parties hereto shall be entitled to an injunction or injunctions to prevent breaches of this Agreement and to enforce specifically the terms and provisions of this Agreement in accordance with this Agreement, this being in addition (subject to the terms of this Agreement) to any other remedy to which such party is entitled at law or in equity. In the event that any Action is brought in equity to enforce the provisions of this Agreement, no party hereto shall allege, and each party hereto hereby waives any defense or counterclaim, that there is an adequate remedy at law. If, prior to the Outside Date, any party hereto brings any Action in accordance with this Section 11.14 to enforce specifically the performance of the terms and provisions hereof by the other party, the Outside Date shall be automatically extended (i) for the period during which such action is pending, plus 10 Business Days or (ii) by such other time period established by the court presiding over such action, as the case may be.

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IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

AETNA INC.

By: /s/ Bjorn Thaler

Name: Bjorn Thaler

Title: Authorized Signatory

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

By: /s/ Michael Concannon

Name: Michael Concannon

Title: Authorized Signatory

[Signature Page to Master Transaction Agreement **]**

Exhibit 10.36

2018 Management Incentive Plan

I. Objectives and Summary

CVS Health Corporation's Management Incentive Plan (the "MIP") is designed to reward incentive-eligible employees ("Eligible Participants") of CVS Health Corporation and its subsidiaries (together, "the Company") for their role in driving performance and to encourage Eligible Participants' continued employment with the Company. Funding for the payment of incentive awards will be based on actual results measured against pre-established financial goals and/or operating goals. The amount of each incentive award paid will be based on the performance of the Company and the performance of the individual Eligible Participant.

The MIP shall be administered by the Management Planning and Development Committee (the "Committee") of the Board of Directors (the "Board") under the provisions herein and of the 2017 Incentive Compensation Plan or any successor plan (the "ICP"), and the Committee may delegate to officers of CVS Health the authority to perform administrative functions of the MIP as the Committee may determine and may appoint officers and others to assist it in administering the MIP.

II. Plan Year

The MIP is a calendar year plan, which runs from January 1 to December 31, 2018 ("Plan Year"). All dates in this document occur during the current Plan Year unless otherwise stated.

III. Eligibility

A. Eligibility for Participation

The Chief Executive Officer of CVS Health Corporation ("CEO") or the CEO's designee determines those employees who are eligible to participate in the MIP except as set forth in Section III.B, below. In general, Eligible Participants include exempt employees who are not covered by any other incentive plans and who are employed on or before November 1 of the Plan Year.

The CEO may, for any reason and in his or her sole discretion, at any time during the Plan Year, determine an employee's eligibility for participation in the MIP except as set forth in Section III.B. Eligible Participants are subject to the terms and conditions relating to incentive awards set forth in the MIP.

B. Section 16 Officers

The Committee shall determine the eligibility of Section 16 Officers of CVS Health, whom will also be included in the term "Eligible Participants" unless otherwise noted. The Committee shall retain sole discretion to determine Section 16 Officer eligibility for an award, the target award, and the amount of the actual award.

C. Newly-Eligible Employees

The award, if any, to an Eligible Participant who became an Eligible Participant after the beginning of the Plan Year may be prorated based on the date of eligibility.

D. Position Change

An employee who becomes an Eligible Participant on or before November 1 of the Plan Year as a result of a position change may be eligible for a prorated incentive award. If a position change results in an employee becoming an Eligible Participant for part of the Plan Year and other incentives during other parts of the Plan Year, the employee may be eligible to receive a prorated award for the amount of time in each incentive eligible position, subject to the terms of each applicable incentive plan. A position change from one MIP-eligible

position to another MIP-eligible position during the Plan Year also may result in a prorata award as described below under Section V. (B).

E. Demotions

If a previously Eligible Participant is demoted to a non-incentive eligible position due to his or her violation of CVS Health policy or his or her performance, or if he or she voluntarily transfers to a non-incentive eligible position during the Plan Year, and is in the non-incentive eligible position on the last day of the Plan Year, he or she will not be eligible to earn an incentive award for the Plan Year under the MIP.

F. Terminations

Unless otherwise stated in Section VII of the MIP, if an Eligible Participant's employment terminates prior to March 1 following a Plan Year, he or she will not be eligible to receive an incentive award under the MIP for the most recently completed Plan Year.

G. Rehires

Employees who are rehired as Eligible Participants on or before November 1 of the Plan Year may be eligible for a prorated incentive award. For purposes of proration, credit will only be given for time worked during the Plan Year in incentive-eligible positions.

IV. MIP Funding

A. Consolidated Company Funding

MIP funding is based on consolidated Company performance, measured by Operating Profit, and modified by performance measurements set forth in Exhibit A, for a given Plan Year. Achievement of the Company's Operating Profit target and MIP modifiers will determine the total funding (the "Total Pool") as described below.

1. Operating Profit

Operating Profit may be adjusted by the financial adjustments as approved by the Committee prior to the end of the first fiscal quarter of the Plan Year (the "Financial Adjustments").

If Operating Profit is below the minimum performance threshhold, no formulaic funding will be made available for incentive awards, regardless of MIP modifier metrics performance, and there shall be no incentive awards paid under the MIP.

B. Total Pool Funding

After the minimum threshold for Operating Profit has been achieved, performance of MIP modifiers against target will be calculated for the Plan Year. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The CEO (or, as to Section 16 Eligible Participants, the Committee) may, for any reason and in his or her (or Its) sole discretion, adjust the funding of the Total Pool based on (a) input from senior Company executives regarding their assessment of the overall performance of the Company; and (b) assessment of the achievement of Plan Year performance goals. In no case, however, can the CEO or the Committee increase Total Pool funding due solely to the results of the MIP modifiers.

C. Individual Performance

The Total Pool will be available for award to Eligible Participants under the MIP, taking into account the individual contribution of each Eligible Participant. The amount, if any, of the incentive award for an Eligible Participant shall be detemined in the sole discretion of the Company, which shall be final, binding and conclusive as to all parties having an interest therein. The amount, if any, of the incentive award for a Section 16 Eligible Participant shall be determined in the sole discretion of the Committee, which shall be final, binding and conclusive as to all parties having an interest therein.

V. Earnings, Proration, and Payout

A. Timing

Incentive awards will be paid to Eligible Participants, as soon as administratively feasible following the date the Total Pool is determined and approved, but no later than March 15 of the calendar year immediately following the Plan Year. Incentive payments under the MIP may be subject to garnishments and other state or federal requirements.

B. Calculations

Calculations for full and partial awards for each Eligible Participant will be based on "Eligible Earnings" (defined below) for the Plan Year while in a MIP-eligible position. Eligible Earnings will be multiplied by the individual target opportunity of the Eligible Participant. If the Eligible Participant has been employed in multiple MIP-eligible positions during the Plan Year, then the individual opportunity will be prorated based on the number of days worked in each position.

Eligible Earnings include reoccurring items such as pay earned for hours worked, paid time off (e.g. vacation, sick, holiday, funeral, jury duty, military) but will exclude one-time payments such as annual cash incentives, commissions and similar payments, and earnings associated with equity releases and stock option exercises.

For purposes of proration under the MIP and except as otherwise provided in Section VII of the MIP, calculations will be based on the number of days that the employee was an Eligible Participant in the MIP during the Plan Year.

C. Award Opportunity

Individual target awards will be determined by position and may vary based on the Eligible Participant's level in the organization.

D. Obligation to Pay Out Percentage of Total Pool

Eligible Participants, as a group, have a right to receive an amount at least equal to the Total Pool, but no individual Eligible Participant shall be entitled to receive an award or any specific amount of the Total Pool. In no event will the aggregate of the total awards paid from the MIP be less than 92.5% of the Total Pool. To discourage unmerited litigation, any party or class asserting a challenge or claim against the Company under any provision of the MIP, including this Section V, shall bear their own costs relating to such challenge or claim, and if the challenge or claim is unsuccessful, such party or class shall reimburse the Company for all reasonable costs incurred by the Company in responding to such challenge or claim.

VI. MIP Dispute Resolution

Any questions by an Eligible Participant regarding an incentive award granted under the MIP shall first be submitted by the Eligible Participant to his or her Human Resources Business Partner ("HRBP") within 7 days of distribution of such incentive award, and the HRBP shall submit any correction that the HRBP deems appropriate to the Compensation Department by the first business day of April immediately following the distribution date.

In the event of a dispute regarding an incentive award under the MIP after the Eligible Participant has submitted his or her question to the HRBP and received a response, as provided above, the Eligible Participant may submit an appeal for resolution of such dispute to CVS Health's Advice and Counsel in writing within 30 days of the distribution of the incentive award. Failure to follow these procedures or submit a question or dispute in a timely manner may result in a waiver of the Eligible Participant's right to dispute the MIP provision or amount of the incentive award.

VII. Eligible Participant Status

A. Performance

The CEO or other designated executives have full discretion in determining the amount, if any, of an incentive awarded to an Eligible Participant, and the Participant's individual performance throughout the Plan Year will be considered by the Company in the final determination of the Eligible Participant's incentive award.

B. Leaves of Absence

An Eligible Participant on a Company-approved leave of absence at any time during the Plan Year who remains employed in an eligible position as of the last day of the Plan Year will earn a prorated incentive award based on the number of days actively worked (including time compensated as vacation, myTime or Paid Time Off ("PTO")) during the Plan Year, provided he or she meets all other eligibility criteria for an incentive award.

C. Reduction in Force, Retirement and Death

1. Reduction in Force

If an Eligible Participant is separated from employment by the Company during the Plan Year due to a reduction in force, he or she may be eligible, at the Company's discretion, to receive a prorated incentive award based on the calculation methodology described in Section V.(B) above, provided the Eligible Participant meets all other eligibility criteria for an incentive award.

2. Retirement

If an Eligible Participant is at least age 55 and has a minimum of 10 years of service with CVS Health or a predecessor company/subsidiary or is at least age 60 and has a minimum of 5 years of service with CVS Health or a predecessor company/subsidiary and the Eligible Participant retires during the Plan Year, he/she may be eligible to receive a prorated incentive award based on the calculation methodology described in Section V.(B) above, provided he/she meets all other eligibility criteria for an incentive award. Eligible Participants who do not meet the minimum retirement requirements under Section VII at the time of retirement will not be eligible for an incentive award for the Plan Year.

3. Death

In case of the death of an Eligible Participant, a prorated incentive award may be paid to the Eligible Participant's spouse, if living; otherwise, in equal shares to surviving children of the Eligible Participant. If there are no surviving children, the benefit shall be paid to the Eligible Participant's estate. The incentive award will be prorated based on the calculation methodology described in Section V.(B) above. The incentive award shall be paid as soon as administratively practicable, following the death of the Eligible Participant but no later than March 15 of the calendar year immediately following the Plan Year.

VIII. Miscellaneous

A. No Promise of Continued Employment

The MIP does not create an express or implied contract of employment between CVS Heath or and an Eligible Participant. Both CVS Health and the Eligible Participant retain the right to terminate the employment relationship at will, at any time and for any reason.

B. Rights are Non-Assignable

Neither the Eligible Participant, nor any beneficiary, nor any other person shall have any right to assign, in whole or in part, the right to receive payments under the MIP. Payments are non-assignable and non-transferable, whether voluntarily or involuntarily.

C. Compliance with Applicable Law

An Eligible Participant must comply with all applicable state and federal laws and CVS Health policies to be eligible to receive an incentive award under the MIP.

CVS Health will comply with all applicable laws concerning incentive awards; the MIP and its administration are not intended to conflict with any applicable state or federal law.

D. Change in Control

In the event of a change in control of CVS Health, as defined in the ICP, the MIP shall remain in force. Any amendments, modifications, termination or dissolution of the MIP by the acquiring entity may only occur prospectively and will not affect incentive targets or awards or eligibility in place immediately before the date of the change in control or such later date as it may be modified or dissolved by the acquiring entity.

Provisions regarding the payment of annual incentive awards that are set forth in change in control agreements with Eligible Employees shall supersede those appearing in the MIP.

E. Withholding

All required deductions will be withheld from the incentive awards prior to distribution. This includes all applicable federal, state, or local taxes, as well as any eligible 401(k) deductions and deferred compensation contributions, as defined by the applicable plans. Incentive awards that are deferred will be taxed according to applicable federal and state tax law. Each Eligible Participant shall be solely responsible for any tax consequences of his or her award hereunder.

F. MIP Amendment/Modification/Termination

CVS Health retains the right to amend, modify, or terminate the MIP at any time on or before the last day of the Plan Year for any reason, with or without notice to Eligible Participants.

G. MIP Interpretation

CVS Health retains sole, full and final authority to prescribe rules and regulations for the administration of the Plan, construe and interpret the Plan and Award agreements and correct defects, supply omissions or reconcile inconsistencies therein and to make all other decisions and determinations as it may deem necessary or advisable for the administration of the Plan.

Capitalized terms not otherwise defined herein shall have the meaning assigned to such defined term(s) in the ICP. In the event of any conflict between the ICP and the MIP, the terms of the ICP shall govern.

H. Recoupment of Incentive Awards

Each incentive award under the MIP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Eligible Employee to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the MIP.

I. Section 409A of the Internal Revenue Code

The Company intends that the MIP not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Code, as amended, and the regulations and guidance thereunder (collectively, "Section 409A"), and that to the extent any provisions of the Plan do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. Payments hereunder are intended to qualify as short-term deferral payments under Section 409A. In all events, the provisions of CVS Health Corporation's Universal 409A Definition Document are hereby incorporated by reference, and notwithstanding the any other provision of the Plan or any Award to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code (requiring certain delays for "specified employees"), payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh (7th) month following the date of termination of employment. For purposes of any provision of the Plan providing for the payment of any amounts or

benefits in connection with a termination of employment, references to an Eligible Person's "termination of employment" (and corollary terms) shall be construed to refer to the Eligible Person's "separation from service" with the Company as determined under Section 409A.

J. Restrictive Covenant Agreement

Any award pursuant to the MIP is expressly subject to and contingent upon the requirement that the Eligible Participant shall have fully executed and delivered to the Company a restrictive covenant agreement deemed appropriate by the Company; the Company may waive such requirement in its sole discretion. Any applicable agreement containing the restrictive covenants the Company requires in connection with this award is referred to herein as the "Restrictive Covenant Agreement".

If the Company requires an Eligible Participant to execute and deliver the Restrictive Covenant Agreement in connection with any MIP award, the Company shall provide such Restrictive Covenant Agreement to the Eligible Participant. The Eligible Participant must execute and deliver such agreement by the deadline set forth by the Company. The failure of an Eligible Participant to execute and return the Restrictive Covenant Agreement by the deadline set forth by the Company, if required, shall result in the immediate and irrevocable forfeiture of any MIP award.

This Section VIII (J) of the MIP shall not constitute the Company's exclusive remedy for Eligible Participant's violation of the Restrictive Covenant Agreement. The Company reserves all rights to seek all available legal or equitable remedies in the event of Eligible Participant's violation or threatened violation of the Restrictive Covenant Agreement, including injunctive relief.

Exhibit 10.37

CVS HEALTH SEVERANCE PLAN FOR NON-STORE EMPLOYEES (Amended as of November 28, 2018)

CVS HEALTH SEVERANCE PLAN

FOR NON-STORE EMPLOYEES

(Amended as of November 28, 2018)

WHEREAS, CVS Health Corporation (the "Company") has established the CVS Health Severance Plan for Non-Store Employees (the "Plan") to provide financial assistance to employees in non- store positions who are involuntarily terminated and are eligible within the terms and conditions of the Plan;

WHEREAS, it is intended that the Plan constitute an employee welfare benefit plan within the scope of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), that the Plan constitute a separation pay plan within the scope of Department of Labor ("DOL") Regulation Section 2510.3-2(b), and that all payments made under the Plan be deductible by the Company under Section 162(a) of the Internal Revenue Code of 1986, as amended (the "Code");

WHEREAS, the benefits provided under the Plan are intended to constitute separation pay within the meaning of Treasury Regulation Section 1.409A-1(b)(9)(iii);

WHEREAS, this document is the official plan document; and

WHEREAS, the Company wishes to make certain amendments to the Plan, effective as of November 28, 2018 (the "Effective Date");

NOW, THEREFORE, as of the Effective Date, the Company does hereby amend the Plan to provide as follows:

ARTICLE 1

DEFINITIONS

For purposes of the Plan, the following terms, when used with an initial capital letter, shall have the meaning set forth below unless a different meaning is plainly required by the context.

1.1 " Affiliate " shall mean (a) any corporation which is required to be aggregated with the Company under Code Section 414(b), (c), (m), or (o) and (b) any other entity in which the Company has an ownership interest and which the Company designates as an Affiliate for purposes of the Plan.

1.2 " Cause " shall refer to a termination of an Eligible Employee's employment because of the Eligible Employee's (a) poor performance; (b) acts of unethical business activity, including but not limited to fraud, misappropriation, embezzlement, dishonesty, harassment, discrimination in violation of Employer policies, or willful or negligent destruction of property of an Employer or an Affiliate; (c) misconduct that is reasonably likely to cause material damage (monetary or otherwise) to the Employer, an Affiliate, or any personnel thereof; (d) conviction of or a plea of guilty or nolo contendere to any felony, whether or not any right to appeal has been or may be exercised; (e) negligence of duty; (f) insubordination; or (g) a violation of the Employer's policy, procedure, or practice.

1.3 " Code " shall mean the Internal Revenue Code of 1986, as amended.

1.4 " Eligible Employee " shall mean an individual who is employed by the Employer on a regular basis in a non-store position and has been employed by the Employer in any position for a minimum of twelve (12) months prior to the individual's separation of employment. For purposes of the Plan, distribution warehouse employees, field managers and employees employed by CVS ProCare, Inc. working at Company headquarters, shall be treated as working in a non-store location and therefore not subject to exclusion from eligibility. For purposes of the Plan, individuals in the following categories will not be considered Eligible Employees:

(a) individuals who are covered by a collective bargaining agreement, provided welfare benefits were the subject of good faith bargaining, unless the terms of the collective bargaining agreement provide for participation in the Plan;

(b) individuals who are seasonal employees, leased employees, independent contractors, temporary employees, or consultants;

(c) individuals who work for the Employer or an Affiliate in a store location of the Company or an Affiliate, or whose compensation is paid through or according to a store payroll, including but not limited to: pharmacists, store managers, assistant store managers, crew, and pharmacy staff;

(d) individuals employed by MinuteClinic, L.L.C. or by any practitioner-owned entity managed by MinuteClinic, L.L.C.;

(e) the President and CEO of CVS Health Corporation;

(f) individuals employed in Puerto Rico; and

(g) individuals employed outside the United States of America.

The decision of whether an individual falls into one of these categories and whether an individual is employed by an Employer on a regular basis in a non-store position for a minimum of 12 months shall be made by the Employer in its sole discretion. Any individual who is excluded from being considered an Eligible Employee under the Plan shall be excluded from the Plan regardless of the individual's reclassification by a government agency, including a reclassification by the Internal Revenue Service for tax withholding purposes.

1.5 " Employer " shall mean CVS Pharmacy, Inc. and Caremark Rx, L.L.C. and any current or future Affiliate thereof that does not maintain its own severance plan for employees of that Affiliate.

1.6 " ERISA " shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.7 " Exempt Employee " shall mean an Eligible Employee who is paid on a salaried basis for payroll purposes and classified in the sole discretion of the Employer under its normal classification procedures as an exempt employee under the Fair Labor Standards Act.

1.8 " Involuntary Termination " shall mean an Eligible Employee's termination of employment with the Employer due to the unilateral action of the Employer, including but not limited to a termination as a result of the elimination of an Eligible Employee's position due to a reorganization or changes in responsibilities, a reduction in force, or a closing of the business unit in which the Eligible Employee works; provided, however, that such Involuntary Termination constitutes a separation from service under Treasury Regulation Section 1.409A-1(h). Notwithstanding the foregoing, an Eligible Employee will not have an Involuntary Termination if the Eligible Employee: (a) is terminated for Cause, as determined by the Employer in its sole discretion; (b) voluntarily terminates employment or resigns prior to an Involuntary Termination; (c) takes a leave of absence; (d) is administratively terminated for failure to return from a leave of absence upon expiration of his or her leave; (e) terminates employment due to his or her death; (f) transfers to an Affiliate; (g) transfers to a new employer in connection with the sale of an Employer facility; or (h) fails to accept an offer for a job with the Employer that is comparable to the job that he or she is performing for the Employer at the time of the offer. For purposes of Subsection (h) of this Section 1.8, whether a job is considered "comparable" shall be determined in the sole discretion of the Employer, taking into account whether the new job is located 50 or fewer miles from the Eligible Employee's job at the time of the offer, whether the compensation offered is materially less than the Eligible Employee's compensation at the time of the offer, and whether the new job will result in a substantial change of duties from the Eligible Employee's job at the time of the offer. The determination of whether an Eligible Employee's termination of employment is an Involuntary Termination shall be made in the sole discretion of the Employer. If an Employer deems an Eligible Employee's termination of employment to be an Involuntary Termination and, Employer later learns of facts and circumstances that, had

the Employer known such facts and circumstances at the time of termination, would have resulted in a termination of employment for Cause, the Eligible Employee's termination shall be deemed as of the date of termination to not have been an Involuntary Termination.

1.9 " Non-exempt Employee " shall mean an Eligible Employee who is paid on an hourly basis for time worked and classified in the sole discretion of the Employer under its normal classification procedures as a non-exempt employee under the Fair Labor Standards Act.

1.10 " Plan Administrator " shall mean the Senior Vice President of Human Resources of CVS Pharmacy, Inc., or such other person designated to act as the Plan Administrator.

1.11 " Rehire Date " shall mean the date an Eligible Employee accepts reemployment with any Employer.

1.12 " Severance Pay " shall mean the pay an Eligible Employee is eligible to receive under Subsection (b) of Section 2.1 of the Plan upon his or her Involuntary Termination.

1.13 " Severance Period " shall mean the period of time during which an Eligible Employee is eligible to receive Severance Pay.

1.14 " Transaction-Related Termination " shall mean an Involuntary Termination, of an Eligible Employee in a Corporate/Shared Services function, that is deemed by the Plan Administrator, in his or her sole discretion, after consultation with the Employer, to have resulted from the Company's acquisition of Aetna, Inc., at any time during the period beginning with the date the acquisition closes and ending on the second anniversary of such closing date. For this purpose, a Corporate/Shared Services function shall exclude all functions in MinuteClinic, MinuteClinic IT, Omnicare, Specialty/Coram, Retail Merchandising, Retail & Pharmacy Growth, Retail Supply Chain, Retail Pharmacy Operations, Retail Stores & Field and in any other business unit that may be determined by the Plan Administrator from time to time, regardless of which Employer employs the Eligible Employee.

1.15 " Weekly Rate " shall mean, (a) with respect to an Eligible Employee paid on a salaried basis, an Eligible Employee's annual base salary (as determined by the Employer), as of the date of the Eligible Employee's Involuntary Termination, expressed on a weekly basis (as determined in the sole discretion of the Employer), and (b) with respect to an Eligible Employee paid on an hourly basis, the hourly wage rate of the Eligible Employee as of the date of the Eligible Employee's Involuntary Termination multiplied by the Eligible Employee's regularly scheduled number of hours of service per week (as determined by the Employer), not in excess of 40 hours. Weekly Rate shall exclude any overtime, incentive, and bonus payments, unless otherwise required by law.

1.16 " Year of Service " shall mean each full year of service performed by the Eligible Employee for an Employer as reflected in the records of the Employer and as determined as of the Eligible Employee's date of termination of employment, based on the Employer's policies and procedures for determining periods of service, and the applicable law.

ARTICLE 2
SEVERANCE PAY AND ELIGIBLE EMPLOYEE BENEFITS

2.1 (a) Eligibility . Upon his or her Involuntary Termination, an Eligible Employee may, in the discretion of the Plan Administrator, be granted Severance Pay and benefits provided under Subsections (b), (c), and (d) of this Section 2.1, provided the conditions of Section 2.2 are satisfied. The determination of whether Severance Pay is payable under the Plan, and the form and amount of such pay, shall be made in the sole discretion of the Plan Administrator.

(b) Severance Pay . The Severance Pay payable to an Eligible Employee in the event of Involuntary Termination shall be determined by the Plan Administrator in its sole discretion, using the following guidelines

for the applicable Eligible Employee classification:

(i) For Eligible Employees who are Non-exempt Employees:

(A) the Eligible Employee's Weekly Rate multiplied by two (2), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Non-exempt employees should not exceed the Eligible Employee's Weekly Rate multiplied by thirteen (13);

(ii) For Eligible Exempt Employees in grades 105-108, 201-203, 301, 302, 405-408:

(A) the Eligible Employee's Weekly Rate multiplied by four (4), plus,

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by twenty (20);

(iii) For Eligible Exempt Employees in grades 109-111, 204, 205, 303, 304, 409-411, the greater of

(A) the Eligible Employee's Weekly Rate multiplied by thirteen (13) or,

(B) the amount determined under the formula set forth in the immediately preceding Paragraph (ii), provided Severance Pay should not exceed the Eligible Employee's Weekly Rate multiplied by twenty (20);

(iv) For Eligible Exempt Employees in grades 112, 206, 305, 412, the Eligible Employee's Weekly Rate multiplied by twenty-six (26);

(v) For Eligible Exempt Employees in grades 36A-Z, the Eligible Employee's Weekly Rate multiplied by fifty-two (52); and

(vi) For Eligible Exempt Employees in grades 38A-Z and 39 A-Z, the Eligible Employee's Weekly Rate multiplied by fifty-two (52).

Notwithstanding the above guidelines, in the event of a Transaction-Related Termination of an Eligible Employee, Severance Pay shall be determined by the Plan Administrator in its sole discretion, using the following guidelines for the applicable Employee classification:

(1) For Eligible Employees who are Non-exempt Employees:

(A) the Eligible Employee's Weekly Rate multiplied by two (2), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the

number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Non-exempt employees should not exceed the Eligible Employee's Weekly Rate multiplied by thirty-one (31);

(2) For Eligible Exempt Employees in grades 105-108, 201-203, 301, 302, 405-408:

(A) the Eligible Employee's Weekly Rate multiplied by four (4), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by thirty-one (31);

(3) For Eligible Exempt Employees in grades 109-111, 204, 205, 303, 304, 409-411, the greater of (A) the Eligible Employee's Weekly Rate multiplied by thirteen (13) or, (B) the amount determined under the formula set forth in the immediately preceding Paragraph (2), provided Severance Pay should not exceed the Eligible Employee's Weekly Rate multiplied by forty-four (44);

(4) For Eligible Exempt Employees in grades 112, 206, 305, 412:

(A) the Eligible Employee's Weekly Rate multiplied by twenty-six (26), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by ninety-six (96);

(5) For Eligible Exempt Employees in grades 36A-Z, who have completed at least five (5) Years of Service:

(A) the Eligible Employee's Weekly Rate multiplied by fifty-two (52), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed in excess of four (4) Years of Service by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by ninety-six (96); and

(6) For Eligible Exempt Employees in grades 38A-Z and 39 A-Z:

(A) the Eligible Employee's Weekly Rate multiplied by seventy-eight (78), plus

(B) provided the Eligible Exempt Employee has completed at least five (5) Years of Service, an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed in excess of four (4) Years of Service by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by ninety-six (96).

Notwithstanding the above guidelines, the Plan Administrator may increase or decrease (including, to zero) the amount of Severance Pay with respect to any Eligible Employee for reasons it deems appropriate in its sole discretion (including, but not limited to, an increase to provide consideration for Eligible Employees who have outstanding employment agreements with an Employer or a decrease to take into account any debts owed to an Employer), at any time, whether before or after payments of Severance Pay have commenced.

(c) COBRA Assistance . In the event an Eligible Employee who has an Involuntary Termination (i) is eligible to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended ("COBRA") in accordance with the terms of the medical and prescription drug plan and/or dental plan of the Employer and (ii) properly and timely elects such continuation coverage, the Employer may pay for a portion of the cost of COBRA coverage equivalent to the contribution which the Employer makes on behalf of similarly situated active employees under such plan for the appropriate tier of coverage selected and in place immediately prior to the date of the Eligible Employee's Involuntary Termination (*e.g.* , employee-only, family coverage), for a period determined in the sole discretion of the Plan Administrator, which generally shall be the Severance Period but in any event no longer than eighteen (18) months from the date of the Involuntary Termination. Any COBRA assistance provided under this Subsection (c) shall be paid by the Employer directly to the insurance carrier, if applicable. The portion of the COBRA premium not covered by the COBRA assistance specified in this Subsection (c) must be paid by the Eligible Employee directly to the insurance carrier or service provider that administers COBRA, as applicable, based on the standard rules under the respective plan for payment of COBRA premiums. This Subsection (c) does not provide COBRA assistance in the event the Eligible Employee fails to properly and timely elect COBRA continuation coverage, regardless of whether his or her covered dependents elect COBRA continuation coverage.

(d) Outplacement Services . Upon an Involuntary Termination, the outplacement services provided to an Eligible Employee shall be provided in the sole discretion of the Plan Administrator based on the guidelines contained in this Subsection (d).

(i) If an Eligible Employee so desires, he or she may be eligible for outplacement services for assistance in obtaining new employment, provided through a vendor selected by the Employer, with the Employer directly providing payment to such vendor. The provision of outplacement services is contingent upon the Eligible Employee's cooperation with the outplacement service vendor, upon the active efforts of the Eligible Employee to locate a new position, and upon the Eligible Employee initiating outplacement services during the Severance Period.

(ii) Subject to the requirements of Paragraph (i) of this Subsection (d), outplacement services shall be offered for a period of time determined in the sole discretion of the Plan Administrator, based on guidelines that include:

(A) a virtual or group training session for Eligible Non-exempt Employees and Exempt Employees in grades 105-108, 201-203, 301, 302, 405-408;

(B) three (3) months of outplacement services for Eligible Exempt Employees in grades 109-112, 204-206, 303-305, 409-412; and

(C) six (6) months of outplacement services for Eligible Exempt Employees in grades 36A-Z, 38A-Z, and 39 A-Z;

provided, in no event shall such services extend beyond twelve (12) months following the Involuntary Termination of the Eligible Employee.

(e) Form and Timing of Payment . In the event an Eligible Employee is awarded Severance Pay

under the terms of Subsection (a) of this Section 2.1, such Severance Pay shall be paid following an Eligible Employee's Involuntary Termination (except as provided in Section 2.3, below), as follows: No Severance Pay shall commence (with respect to salary continuation payments) or be paid (with respect to a lump sum) (i) prior to the expiration of the later of a period that is identified in a separate agreement with the Eligible Employee during which he or she may consider the execution of the release of claims form (the "Consideration Period") or a period ending at least seven (7) days following the execution of the release of claims form (the "Revocation Period"), or (ii) later than sixty (60) days following the date of Eligible Employee's Involuntary Termination. Severance Pay that is paid in the form of salary continuation shall commence as soon as feasible following expiration of the later of the Consideration Period or the Revocation Period, which generally shall be the first regularly scheduled payroll date following the expiration of the Consideration Period or the Revocation Period, as the case may be, and shall thereafter be paid in substantially equal installments in accordance with the Employer's regular payroll practice, except as provided in Section 2.3 of the Plan. Further, in the Plan Administrator's sole discretion, Severance Pay may be paid to any Eligible Employees in a single lump sum, in which event Severance Pay shall be paid within the period that satisfies the 409A requirements for short-term deferrals under Section 409A of the Code.

(f) Withholding . Any payment of Severance Pay to an Eligible Employee shall be subject to normal withholding for state and federal income taxes and Social Security taxes.

(g) Death . Upon the death of the Eligible Employee who had an Involuntary Termination and who has not received all Severance Pay payable under the Plan, the Severance Pay otherwise payable under Section 2.1(b) of the Plan shall be paid in the form of a lump sum to the Eligible Employee's estate or beneficiary as soon as practicable, but in no event later than 60 days following death. Any other severance benefits provided under this Section 2.1 (COBRA assistance and outplacement services) shall cease upon the Eligible Employee's death.

2.2 Conditions on Payment of Severance Pay and Benefits . Payment of the Severance Pay and benefits provided in Section 2.1 of the Plan shall be subject to and conditioned upon the following:

(a) to the extent an Eligible Employee receives notice of a date selected by the Employer (in its sole discretion) on which the Eligible Employee's Involuntary Termination shall occur (a "Designated Termination Date"), the Eligible Employee must continue to work in a satisfactory manner until his or her Designated Termination Date;

(b) the Eligible Employee must cooperate in transitioning all of the Eligible Employee's work in consultation with the Eligible Employee's supervisor or other designated employee;

(c) the Eligible Employee must execute and deliver a release of claims form (in the form specified by the Employer from time to time which may include restrictive covenants and, if applicable, a waiver as described in Subsection (d) of this Section 2.2) within the time period specified under the terms of the applicable severance offer. Further, in no event will Severance Pay be paid with respect to an Eligible Employee in the event the release of claims form is revoked during the Revocation Period (described in Section 2.1(e) of the Plan); and

(d) the Eligible Employee must waive the right to receive any other severance payment relating to salary continuation or salary replacement the Eligible Employee may otherwise be eligible to receive upon termination of employment under any employment agreement, severance plan, practice, policy or program of the Employer or an Affiliate.

2.3 Maximum Severance Pay . Notwithstanding any other provisions to the contrary, benefits paid hereunder (a) shall not exceed two times the lesser of (i) the Eligible Employee's Compensation (as defined in this Section 2.3) during the calendar year immediately preceding the Eligible Employee's Involuntary Termination

or (ii) the maximum amount that may be taken into account under a qualified plan pursuant to Section 401(a)(17) of the Code for the calendar year in which the Eligible Employee's Involuntary Termination occurs and (b) shall be paid in full within twenty-four (24) months after the date the Eligible Employee's Involuntary Termination occurs. In the event that any Severance Pay payable to an Eligible Employee would exceed the twenty-four (24) month period provided in the foregoing sentence if the Severance Pay continued to be paid in accordance with the Employer's regular payroll practice, any Severance Pay that would otherwise exceed the twenty-four (24) month time period will be paid to the Eligible Employee in a lump sum on the last regular payroll date within the twenty-four (24) month period. For purposes of this Section 2.3, "Compensation" shall mean the Eligible Employee's total annualized compensation, based upon the annual rate of pay for services provided to the Employer for the calendar year preceding the calendar year in which the Eligible Employee's Involuntary Termination occurs, adjusted for any increase in such preceding calendar year that was expected to continue indefinitely if the Eligible Employee had not had an Involuntary Termination.

2.4 Cessation of Severance Pay Upon Reemployment . If an Eligible Employee who had an Involuntary Termination and who is receiving Severance Pay thereafter accepts reemployment with any Employer during the Severance Period, such Employee's Severance Pay shall cease on the Rehire Date and any remaining Severance Pay shall be forfeited.

2.5 Cessation of Severance Pay After Commencement of Payments . If an Eligible Employee is deemed to have an Involuntary Termination and begins to receive Severance Pay under the Plan and the Employer or the Plan Administrator becomes aware of facts and circumstances that, had the Employer known same at the time of the Eligible Employee's termination of employment, would have affected the Employer's determination as to whether such Employee's termination was an Involuntary Termination, the Plan Administrator may suspend any future Severance Pay payments to the Eligible Employee while the Employer investigates the facts and circumstances and finalizes such investigation, and, if the Employer determines that the Eligible Employee should have been terminated for Cause, such Eligible Employee's Severance Pay shall cease as of the suspension date, any remaining Severance Pay shall be forfeited and any Severance Pay that has been paid shall be subject to repayment by the Eligible Employee.

2.6 Impact of Debt on Severance Pay . In the event an Eligible Employee is indebted to the Company or Employer (determined in the sole discretion of the Company or Employer, as applicable), the Plan Administrator reserves the right to reduce, offset, withhold, and/or forfeit the Severance Pay otherwise payable under the Plan.

2.7 Employee Benefits . As of the date of an Eligible Employee's Involuntary Termination, the Eligible Employee's active participation in any benefit plan, program, or policy sponsored or subsidized by the Employer shall cease, unless otherwise continued pursuant to the terms of such plan, program or policy.

2.8 Awards . Any award or grant made to the Eligible Employee under any stock option, stock purchase, or stock appreciation rights plan of the Company or Employer shall be administered and interpreted in accordance with the terms of the applicable plan documents.

2.9 Paid Time Off . Any pay for accrued paid time off shall be determined under the terms of the Employer's applicable policies.

2.10 Benefits Not Vested . No one under any circumstance is automatically entitled to Severance Pay and benefits described in Section 2.1 of the Plan. Notwithstanding anything in the Plan to the contrary, the Plan Administrator reserves the right, at its sole discretion, to increase, decrease, or eliminate Severance Pay and benefits under the Plan.

2.11 Bonuses . Whether any bonuses are payable to an Eligible Employee shall be determined based on the terms of any applicable bonus program, plan, or policy.

ARTICLE 3
ADMINISTRATION OF THE PLAN

3.1 Control and Administration . Notwithstanding any other provision in the Plan, and to the full extent permitted under ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and final authority, in its sole and absolute discretion, to administer, apply, construe and interpret the terms of the Plan and all related plan documents and all facts surrounding claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that an Eligible Employee is entitled to benefits, and the Plan Administrator shall decide all questions regarding the form, amount and duration of benefits. The Plan Administrator may consult with attorneys, consultants and other persons for advice, counsel and reports to make determinations under the Plan, and the Plan Administrator may delegate its administrative duties and responsibilities to persons or entities of its choice, in all cases who may be employees of the Company. All determinations of the Plan Administrator shall be conclusive and binding on all parties. The Plan Administrator shall be the named fiduciary of the Plan for purposes of ERISA.

3.2 Claim Procedures .

(a) Procedure for Granting or Denying Claims . An Eligible Employee, or his or her duly authorized representative, may file a claim for payment of benefits under the Plan within 30 days after termination of employment. Such a claim must be made in writing and be delivered to the Plan Administrator, in person or by mail, postage paid. Within 90 days after receipt of such claim, the Plan Administrator shall notify the claimant of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 90 days from the end of the initial 90-day period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 90-day period. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part.

(b) Requirement for Notice of Claim Denial . The Plan Administrator shall provide to every claimant who is denied a claim for benefits a written or electronic notice setting forth in a manner calculated to be understood by the claimant:

(i) The specific reason or reasons for the denial;

(ii) Specific reference to pertinent Plan provisions on which the denial is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and

(iv) An explanation of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

(c) Right to Appeal on Claim Denial . Within 60 days after receipt by the claimant of written or electronic notification of the denial (in whole or in part) of his or her claim, the claimant or his or her duly authorized representative may make a written application to the Plan Administrator, in person or by certified mail, postage prepaid, to be afforded a full and fair review of such denial. The claimant or his or her duly authorized representative may submit written comments, documents, records, and other information relating to the claim for benefits. Moreover, the claimant or his or her duly authorized representative shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(d) Disposition of Disputed Claims . Upon receipt of a request for review, the Plan Administrator shall make a decision on the claim. The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The decision on review shall be made not later than 60 days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than 120 days after receipt of the request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial 60-day period.

The Plan Administrator shall provide the claimant or his or her duly authorized representative with written or electronic notification of the Plan's determination on review. In the case of an adverse determination, the notification shall set forth, in a manner calculated to be understood by the claimant, the specific reason or reasons for the decision as well as specific references to the Plan provisions on which the decision was based. The decision shall also include a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Moreover, the decision shall contain a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

3.3 Conditions to Legal Action. No legal action may be commenced or maintained against the Plan, the Company or any Employer prior to the claimant's exhaustion of the claims procedures set forth in Section 3.2 of the Plan. In addition, no legal action may be commenced against the Plan more than ninety (90) days after the Plan Administrator's final claim determination on review pursuant to Section 3.2(d) of the Plan. Any legal action must be conducted in the United States District Court for Rhode Island.

3.4 Named Fiduciary . The Plan Administrator of the Plan shall be the Named Fiduciary of the Plan for purposes of ERISA Section 402(a)(1).

ARTICLE 4
MISCELLANEOUS

4.1 Amendment or Termination . The Plan may be amended, terminated, withdrawn or suspended at any time in writing by the Management Planning and Development Committee of the Company or any individual designated by such Committee to take such actions.

4.2 Choice of Law . The validity, interpretation, construction and performance of the obligations created under the Plan shall be governed by ERISA, and to the extent not preempted by federal law, the laws of the State of Rhode Island without regard to its conflicts of law principles.

4.3 Validity . The invalidity or unenforceability of any provision of the Plan shall not affect the validity or enforceability of any other provision of the Plan, which shall remain in full force and effect.

4.4 Plan Exclusive Source of Rights . The Plan contains all of the terms and conditions with respect to the benefits provided hereunder, and no Eligible Employee or former Eligible Employee may rely on any other communication or representation, whether oral or written, of the Employer or any of its subsidiaries, or any officer or Eligible Employee thereof, as creating any right or obligation not expressly provided by the Plan.

4.5 Nonassignability . No benefit which shall be payable under the Plan to any Eligible Employee shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge (except as required by law), and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge a benefit shall be null and void. No benefit shall in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any Eligible Employee. No benefit shall be subject to legal attachment or legal process for, or against, the Eligible Employee and the same shall not be recognized under the Plan. Notwithstanding

the preceding sentence, the Employer retains the discretion, in accordance with federal and/or state laws, to reduce the amount of benefits payable under the Plan to any Eligible Employee to recover any amounts that the Eligible Employee owes to the Employer.

4.6 No Employment Rights . The Plan shall not give any Eligible Employee any right or claim except to the extent that the right is specifically provided under the terms of the Plan. The establishment of the Plan shall not be construed (a) to give any Eligible Employee a right to continue in the employ of the Employer or (b) to interfere with the right of the Employer to terminate the employment of any Eligible Employee at any time.

4.7 Headings. Article and section headings are for convenience only and the language of the Plan itself will be controlling.

4.8 Gender and Numbers . Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

4.9 Code Section 409A . The benefits provided under the terms of the Plan are intended to fall within the short-term deferral exception, the separation pay exception or another exception to the application of Section 409A of the Code and the applicable guidance issued thereunder. In furtherance of this intent, the Plan shall be interpreted, operated and administered in a manner consistent with this intention. To the extent the benefits provided under the Plan become subject to Code Section 409A and applicable guidance issued thereunder, the Plan shall be construed, and benefits paid hereunder, as necessary to comply with Section 409A of the Code and such guidance. Further, to the extent that an Eligible Employee becomes entitled to receive Severance Pay under the terms of the Plan, and, at the time of the Eligible Employee's Involuntary Termination, he or she is a "specified employee" within the meaning of Treasury Regulation Section 1.409A- 1(i), any portion of Severance Pay payable to such Eligible Employee that is subject to Code Section 409A and applicable guidance thereunder shall be delayed until the date that is the earlier of (i) the Eligible Employee's death or (ii) six months following the date of the Eligible Employee's Involuntary Termination, at which time the payments that were delayed for such six month period shall be paid in a lump sum on the date of the next occurring regular payroll date of the Employer, and any remaining payments shall be paid according to the original schedule provided herein. In addition, each payment of a salary continuation stream of installment payments hereunder shall be a separate payment for purposes of Section 409A of the Code.

4.10 Funding . The Plan is not funded, and Severance Pay and benefits under the Plan are paid from the general assets of the Employer.

4.11 Plan Year. The Plan's records shall be maintained on the basis of the calendar year.

IN WITNESS WHEREOF, the Management Planning and Development Committee of the Company, or its duly authorized delegate, has amended the Plan as of the Effective Date pursuant to the execution hereof on its behalf by a duly authorized officer on .

CVS HEALTH CORPORATION

By: /s/ Lisa G. Bisaccia
Title: Executive Vice President and Chief Human Resources Officer, CVS Pharmacy, Inc.

Exhibit 10.38

CVS Health Corporation
Performance-Based Restricted Stock Unit Program

I. Objectives and Summary

The objective of the CVS Health Corporation (the "Company") Performance-Based Restricted Stock Unit Plan ("PBRS Plan") is to reward eligible participants for their role in achieving the Company's Earnings before Interest and Taxes ("EBIT") target and to encourage continued employment with the Company and its subsidiaries. PBRS Awards are generally delivered as restricted stock units ("RSUs") and are based on actual results measured against pre-established targets.

II. Administration

The PBRS Plan shall be administered by the Management Planning and Development Committee (the "Committee") of the Board of Directors, or its designee, under the provisions of the 2017 Incentive Compensation Plan or any successor plan (the "ICP"). The Committee shall have full and final authority, in each case, subject to and consistent with the provisions of the ICP and the PBRS Plan, to construe and interpret rules and regulations for the administration of the PBRS Plan, correct defects, supply omissions or reconcile inconsistencies therein, and to make all other decisions and determinations as the Committee may deem necessary or advisable for the administration of the PBRS Plan. Capitalized terms not otherwise defined herein shall have the meaning assigned to such terms in the ICP. In the event of a conflict between the ICP and the PBRS Plan, the provisions of the ICP shall control.

III. PBRS Plan Year

The "PBRS Plan Year" commences on January 1 and ends on December 31 of each year, unless otherwise approved by the Committee. All dates in this document occur during the current PBRS Plan Year unless otherwise stated.

IV. Eligibility

A. Eligible Employees

The Chief Executive Officer (the "CEO") or the CEO's designee determines those employees of the Company and its subsidiaries who are eligible to participate in the PBRS Plan ("Eligible Employees"). In general, Eligible Employees are those employees who are (i) officers of CVS Pharmacy, Inc. who are Vice Presidents or above, and (ii) senior officers of other subsidiaries who have been designated as Eligible Employees by the CEO or his or her designee. Generally, Business Planning Committee ("BPC") members are not eligible to participate, unless otherwise named as an Eligible Employee by the Committee.

B. Newly-Hired Eligible Employees

A newly-hired employee satisfying the requirements set forth in Paragraph IV.A is an Eligible Employee and may receive a PBRS Award for the PBRS Plan Year in which he or she is hired provided he or she is hired on or before November 1 and remains in an Eligible Employee position through December 31 of the PBRS Plan Year.

C. Participants

Unless the Committee is required to make such determinations under applicable law or the ICP, the CEO or the CEO's designee shall determine which Eligible Employees will receive an award under the PBRS Plan (a "PBRS Award"). All such determinations, whether by the CEO, the CEO's designee, or the Committee, with respect to a PBRS ("Plan Year") shall be made no later than the last business day of February immediately

following the PBRS Plan Year (the "PBRS Award Date"). Each Eligible Employee who receives a PBRS Award is a "Participant". No Eligible Employee has any right to receive a PBRS Award, regardless of whether such Eligible Employee is employed on the last day of the PBRS Plan Year, and the determination of whether an Eligible Employee will be a Participant shall be made in the sole discretion of the CEO, the CEO's designee or the Committee, as the case may be.

D. Status Changes

(i) **Promotions** . An employee who is promoted on or before November 1 of the PBRS Plan Year to a position satisfying the requirements set forth on Paragraph IV.A is an Eligible Employee and may receive a PBRS Award for the year in which the promotion occurs.

(ii) **Demotions:** An Eligible Employee who is demoted after November 1 of the PBRS Plan Year to a position not satisfying the requirements set forth on Paragraph IV.A will remain an Eligible Employee and may receive a PBRS Award provided such demotion is not the result of voluntarily transfer to a lower level position, is not related to unsatisfactory performance, and is not as a result of a violation of a Company policy or Code of Ethics.

(iii) **Termination of Employment**

a) **In General.** Except as provided in sub-paragraph (b) below, if for any reason the employment of an Eligible Employee with the Company and any subsidiary of the Company terminates during a PBRS Plan Year, the Eligible Employee will not receive a PBRS Award for that PBRS Plan Year.

b) **Death or Disability** . If an Eligible Employee dies or commences a long-term disability (as defined in the either Company's long-term disability plan or by the Social Security Administrator, as determined by the "Committee") during a PBRS Plan Year, the Eligible Employee may receive a PBRS Award at the same time PBRS Awards are made to other Participants. Such PBRS Award will be pro-rated for the number of full months (a partial month will be counted as a full month) during which the Eligible Employee was an active employee based on a full calendar year and will (unless otherwise determined by the CEO or the Committee) be paid in cash based on the Eligible Earnings of the Eligible Employee as of the time of death or commencement of long-term disability. PBRS Awards with respect to deceased Eligible Employees shall be paid to the Eligible Employee's Beneficiary.

The decision to pay a pro rata or full award to an Eligible Employee who terminates employment with the Company and its subsidiaries prior to the PBRS Award Date for any reason other than death or long-term disability, as defined above in this section, will be at the sole discretion of the CEO or the Committee (as the case may be).

V. PBRS Funding

A. Consolidated Company Funding

PBRS funding is based on consolidated Company performance, measured by Earnings before Interest and Taxes (EBIT), and modified by customer service and client satisfaction measurements. Achievement of the Company's EBIT target and modifiers will determine the total funding (the "Total Pool").

EBIT may be adjusted by the financial adjustments as approved by the Committee prior to the end of the first fiscal quarter of the Plan Year (the "Financial Adjustments"). If EBIT is below the minimum performance threshold, no formulaic funding will be made available for awards, regardless of PBRS modifier metrics performance, and there shall be no awards paid under the PBRS.

B. Total Pool Funding

After the minimum threshold for EBIT has been achieved, performance of PBRS modifiers to target will be calculated for the Plan Year. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The CEO may, for any reason and in his or her sole discretion, adjust the funding of the Total Pool based on (a) input from senior Company executives regarding their assessment of the overall performance of the Company; and (b) assessment of the achievement of Plan Year performance goals. In no case, however, can the CEO or the Committee increase Total Pool funding due to the results of the PBRS modifiers.

C. Individual Performance

The Total Pool will be available for award to Eligible Employee's under the PBRS, taking into account the individual contribution of each Eligible Employee. The award, if any, for an Eligible Employee shall be determined in the sole discretion of the Company, which shall be final, binding and conclusive as to all parties having an interest therein.

VI. Plan Payout

A. Target PBRS Award

The target PBRS award for each Employee is 25% of "Eligible Earnings" (defined below) while in a PBRS Eligible position for the PBRS Plan Year. Eligible Earnings will be multiplied by the 25% target opportunity of the Eligible Participant.

Eligible Earnings include reoccurring items such as pay earned for hours worked, paid time off (e.g. vacation, sick, holiday, funeral, jury duty, military) but will exclude one-time payments such as annual cash incentives, commissions and similar payments, and earnings associated with equity releases and stock option exercises.

B. PBRS Award Determination and Vesting

After the achievement of at least threshold for Operating Profit has been confirmed, performance of modifiers compared to target for the Plan Year will be calculated. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The approved PBRS Award is generally payable in RSUs. The number of RSUs that the Participant will receive is equal to the PBRS Award divided by the closing price of Company common stock on the PBRS Award Date.

C. Vesting

The RSUs issued in respect of any PBRS Award will vest in accordance with and subject to the terms and conditions of the ICP and the applicable agreement for each PBRS Award. PBRS Awards unvested as of a Participant's termination of employment shall be governed by the terms and conditions of the applicable agreement for each PBRS Award and the PBRS Plan in effect at the time of grant of each award.

VII. Plan Administration

A. Employment Rights

The PBRS Plan does not create any express or implied contract of employment between the Company and an Eligible Employee or any other person. Both the Company and an Eligible Employee (whether or not a Participant) retain the right to terminate the employment relationship at any time and for any reason.

B. Rights are Non-Assignable

Neither a Participant nor any beneficiary nor any other person shall have any right to assign the right to receive payments hereunder, in whole or in part, which payments are non-assignable and non-transferable, whether voluntarily or involuntarily.

C. Change in Control

In the event of a Change in Control, the PBRS Plan shall remain in full force and effect. Any modifications to or dissolution of the PBRS Plan by the acquiring entity may only occur prospectively and will not affect entitlements, awards or eligibility before the date of the Change in Control.

D. Plan Amendment/Modification/Termination

The Company retains the right to amend, modify, or terminate the PBRS Plan for any reason and at any time on or before December 31 of the PBRS Plan Year, with or without notice to Eligible Employees or any other person. No representative of the Company or its subsidiaries has the authority to modify the terms of that PBRS Plan without written consent of the Chief Human Resources Officer or his or her designee.

E. Withholding

The Company may provide for the withholding from any benefits payable under the PBRS Plan all federal, state, city or other taxes as shall be required pursuant to any law or governmental regulation or ruling.

F. Section 409A of the Code

The Company intends that the PBRS Plan not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and the regulations and guidance thereunder (collectively, "Section 409A") and that to the extent any provisions of the PBRS Plan do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. In all events, the provisions of CVS Health Corporation's Universal 409A Definitions Document are hereby incorporated by reference and, notwithstanding any other provision of the Plan or any Award to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh month immediately following the date of termination of employment. For purposes of any provision of the PBRS Plan providing for the payment of any amounts or benefits in connection with a termination of employment, references to an Eligible Employee's "termination of employment" (and corollary terms) shall be construed to refer to the Eligible Employee's "separation from service" with the Company as determined under Section 409A.

G. Request for Plan Interpretation

Any dispute or request for interpretation of any provision in the PBRS Plan must be submitted to the appropriate Human Resources Business Partner by the Eligible Employee or his or her manager in writing.

H. Compliance with Applicable Regulations

In order to be eligible to receive a PBRS Award under the PBRS Plan, a Participant must comply with all applicable state and federal regulations and Company policies.

I. Governing Law

The validity, construction and effect of the PBRS Plan, and any rules and regulations under the Plan shall be determined in accordance with Delaware law, without giving effect to principles of conflicts of laws, and applicable federal law.

J. Recoupment

Except as may be specifically provided in the PBRS Award, each PBRS Award under the PBRS Plan shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive under the PBRS Plan.

Exhibit 10.39

CVS HEALTH CORPORATION
NONQUALIFIED STOCK OPTION AGREEMENT

GRANT DATE: [_____]

1. **GRANT OF AWARD** . Pursuant and subject to the provisions of the 2017 Incentive Compensation Plan of CVS Health Corporation (the " **ICP** "), on the date set forth above (the " **Grant Date** "), CVS Health Corporation (the " **Company"**) has granted and hereby evidences the Grant to the person named below (the " **Participant** "), subject to the terms and conditions set forth or incorporated in this Nonqualified Stock Option Agreement (" **Agreement** "), the right, and option, to purchase from the Company the aggregate number of shares of Common Stock ($.01 par value) of the Company (" **Shares** ") set forth below, at the purchase price indicated below (the " **Option** "), such Option to be exercised as hereinafter provided. The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. The Option is a nonqualified option as defined in the ICP.

Participant:	**[_____]**
Employee ID:	**[_____]**
Shares:	**[_____]**
Option Price:	**[_____]**

2. **TERM OF OPTION** **.** The term of this Option shall be for a period of seven (7) years from the Grant Date, subject to the earlier termination of the Option, as set forth in the ICP and in this Agreement. No portion of the Option shall be exercisable after the term of the Option.

3. **EXERCISE OF OPTION** **.** (a) The Option, subject to the provisions of the ICP, shall be exercised by submitting a request to exercise to the Company's stock option administrator, in accordance with the Company's current exercise policies and procedures, specifying the number of Shares to be purchased, which number may not be less than one hundred (100) Shares (unless the number of Shares purchased is the total balance which is then exercisable). An exercise by Participant of all or part of this Option shall be effected through the Company's "cashless exercise" procedures. Otherwise, at the time of exercise, Participant shall tender to the Company cash or cash equivalent for the aggregate option price of the Shares Participant has elected to purchase or certificates for Shares of Common Stock of the Company owned by Participant for at least six (6) months with a fair market value at least equal to the aggregate option price of the Shares Participant has elected to purchase, or a combination of the foregoing.

(b) Prior to its expiration or termination and except as otherwise provided herein, the Option will become vested in accordance with the vesting schedule set forth below, each date on which vesting occurs a " **Vesting Date** ", and any vested Option will be exercisable by Participant prior to the expiration of its term so long as Participant has maintained continuous employment with the Company or a subsidiary of the Company from the Grant Date through the exercise date:

(i) 25% of the Option shall vest on the 1st anniversary of the Grant Date.
(ii) 25% of the Option shall vest on the 2nd anniversary of the Grant Date.
(iii) 25% of the Option shall vest on the 3rd anniversary of the Grant Date.
(iv) 25% of the Option shall vest on the 4th anniversary of the Grant Date.

4. **TAXES .** Upon a cashless exercise of the Option the Company shall withhold from the proceeds of the exercise of the Option any required taxes. If the Option is exercised other than through a cashless exercise Company shall have the right to require Participant to pay the amount of any withholding taxes immediately, upon notification from the Company, before the proceeds from the exercise of the Option are delivered to Participant. Furthermore, the Company may elect to deduct such taxes from any other amounts then payable to Participant in cash or in Shares or from any other amounts payable any time thereafter to Participant to the extent allowed under applicable law.

5. **NON-TRANSFERABILITY .** The Option shall not be transferable by Participant other than by will or by the laws of descent and distribution, and during Participant's lifetime shall be exercised only by the Participant during the continuance of Participant's employment with the Company and any of its subsidiaries.

6. **FORFEITURE OF OPTION UPON TERMINATION OF EMPLOYMENT** . Unless otherwise provided for in the ICP or in this Agreement, as of the date on which Participant's employment with the Company and its subsidiaries terminates, the Option, to the extent unexercised as of the employment termination date, shall be forfeited immediately in its entirety, provided that, if the Participant's employment with the Company and its subsidiaries terminates without Cause, the Option, to the extent vested and unexercised, shall be exercisable at any time on or before the ninetieth (90 th) day immediately following the employment termination date and, to the extent unvested, shall be forfeited immediately.

7. **TERMINATION OF PARTICIPANT'S EMPLOYMENT WITHOUT CAUSE.** In the event that Participant's employment with the Company and its subsidiaries is terminated without Cause and Participant receives severance pay following Participant's employment pursuant to a written agreement, vesting of the Option shall continue through the end of the severance period set forth in the agreement providing for such severance pay. To the extent vested, the Option shall be exercisable at any time during the severance period and on or before the ninetieth (90th) day following the last day of the severance period, as long as no government regulations or rules are violated by such continued vesting or exercise period; provided, however, that in no event will the Option be exercisable beyond its original term. Any portion of the Option not vested as of the last day of the severance period shall be forfeited as of the last day of the severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting.

8. **RETIREMENT OF PARTICIPANT .** In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a Qualified Retirement, Participant (a) shall continue to vest in the Option, to the extent unvested as of the retirement date, for a period of three (3) years following Participant's retirement date and (b) may exercise the Option, to the extent vested, at any time within the period of three (3) years following Participant's retirement date, but not beyond the original term of the Option, in both cases as long as no government regulations or rules are violated by such continued vesting or exercise period. To the extent unvested or unexercised at the end of the three (3) year period following Participant's retirement date, the Option shall be forfeited. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 8 shall apply with respect to the vesting and exercise of the Option as of the Participant's employment termination date. " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 13 below, of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above during the severance period set forth in a severance agreement with the Company.

9. DISABILITY OF PARTICIPANT . In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the Option shall vest as of the employment termination date on a pro-rata basis as follows: the Option shall vest with respect to a total number of Shares as of the employment termination date (which is the last day that Participant is employed by the Company and any subsidiary of the Company) equal to (i) the number of Shares subject to the Option on the Grant Date *multiplied* by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the employment termination date since the Grant Date and (B) the denominator shall be forty-eight (48), *minus* (ii) the number of Shares with respect to which the Option vested prior to the employment termination date (whether or not the Option was previously exercised). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the employment termination date is eight months and five days, the numerator in sub-section (A) above shall be nine **.** The Option may be exercised to the extent vested at any time within one (1) year of Participant's employment termination date but not beyond the original term of the Option. The prorated Option shall vest on the Participant's employment termination date.

10. DEATH OF PARTICIPANT . In the event of Participant's death while Participant is employed with the Company and any subsidiary of the Company, the Option shall immediately vest in full, and the Option shall remain exercisable for a period of one (1) year after Participant's death, or until the Option expiration date, whichever occurs first, by Participant's Beneficiary. At the end of said one (1)-year time period, all rights with respect to any Option that is unexercised shall terminate and the Option shall be cancelled.

11 . TRANSFER OF EMPLOYMENT . Transfer of Participant's employment from the Company to a subsidiary of the Company, among or between subsidiaries of the Company, or from a subsidiary of the Company to the Company shall not be treated as termination of employment.

12. REQUIRED ACCEPTANCE OF AWARD. The Option may not be exercised unless and until the Company has received the Participant's acceptance of the terms and conditions set forth herein. Acceptance shall be submitted electronically as required by the Company.

13. NOTICE . Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to Participant at his or her address as shown on the records of the Company, subject to the right of either party hereafter to designate in writing to the other some other address.

14. RECOUPMENT OF OPTION AWARD . The Option subject to this Agreement under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that a copy of the Company's Recoupment Policy has been made available for the Participant's reference.

15. COMMITTEE AUTHORITY . The Committee shall have the authority, in its sole discretion, to make any interpretations, determinations, and/or take any administrative actions with respect to the ICP and this Agreement, including whether any post-termination payments to Participant shall be deemed severance pay, the duration of any severance period, and/or whether a termination was without cause.

16. GOVERNING LAW . This Nonqualified Stock Option Agreement and the Option evidenced hereby shall be governed by the laws of Delaware, without giving effect to principles of conflict of laws.

17. ACKNOWLEDGEMENT. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 10.40

CVS HEALTH CORPORATION
RESTRICTED STOCK UNIT AGREEMENT - ANNUAL GRANT

GRANT DATE : **[_____]**

1. Pursuant and subject to the provisions of the 2017 Incentive Compensation Plan of CVS Health Corporation (the " **ICP** "), on the date set forth above (the " **Grant Date** "), CVS Health Corporation (the " **Company** ") has awarded and hereby evidences the Restricted Stock Unit (" **RSU** ") award (the " **Award** ") to the person named below (the " **Participant** "), subject to the terms and conditions set forth and incorporated in this Restricted Stock Unit agreement (the " **Agreement** "). The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. On the Grant Date specified above, the Fair Market Value (the "FMV"), which is the Closing Price of the Company's common stock on the Grant Date, of each RSU equals **[_____]** .

Participant:	**[_____]**
Employee ID:	**[_____]**
RSUs (#):	**[_____]**

2. Each RSU represents a right to a future payment of one share (" **Share** ") of Common Stock ($0.01 par value) of the Company, subject to required tax withholding.

3. (a) To the extent dividends are paid on Shares while the RSUs remain outstanding, subject to Section 5(b), a cash amount equivalent to the dividends paid (such cash amount, a "Dividend Equivalent") with respect to the number of Shares covered by the RSUs shall accrue. Any accrued Dividend Equivalent shall be payable only upon vesting of the underlying RSUs. To the extent that the underlying RSUs do not vest hereunder, any related accrued Dividend Equivalent shall be forfeited.

   (b) Participant hereby agrees that the Company may withhold from the Dividend Equivalents, referred to in Paragraph 3(a) above, amounts sufficient to satisfy the applicable tax withholding in respect of such Dividend Equivalents.

4. Subject to the terms and conditions of the ICP and this Agreement and subject to Participant's continued employment, Participant shall be entitled to receive (and the Company shall deliver to Participant) (a) the Shares on the Vesting Date set forth herein, or as soon as administratively practicable, but within 30 days thereafter, unless delivery of the Shares has been deferred in accordance with Section 5 below (the date of such delivery of the Shares being hereafter referred to as the " **Settlement Date** ") and (b) the Dividend Equivalents on the Vesting Date(s) set forth herein, or as soon as administratively practicable but within 30 days thereafter. The " **Vesting Date** ," except as otherwise provided in Section 7, shall be the fourth anniversary of the Grant Date.

5. (a) In accordance with rules promulgated by the Management Planning and Development Committee of the Board of Directors (the " **Committee** "), Participant, to the extent eligible under the CVS Health Deferred Stock Compensation Plan, may elect to defer delivery of Shares in settlement of RSUs covered by this Agreement. Any such deferred delivery date elected by Participant shall become the Settlement Date for purposes of this RSU Agreement.

(b) Notwithstanding Section 3(a), to the extent dividends are paid on such deferred Shares following the Vesting Date and prior to the Settlement Date, Participant shall be entitled to receive a number of additional deferred Shares equal to: (x) the amount of dividend per Share as declared by the Company's Board of Directors on the Company's common stock multiplied by (y) the number of deferred Shares held by Participant on the record date of such dividend, divided by (z) the FMV of a Share on such dividend payment date.

6. On the Settlement Date the number of Shares to be delivered by the Company to Participant shall be reduced by the smallest number of Shares having a FMV at least equal to the dollar amount of federal, state and local tax withholding required to be withheld by the Company with respect to such RSUs on such date.

7. (a) Except as provided in Paragraphs 7 (b) - (f) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all RSUs not then vested in accordance with Section 4 above shall be immediately forfeited.

(a) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, RSUs not then vested in accordance with Section 4 will become immediately vested and the Vesting Date shall be the date of death.

(b) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a "Qualified Retirement", RSUs shall vest on a pro-rata basis as of the Participant's retirement date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company, as follows: the total number of RSUs vesting as of the retirement date shall be equal to (i) the number of RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the retirement date since the Grant Date and (B) the denominator shall be forty-eight (48). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the retirement date is eight months and five days, the numerator in sub-section (A) above shall be nine. " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 10 below, of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above during the severance period set forth in a severance agreement with the Company. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 7(c) or the terms of Section 7(e), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. Any Shares represented by the pro-rated RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(d) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the RSUs shall vest as of the employment termination date on a pro rata basis as follows: the total number of RSUs vested as of the termination date, which is the last date that the Participant is employed by the Company and any subsidiary of the Company, shall be equal to the number of RSUs granted on the Grant Date multiplied by

the following fraction: (A) the numerator shall be the whole number of months elapsed as of Participant's termination date since the Grant Date and (B) the denominator shall be forty-eight (48). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is eight months and five days, the numerator in sub-section (A) above shall be nine. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(e) In the event Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay, RSUs not vested at the time of Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall continue to vest during the severance period and settle in accordance with the original schedule set forth in Section 4 of this RSU Agreement. All RSUs not scheduled to vest during the specified severance period shall be forfeited as of the last day of the Participant's severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period specified in a severance agreement with the Company, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting. In the event Participant's termination of employment qualifies as a Qualified Retirement the terms of this Section 7(e) or the terms of Section 7(c), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. During any severance period, Participant is eligible to accrue Dividend Equivalents on outstanding RSUs as described in Paragraph 3(a) above.

(f) Notwithstanding the above, (i) the provisions of Section 10 of the ICP shall apply in the event of a Change in Control (as defined in such Section 10) and (ii) the provisions of Section 7(e)(iv) of the ICP shall apply.

(g) For purposes of this Section 7, transfer of Participant's employment from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, or transfer from a subsidiary of the Company to the Company shall not be treated as a termination of employment.

(h) Participant will be responsible for any applicable withholding or other taxes that may become due as a result of RSUs that vest as of Participant's employment termination date or thereafter.

8. An RSU does not represent an equity interest in the Company and carries no voting rights. Participant shall have no rights of a shareholder with respect to the RSUs until the Shares have been delivered to Participant.

9. Neither the execution and delivery hereof nor the granting of the Award evidenced hereby shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

10. Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

11. All decisions and interpretations made by the Board of Directors or the Committee with regard to any question arising hereunder or under the ICP shall be binding and conclusive on all persons. In the event of any inconsistency between the terms hereof and the provisions of the ICP, the ICP shall govern.

12. The award of RSUs pursuant to this Agreement is expressly subject to and contingent upon the requirement that the Participant shall have fully executed and delivered to the Company the Restrictive Covenant Agreement, that may be required and provided by the Company. The applicable agreement containing the restrictive covenants that the Company may require in connection with this award is hereafter referred to as the "Restrictive Covenant Agreement".

    If the Company intends to require Participant to execute and deliver a new Restrictive Covenant Agreement in connection with the grant hereunder, the Company shall provide such new Restrictive Covenant Agreement to Participant and Participant agrees to execute and deliver such new Restrictive Covenant Agreement by the deadline set forth by the Company. If Participant is currently subject to a Restrictive Covenant Agreement and the Company does not require Participant to execute and deliver a new Restrictive Covenant Agreement, then by accepting the award of RSUs, pursuant to this Agreement. Participant affirms his or her Restrictive Covenant Agreement and intent to be bound by the restrictions in the Restrictive Covenant Agreement and to comply with all of its provisions.

    Participant agrees that failure to execute and return the new Restrictive Covenant Agreement, if required, by the deadline set forth by the Company shall result in the immediate and irrevocable forfeiture of the RSU Award hereunder and any right to receive dividend equivalents or Shares with respect thereto. Further, if Participant violates any provision of the applicable Restrictive Covenant Agreement, any unvested RSUs will be immediately and irrevocably forfeited, and no payment of any kind, including Dividend Equivalents or Shares, shall be payable with respect thereto. This Section shall not constitute the Company's exclusive remedy for Participant's violation of the Restrictive Covenant Agreement. The Company reserves all rights to seek all available legal or equitable remedies in the event of Participant's violation or threatened violation of the Restrictive Covenant Agreement, including injunctive relief.

13. By accepting this Award, Participant acknowledges that a copy of the ICP has been made available by the Company for Participant's reference and agrees to be bound by the terms and conditions set forth in this Agreement and the ICP as in effect from time to time.

14. By accepting this Award, Participant further acknowledges that the Federal securities laws and/or Company's policies regarding trading in its securities may limit or restrict Participant's right to trade Shares, including without limitation, sales of Shares acquired in connection with RSUs. Participant agrees to comply with such Federal securities law requirements and Company policies, as such laws and policies may be amended from time to time.

15. The Company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and that to the extent any provisions of this Agreement do not comply with Code Section 409A the Company will make such changes in order to comply with Code Section 409A to the extent it considers reasonable. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A of the Code shall be delayed until the first business day of the seventh month immediately following the employment termination date. For purposes of any provision of this Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to the "termination of employment" (and corollary terms) shall be construed to refer to "separation from service" (within the meaning of Treas. Reg. Section 1.409A-1(h)). Notwithstanding the foregoing, the Company makes no representations as to the tax treatment or consequences of any payment made hereunder, and Participant, by accepting this Award, acknowledges that Participant shall be solely responsible for same.

16. The Award subject to this RSU Agreement under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay

to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for the Participant's reference.

17. This Agreement shall be governed by the laws of Delaware, without giving effect to its choice of law provisions.

18. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 10.41

CVS HEALTH CORPORATION
PERFORMANCE-BASED RESTRICTED STOCK UNIT AGREEMENT

GRANT DATE : **[_____]**

1. Pursuant and subject to the provisions of the 2017 Incentive Compensation Plan of CVS Health Corporation (the " **ICP** "), on the date set forth above (the " **Grant Date** "), the CVS Health Corporation (the " **Company** ") has awarded and hereby evidences the Performance-Based Restricted Stock (" **PBRS** ") unit award (the " **Award** ") to the person named below (the " **Participant** "), subject to the terms and conditions set forth and incorporated in this PBRS Agreement (the " **PBRS Agreement** "), the Restricted Stock Units (" **RSUs** ") set forth below. The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. On the Grant Date specified above, the Fair Market Value (the " **FMV** ") of a share of Stock equals **[_____]** , which is the closing price on such date.

Participant	**[_____]**
Employee Number	**[_____]**
RSUs (#)	**[_____]**

2. Each RSU represents a right to a future payment of one share (" **Share** ") of Common Stock ($0.01 par value) of the Company, subject to required tax withholding.

3. (a) To the extent dividends are paid on Shares while the RSUs remain outstanding, subject to Paragraph 5(b), a cash amount equivalent to the dividends paid (such cash amount, a "Dividend Equivalent") with respect to the number of Shares covered by the RSUs shall accrue. Any accrued Dividend Equivalent shall be payable only upon vesting of the underlying RSUs. To the extent that the underlying RSUs do not vest hereunder, any related accrued Dividend Equivalent shall be forfeited.

   (b) Participant hereby agrees that the Company may withhold from the Dividend Equivalents, referred to in Paragraph 3(a) above, amounts sufficient to satisfy the applicable tax withholding in respect of such Dividend Equivalents.

4. Subject to the terms and conditions of the ICP and this PBRS Agreement, and subject to Participant's continued employment, Participant shall be entitled to receive (and the Company shall deliver to Participant) (a) the Shares on the Vesting Date(s) set forth herein, or as soon as administratively practicable thereafter, but within 30 days, thereafter unless delivery of the Shares has been deferred in accordance with Paragraph 5 below (the date of such delivery of the Shares being hereafter referred to as the "Settlement Date") and (b) the Dividend Equivalents on the Vesting Date(s) set forth herein, or as soon as administratively practicable but within 30 days thereafter. Each "Vesting Date," except as otherwise provided in Paragraph 7, shall be in accordance with the schedule set forth below:

   (a) one-third (1/3) of the RSUs on the first anniversary of the Grant Date;
   (a) one-third (1/3) of the RSUs on the second anniversary of the Grant Date; and
   (b) one-third (1/3) of the RSUs on the third anniversary of the Grant Date.

5. (a) In accordance with rules promulgated by the Management Planning and Development Committee of the Board of Directors (the " **Committee** "), Participant, to the extent eligible under the CVS Health Deferred Stock Compensation Plan, may elect to defer delivery of Shares in settlement of RSUs covered by this PBRS Agreement. Any such deferred delivery date elected by Participant shall become the Settlement Date for purposes of this PBRS Agreement.

   (b) Notwithstanding Paragraph 3(a), to the extent dividends are paid on such deferred Shares following the Vesting Date and prior to the Settlement Date, Participant shall be entitled to receive a number of additional deferred Shares equal to: (x) the amount of dividend per Share as declared by the Company's Board of Directors on the Company's common stock multiplied by (y) the number of deferred Shares held by Participant on the record date of such dividend, divided by (z) the FMV of a Share on such dividend payment date.

6. On the Settlement Date the number of Shares to be delivered by the Company to Participant shall be reduced by the smallest number of Shares having a FMV at least equal to the dollar amount of Federal, state and local tax withholding required to be withheld by the Company with respect to such RSUs on such date.

7. (a) Except as provided in Paragraphs 7 (b) - (f) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all RSUs not then vested in accordance with Paragraph 4 above, shall be immediately forfeited.

   (a) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, RSUs not then vested in accordance with Paragraph 4 will become immediately vested and Vesting Date shall be the date of death.

   (c) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a "Qualified Retirement", RSUs will become immediately vested as of Participant's retirement date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company. The Vesting Date shall be the effective date of the Participant's termination of employment. " **Qualified Retirement** " shall mean a Participant's termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 9 below, of the date of his or her termination of employment or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above as of during the severance period set forth in a severance agreement with the Company. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 6(c) or the terms of Section 6(e), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this PBRS Agreement.

   (d) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the RSUs shall vest as of the employment termination date on a pro rata basis as follows: the total number of RSUs vesting as of the termination date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company shall be equal to (i) the number of RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the

termination date since the Grant Date and (B) the denominator shall be thirty-six (36) *minus* (ii) the number of RSUs that had vested prior to the termination date. For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is eight months and five days, the numerator in sub-section (A) above shall be nine. The Vesting Date shall be the effective date of the Participant's termination of employment. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this PBRS Agreement.

(e) In the event Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay, RSUs not vested at the time of Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall continue to vest during the severance period and settle in accordance with the original schedule set forth in Section 4 of this PBRS Agreement. All RSUs not scheduled to vest during the specified severance period shall be forfeited as of the last day of the Participant's severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period specified in a severance agreement with the Company, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting. In the event Participant's termination of employment qualifies as a Qualified Retirement the terms of this Section 6(e) or the terms of Section 6(c), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. During any severance period, Participant is eligible to accrue Dividend Equivalents on outstanding RSUs as described in Paragraph 3(a) above.

(f) Notwithstanding the above, (i) the provisions of Section 10 of the ICP shall apply in the event of a Change in Control (as defined in such Section 10) and (ii) the provisions of Section 7(e)(iv) of the ICP shall apply.

(g) For purposes of this Section 7, transfer of Participant's employment from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, or transfer from a subsidiary of the Company to the Company shall not be treated as termination of employment.

(h) Participant will be responsible for any applicable withholding or other taxes that become due as a result of RSUs that vest as of Participant's employment termination date or thereafter.

8. An RSU does not represent an equity interest in the Company and carries no voting rights. Participant shall have no rights of a shareholder with respect to the RSUs until the Shares have been delivered to Participant.

9. Neither the execution and delivery hereof nor the granting of the award evidenced hereby shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

10. Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

11. All decisions and interpretations made by the Board of Directors or the Committee with regard to any question arising hereunder or under the ICP shall be binding and conclusive on all persons. In the event of any inconsistency between the terms hereof and the provisions of the ICP, the ICP shall govern.

12. By accepting this Award, Participant acknowledges that a copy of the ICP has been made available for the Participant's reference, and agrees to be bound by the terms and conditions set forth in this Agreement and the ICP as in effect from time to time.

13. By accepting this Award, Participant further acknowledges that the Federal securities laws and/or Company's policies regarding trading in its securities may limit or restrict Participant's right to buy or sell Shares, including without limitation, sales of Shares acquired in connection with RSUs. Participant agrees to comply with such Federal securities law requirements and Company policies as such laws and policies may be amended from time to time.

14. The company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and the regulations and guidance thereunder (collectively, "Section 409A") and that to the extent any provisions of this PBRS Agreement do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and, notwithstanding any other provision of the Plan or this PBRS Agreement to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh month immediately following the date of termination of employment. For purposes of any provision of this PBRS Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to the "termination of employment" (and corollary terms) shall be construed to refer to "separation from service" as determined under Section 409A.

15. The Award subject to this PBRS Agreement under the Plan and ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for Participant's reference.
16. This Agreement shall be governed by the laws of Delaware, without giving effect to its choice of law provisions.

17. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 10.42

PARTNERSHIP EQUITY PROGRAM
Participant Purchased RSUs, Company Matching RSUs
and Company Matching Option Agreement

AGREEMENT, by and between CVS Health Corporation, a Delaware corporation (the "Company"), and _____ ("Participant"), effective on _____ , herein after known as the "Grant Date" (this "Agreement") **.**

WHEREAS, Participant has been selected as an Eligible Participant to invest under the Company's Partnership Equity Program (the "PEP") and has elected in the Participant's Election Form to invest $ _____ in the PEP, subject to the terms and conditions set forth in the PEP and in this Agreement;

WHEREAS, the Company desires to provide Participant with written evidence acknowledging Participant's investment under the PEP through Participant Purchased RSUs and the corresponding grant of Company Matching RSUs and a Company Matching Option under the PEP.

WHEREAS, the provisions of the PEP and the Company's 2017 Incentive Compensation Plan (the "ICP") are hereby incorporated by reference and shall have the same force and effect as though fully set forth herein; Participant hereby acknowledges that a copy of the PEP and the ICP have been made available to Participant and agrees to be bound by such provisions (as presently in effect or hereafter amended); if any provision of this Agreement is inconsistent with a provision of the PEP or the ICP, the terms of the PEP and/or the ICP, or any successor thereto, shall control; capitalized terms used in this Agreement but not defined herein shall have the same meanings as in the PEP or the ICP, as the case may be; and on the Grant Date specified above, the Fair Market Value (the "FMV") of a share of CVS Health Common Stock ("Stock") equals $ ____ which is the closing price on such date.

NOW, THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the parties hereto agree as follows:

I. PARTICIPANT PURCHASED RSUs AND COMPANY MATCHING RSUs

(A) **Participant Purchased RSUs** . The Company has received from Participant a completed Participant Election Form authorizing the Company to apply designated compensation of $_____ to the purchase of _____ Participant Purchased RSUs on the Grant Date under the PEP, and the Company has accordingly credited Participant's Account under the PEP with the Participant Purchased RSUs. Except as provided under Section III of this Agreement, the Participant Purchased RSUs (including any Participant Purchased RSUs credited to Participant pursuant to Section I(C)(ii)) shall be fully vested as of the Grant Date and shall settle on the fifth (5 th) anniversary of the Grant Date.

(B) **Crediting of Company Matching RSUs** . As of the Grant Date, the Company hereby awards the Participant, subject to the terms and conditions set forth and incorporated in this Agreement and the PEP, _____ Company Matching RSUs.

(C) **Additional Transactions in Participant Accounts** .

(i) Each Participant Purchased RSU and Company Matching RSU represents a right to a future payment of one share of Stock, subject to applicable tax withholding.

(ii) To the extent that dividends are declared and paid on shares of Stock while the Participant Purchased RSUs and Company Matching RSUs remain outstanding and prior to a Settlement Date (as defined below), the Company shall credit to Participant's Purchased RSU account and Company Matching RSU account (as applicable) an additional number of Participant Purchased RSUs and Company Matching RSUs calculated by multiplying (a) the amount of dividend per share of Stock approved by the Company's Board of Directors by (b) the number of Participant Purchased RSUs and Company Matching RSUs held by Participant on the dividend record date, and dividing the product by (c) the FMV of a share of Stock on such dividend payment date.

(iii) Provided, however, that if such dividend is paid prior to the Vesting Date of Participant Purchased RSUs and/or the Company Matching RSUs, as set forth in Section I (D) below, Participant shall not be entitled to any

payment in respect of such dividend unless Participant is still employed by the Company on such dividend payment date.

(iv) Participant hereby agrees that, prior to the Settlement Date, the Company may withhold from the dividend equivalent amounts described to in Section I(C)(ii) amounts sufficient to satisfy the applicable tax withholding in respect of such dividend equivalent payments, as applicable.

(D) Vesting of Company Matching RSUs . Subject to the terms and conditions of the PEP and this Agreement, and to Participant's continued employment through such date, the Company Matching RSUs, and the dividend equivalent amounts attributed to same, shall vest on the fifth (5 th) anniversary of the Grant Date.

(E) Settlement of Company Matching RSU.

(i) A "Settlement Date" shall mean the date shares of Stock are delivered to Participant pursuant to the PEP and this Agreement.

(ii) Within fifteen (15) days following the earliest of the fifth (5 th) anniversary of the Grant Date, Participant's death, or termination of employment without Cause within the two-year period following a Change in Control, Participant shall be entitled to receive and the Company shall deliver to Participant the total number of shares of Stock (giving effect to Sections I(C)(ii) and I(C)(iv)) underlying the Company Matching RSUs on the Vesting Date set forth herein, or as soon as administratively practicable, but within 30 days thereafter, unless delivery of the Shares has been deferred in accordance with Section I(E)(iii) below (the date of such delivery of the Shares being hereafter referred to as the " **Settlement Date** "). Notwithstanding the foregoing, no shares of Stock shall be delivered upon termination of employment unless such termination of employment is considered a "separation from service" (within the meaning given of Treasury Regulation §1.409A-1(h) or successor guidance thereto).

(iii) Subject to the rules promulgated by the Committee, the terms of the CVS Health Deferred Stock Compensation Plan and Section 409A, Participant may elect to defer settlement of Participant Purchased RSUs or Company Matching RSUs covered by this Agreement.

II. COMPANY MATCHING OPTION

(A) Grant of Option . The Company hereby awards and evidences the grant to Participant, subject to the terms and conditions incorporated in this Agreement, the right, and option, to purchase from the Company _____ shares of Stock, with an exercise price per share of Stock equal to the FMV of a share of Stock on the Grant Date, such Company Matching Option to be exercised as hereinafter provided. The Company Matching Option is a nonqualified option as defined in the ICP.

(B) Term of Company Matching Option . The term of this Company Matching Option shall be for a period of ten (10) years from the Grant Date, subject to the earlier termination of the Company Matching Option, as set forth in the ICP and in this Agreement.

(C) Vesting and Exercise of Company Matching Option

(i) Prior to its expiration or termination, and except as otherwise provided herein, the Company Matching Option shall vest and may be exercised by Participant, provided Participant has maintained continuous employment with the Company or a subsidiary of the Company from the Grant Date until the applicable vesting date, within the following time limitations:

a. On or after three (3) years from the Grant Date, the Company Matching Option shall be vested and may be exercised as to one-third (1/3) of the shares of Stock subject to the Company Matching Option;

b. On or after four (4) years from the Grant Date, the Company Matching Option shall be vested and may be exercised as to an aggregate of two-thirds (2/3) of the shares of Stock subject to the Company Matching Option; and

c. On or after five (5) years from the Grant Date, the Company Matching Option shall be vested and may be exercised as to all of the shares of Stock subject to the Company Matching Option.

(ii) The Company Matching Option, subject to the provisions of the ICP, shall be exercised by submitting a request to exercise to the Company's stock option administrator, in accordance with the Company's current exercise policies and procedures, specifying the number of shares of Stock to be purchased, which number may not be less than one hundred (100) shares of Stock (unless the number of shares of Stock purchased is the total balance which is then exercisable). An exercise by Participant of all or part of this Company

Matching Option shall be effected through the Company's "cashless exercise" procedures. Otherwise, at the time of exercise, Participant shall tender to the Company cash or cash equivalent for the aggregate exercise price of the shares of Stock Participant has elected to purchase or certificates for shares of Stock of the Company already owned by Participant for at least six (6) months with an aggregate FMV at least equal to the aggregate exercise price of the shares of Stock Participant has elected to purchase, or a combination of the foregoing.

(D) **Company Matching Option Expiration** . The Company Matching Option shall be exercisable only as provided above and shall expire at the close of business on the tenth (10 th) anniversary of its Grant Date or such earlier expiration date as described in Section III below.

III. TERMINATION OF EMPLOYMENT AND CHANGE IN CONTROL

(A)

(i) If Participant's employment with the Company and its subsidiaries terminates within 24 months of the grant date as a result of the Participant's voluntary termination of employment or involuntary termination by the Company or any subsidiary for Cause, the Participant Purchased RSUs shall be immediately forfeited as of the termination date .

(ii) Except as provided in Section III (B)-(F) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all Company Matching RSUs and the Company Matching Option to the extent not vested as of the termination date in accordance with Sections I(D) and II(C)(i) above shall be immediately forfeited as of the termination date. To the extent vested and unexercised as of the termination date, the Company Matching Option shall be exercisable on or before the ninetieth (90 th) day following the termination date, as long as no government regulations or rules are violated by such exercise period; provided, however, that the Company Matching Option shall not be exercisable beyond its original term.

(B) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, Company Matching RSUs and the Company Matching Option not then vested in accordance with Section I(D) and Section II(C)(i), respectively, will become immediately vested and the Vesting Date will be the date of death. Participant Purchased RSUs and Company Matching RSU shall settle as of the date of death and the Company Matching Option shall be exercisable by the Participant's Beneficiary during the twelve (12) month period following the date of death, as long as no government regulations or rules are violated by such accelerated vesting or exercise period; provided, however, that no Company Matching Option will be exercisable beyond its original term.

(C) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such plan, as defined by the Social Security Administration), the Company Matching RSUs and the Company Matching Option shall vest on a pro rata basis as follows:

(i) the total number of Company Matching RSUs vested as of Participant's employment termination date (which is the last day that the Participant is employed by the Company or any subsidiary of the Company) shall be equal to the number of Company Matching RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed since the Grant Date and (B) the denominator shall be sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the Separation Date is eight months and five days, the numerator in sub-section (A) above shall be nine. Participant will be responsible for any applicable withholding taxes that may become due as of Participant's employment termination date. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section I(D) of this PEP Agreement.

(ii) the total number of Company Matching Option vested as of Participant's employment termination date with respect to the number of shares of Stock subject to the Company Matching Options, shall be equal to the number of Company Matching Options granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed since the Grant Date and (B) the denominator shall be sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed

between the Grant Date and the Separation Date is eight months and five days, the numerator in sub-section (A) above shall be nine.

(iii) the vested portion of the Company Matching Option shall be exercisable during the twelve (12) month period following Participant's employment termination date, as long as no government regulations or rules are violated by such accelerated vesting or exercise period; provided, however, that the Company Matching Option shall not be exercisable beyond its original term.

(D) **Involuntary Termination with Severance.** In the event that Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay pursuant to a written agreement in the form required by the Company, Participant's Company Matching RSUs and the Company Matching Option to the extent not vested at the time of the Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall continue to vest during the severance period and settle in accordance with the schedule set forth in Section I(D) and Section II(C)(i), respectively, of this Agreement. Participant will be responsible for any applicable withholding taxes that may become due as of Participant's employment termination date. All Company Matching RSUs and the Company Matching Option to the extent not scheduled to vest during the specified severance period shall be forfeited as of the Participant's employment termination date. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section I(D) of this PEP Agreement. During any severance period, Participant is eligible to receive dividend equivalents on outstanding RSUs as described in Paragraph I(C)(ii) above. To the extent vested, the Company Matching Option shall be exercisable on or before the ninetieth (90 th) day following the last day of the severance period, as long as no government regulations or rules are violated by such continued vesting or exercise period; provided, however, that the Company Matching Option shall not be exercisable beyond its original term.

(E) **Retirement** . " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, then such termination is without cause.

(i) In the event Participant's termination of employment qualifies as a Qualified Retirement, Participant may exercise the Company Matching Option to the extent vested as of Participant's retirement date at any time within two (2) years after Participant's retirement date, but not beyond the original term of the Company Matching Option. To the extent unvested as of the retirement date, the Company Matching Option shall be forfeited. The Committee shall have the authority in its sole discretion to make any interpretations, determinations, and/or take any administrative actions with respect to whether Participant has experienced a Qualified Retirement.

(ii) Company Matching RSUs that are unvested as of the Participant's retirement date are forfeited as of the retirement date.

(iii) In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, each portion of a Participant's Company Matching RSU or Company Matching Option under this Award shall be entitled to the more favorable treatment explicitly applicable to such portion of the Participant's Company Matching RSU or Company Matching Option under the provisions of Section XIII(F) of the PEP with respect to the vesting and settlement of the Company Matching RSUs and the Company Matching Option.

Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section I(D) of this PEP Agreement.

(F) The provisions of Section 10 of the ICP, or any successor thereto, shall apply in the event of a Change in Control.

(G) For purposes of this Section III, transfer of employment by Participant from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, transfer from a subsidiary of the Company to the Company or any other continuation of employment with the Company or a subsidiary of the Company after termination by a related entity shall not be treated as termination of employment.

IV. NON-COMPETITION. The grant of RSUs pursuant to this Agreement is expressly subject to and contingent upon the requirement that the Participant shall have fully executed and delivered to the Company the CVS Health Corporation

Restrictive Covenant Agreement provided by the Company; provided that the Company in its sole discretion may waive such requirement if Participant is currently a party to another agreement with the Company setting forth restrictive covenants, such as non-competition, non-disclosure, and/or non-solicitation obligations. The applicable agreement containing the restrictive covenants the Company requires in connection with this Award, whether previously executed or required to be executed in connection with this Award, is hereafter referred to as the "Restrictive Covenant Agreement".

If the Company intends to require Participant to execute and deliver a new Restrictive Covenant Agreement in connection with the Award hereunder, the Company shall provide such Restrictive Covenant Agreement to Participant and Participant agrees to execute and deliver such agreement by the deadline set forth by the Company, which shall be no less than ten days from the date it is provided to Participant. If Participant is currently subject to a Restrictive Covenant Agreement, Participant hereby affirms his or her agreement and intent to be bound by the restrictions in the Restrictive Covenant Agreement and to comply with all of its provisions.

Participant agrees that failure to execute and return the Restrictive Covenant Agreement by the deadline set forth by the Company, if required, shall result in the immediate and irrevocable forfeiture of the RSU Award hereunder and any right to receive dividend equivalents or Shares with respect thereto. Further, if Participant violates any provision of the applicable Restrictive Covenant Agreement, any unvested RSUs will be immediately and irrevocably forfeited, and no payment of any kind, including dividend equivalents or Shares, shall be payable with respect thereto. This Section shall not constitute the Company's exclusive remedy for Participant's violation of the Restrictive Covenant Agreement, and the Company may seek all available legal or equitable remedies in the event of Participant's violation or threatened violation of the Restrictive Covenant Agreement, including injunctive relief.

V. MISCELLANEOUS .

(A) Withholding Tax . Participant may be subject to withholding taxes as a result of the exercise of the Company Matching Option or settlement of Participant Purchased RSUs or Company Matching RSUs. The number of shares of Stock to be delivered by the Company to Participant shall be reduced by the smallest number of shares of Stock having a FMV at least equal to the dollar amount of federal, state or local tax withholding required to be withheld by the Company with respect to such exercise or settlement. Any shares of Stock so withheld or tendered will be valued as of the date they are withheld or tendered. Participant shall remit to the Company in cash, promptly when the amount of such tax obligations become determinable, all applicable federal, state, local and any foreign withholding taxes that result from each exercise of the Company Matching Option.

(B) Recoupment. This Award under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for Participant's reference.

(C) Certain Terms and Conditions of the PEP . Participant acknowledges and agrees that the terms and conditions of the PEP preclude all transfers of Participant Purchased RSUs, all Company Matching RSUs, and the Company Matching Option, except in limited circumstances in the event of Participant's death, impose a risk of forfeiture on Participant Purchased RSUs, Company Matching RSUs and the Company Matching Option, relieve the Company of certain obligations unless and until laws and regulations have been complied with, provide for adjustments to Participant Purchased RSUs, Company Matching RSUs, and the Company Matching Option upon the occurrence of certain events, and specify the state law which shall govern this Agreement, without giving effect to principles of conflict of laws.

(D) Binding Agreement . This Agreement shall be binding upon the heirs, executors, administrators, and successors of the parties. In particular, Participant's heirs, executors, administrators, and successors shall be subject to the terms and conditions of the PEP, ICP and this Agreement, and the Company may require any such person to execute an agreement or other documents acknowledging and agreeing to such terms and conditions as a condition precedent to any transfer of rights hereunder or shares of Stock issuable under the PEP, including upon exercise of the Company Matching Option, into the name of any such person.

(E) Integration Clause; Amendments to Agreement . This Agreement, together with the PEP and the ICP, constitutes the entire Agreement between the parties with respect to the PEP, and supersedes any prior agreements or documents with respect thereto. This Agreement may be amended, but no amendment or other change which may impose any additional obligation upon the Company or materially impair the rights of Participant under the PEP shall be valid unless contained in a writing signed by the party to be bound thereby.

(F) Employment . Neither the execution and delivery hereof nor the granting of the Company Matching RSUs or

the Company Matching Option evidenced hereby shall constitute or be evidence of any agreement or understanding, expressed or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

(G) **Required Acceptance of Award.** Acceptance may be submitted either electronically, if available, or in writing. The Company Matching Option may not be exercised unless and until the Company has received acceptance by the Participant of the terms and conditions set forth herein.

(H) **Company Matching RSUs.** Neither a Company Matching RSU nor a Participant Purchased RSU represents an equity interest in the Company and neither carries any voting rights. Except as otherwise specifically provided herein, Participant shall have no rights of a shareholder with respect to the RSUs until the related shares of Stock have been delivered to Participant.

(I) **Section 409A.** The Company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and that to the extent any provisions of this Agreement do not comply with Code Section 409A the Company will make such changes in order to comply with Code Section 409A to the extent it considers reasonable. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A of the Code shall be delayed until the first business day of the seventh month immediately following the employment termination date. For purposes of any provision of this Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to the "termination of employment" (and corollary terms) shall be construed to refer to "separation from service" (within the meaning of Treas. Reg. Section 1.409A-1(h)). Notwithstanding the foregoing, the Company makes no representations as to the tax treatment or consequences of any payment made hereunder, and Participant, by accepting this Award, acknowledges that Participant shall be solely responsible for same.

(J) **Notices** . Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

(K) **ACKNOWLEDGEMENT.** This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

CVS HEALTH CORPORATION

By: / **s/ Lisa G. Bisaccia**
Executive Vice President and
Chief Human Resources Officer

Accepted by: _____
PARTICIPANT NAME

_____
EMPLOYEE ID#

_____
Date

Exhibit 10.45

AETNA INC.
2010 STOCK INCENTIVE PLAN

MARKET STOCK UNIT TERMS OF AWARD

Pursuant to its 2010 Stock Incentive Plan (the "Plan"), Aetna Inc. (the "Company") hereby grants Market Stock Units on the terms and conditions hereinafter set forth. The number of Market Stock Units awarded is included in the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of the Market Stock Unit Grant Acknowledgement and Acceptance Form. All capitalized terms used herein which are not otherwise defined herein shall have the meaning specified in the Plan.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) "Change in Control" means the happening of any of the following:

(i) When any "person" as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and as used in Sections 13(d) and 14(d) thereof, including a "group" as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company's then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “Beneficial Owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means the Company's Common Shares, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date" means the date of grant of this award of Market Stock Units.

(h) “Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such date, on the next day on which the Common Stock is traded.

(i) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(j) "Grantee" means the person to whom this award has been granted.

(k) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively, of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(l) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(m) “Net Shares” means the number of shares of Common Stock which will be deposited in a brokerage account in the Grantee’s name at the Company’s designated broker after shares have been withheld to satisfy applicable tax and withholding requirements upon vesting of the Market Stock Units.

(n) "Performance Period" means the [ ] month period following the Effective Date.

(o) "Market Stock Units" means the number of units awarded that will convert to a number of shares of Common Stock based on the operation of Article II of this Agreement, or such other amount as may result by operation of Article III of this Agreement.

(p) "Plan" means the Aetna Inc. 2010 Stock Incentive Plan.

(q) "Retirement" means the termination of employment of a Grantee from active service with the Company, a Subsidiary or Affiliate provided the Grantee's age and completed years of service total 65 or more points at termination of employment.

(r) "Section 162(m)" means Section 162(m) of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(s) "Section 409A" means Section 409A of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(t) "Shares of Stock" or "Stock" means the Common Stock.

(u) "Subsidiary" means an entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock of such entity is held by the Company and/or one or more other subsidiaries.

(v) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to the Market Stock Units by bequest or inheritance or by reason of the death of the Grantee.

(w) "Vest Date" means the date on which this award of Market Stock Units shall vest in accordance with the terms of this Agreement and in the Notice of Market Stock Unit Grant.

(x) "Vest Date Fair Market Value" means the average closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares for the 29 trading days prior to the Vest Date and the Vest Date, or, if no shares were traded on such Vest Date, for the 30 trading days prior to the Vest Date.

ARTICLE II

PERFORMANCE PERIOD & AWARD CONVERSION

Subject to the terms of this Agreement, the Market Stock Units will vest, as of the Vest Date, in accordance with the terms of the Plan and this Terms of Award Agreement, or on such earlier date as provided in Article IV. On the Vest Date the Grantee shall vest in a number of shares of Common Stock for each vested Market Stock Unit based on the formula below, net of applicable taxes and withholding. Such Net Shares will be delivered to the Company's designated broker, in a brokerage account established in the Grantee's name after the Vest Date. To the extent Section 162(m) is applicable to a Grantee, for shares to vest the Committee must also determine that the performance goal set forth on Exhibit A is met. If the Committee determines that the performance goal is not met at the minimum level, as applicable, no shares will vest.

The number of shares of Common Stock that each Market Stock Unit will convert and be awarded to you on the Vest Date, net of applicable taxes, shall be determined in accordance with the following formula:

(Number of Market Stock Units granted)

Multiplied by

((the Vest Date Fair Market Value) divided by (the Grant Date Fair Market Value))

Up to a maximum of 1.5 shares of Common Stock per Market Stock Unit.

Any social security calculation or other adjustments discovered after the payment of Net Shares will be settled in cash, not in Common Stock.

ARTICLE III

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this Plan, then the Committee shall, in such manner as the Committee may deem equitable, adjust the number and kind of shares subject to the award of Market Stock Units. Additionally, the Committee may make provision for cash payment to a Grantee or the Successor of the Grantee to the extent permitted under Section 409A. However, the number of Market Stock Units shall always be a whole number.

ARTICLE IV

CHANGE IN CONTROL

Notwithstanding any other provision of this Agreement to the contrary, upon the occurrence of a Change in Control, the Market Stock Units not previously forfeited pursuant to this Terms of Award Agreement shall become immediately vested and convert to a number of shares of Common Stock based on the formula in Article II but such formula shall use the Fair Market Value on the date on which the Change in Control occurs rather than the Vest Date Fair Market Value. Net Shares will be payable on the Vest Date, provided however, if within the 24 month period following the Change in Control the Company terminates Grantee's employment without cause, the Net Shares will become payable as of such termination of employment date. If an award is considered deferred compensation subject to Section 409A, the award will vest but the Change in Control will not accelerate the payment of the Market Stock Units unless the Change in Control also meets the definition of change in control set forth in Treasury Regulation Section 1.409A-3(i)(5).

ARTICLE V

TERMINATION OF EMPLOYMENT

(a) Except as provided in (c) below, if, during the Performance Period, Grantee shall cease to be employed by the Company, its Subsidiaries or Affiliates, for reason of death, Long-term Disability, Retirement or involuntary termination of employment by the Company, the portion of the Market Stock Units that may vest on the Vest Date, if any, shall be calculated in accordance with the following formula: (i) the number of completed months employed commencing on the first day of the Performance Period divided by the number of months in the Performance Period; multiplied by (ii) the number of Market Stock Units that otherwise would have vested under the term of this Agreement had the Grantee remained actively employed through the Vest Date.

(b) Except as provided in (a) above, any Market Stock Unit not vested as of the date Grantee terminates employment shall be forfeited at the time of cessation of employment; provided, however, that if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the Market Stock Unit in accordance with its terms, then upon the forfeiture of the entire Market Stock Unit, the Company will pay Grantee an amount equal to the value of a single share of Common Stock, whether or not the forfeited Market Stock Unit related to more than a single share of Common Stock, calculated as of the cessation of employment, if requested by Grantee, within 30 days of such cessation of employment.

(c) No Market Stock Unit will vest after the Company has terminated the employment of the Grantee for cause, unless the Committee, in its sole discretion, deems a payment to be warranted under the particular circumstances. In addition, the Market Stock Units will not vest if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(d) Employment for purposes of determining the vesting rights of the Grantee and the expiration of the grant under this Article V shall mean continuous active full-time salaried employment with the Company, a Subsidiary or an Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc. Notwithstanding any period during which Grantee receives salary continuation or severance shall <u>not</u> be considered as part of the continuous employment of the Grantee.

ARTICLE VI

EMPLOYEE COVENANTS

(a) As consideration for this grant of Market Stock Units, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related

information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company or any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement; provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of 12 months or 24 months for executive tier employees (the executive tier status determined as of the effective date of this grant) following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee to be employed or perform services elsewhere;

(iii) Grantee will not, during and for a period of 12 months or 24 months for executive tier employees (the executive tier status determined as of the effective date of this grant) following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company or any Subsidiary to cease or curtail providing services to the Company or any Subsidiary; and

(iv) Grantee will not, during and for a period of 12 months or 24 months for executive tier employees (the executive tier status determined as of the effective date of this grant) following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved.

In addition:

(v) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company or a Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(vi) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an

attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company.

(vii) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). Grantee further acknowledges that while employed by the Company, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company, and the Grantee hereby assigns all right, title, and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting therefrom.

(b) If any provision of Article VI (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the Market Stock Units is Grantee's covenants set forth in Article VI (a) and that the covenants and obligations of Grantee with respect to nondisclosure, non-solicitation and cooperation relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to vest in the Market Stock or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VI. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine.

(d) Employment Dispute Arbitration Program - <u>Mandatory Binding Arbitration of Employment Disputes.</u>

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether the Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VI (d) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VI (d) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VI (d) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VI (a) in accordance with applicable law). However, except as provided in Article VI (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement.

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org. THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the

arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VI (d) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VI (d) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(e) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VI, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

ARTICLE VII

OTHER TERMS

(a) Nothing in this Agreement shall interfere with or limit in any way the right of the Company or any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery hereof nor the granting of the Award shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ or continue the employment of the Grantee for any period.

(b) Until the Market Stock Units have become vested, Grantee shall not have any rights as a stockholder (including the right to payment of dividends) by virtue of this grant of Market Stock Units.

(c) During the Performance Period, the Market Stock Units shall be nontransferable and non-assignable except by will or the laws of descent and distribution.

(d) The award, when vested, will be settled on a net basis. Prior to issuing any Common Shares, the Company will withhold an amount sufficient to satisfy federal, state, local, social security and Medicare withholding tax requirements relating to award. Any social security calculation or other adjustments discovered after net share payment will be settled in cash, not in Shares of Common Stock. Vesting will result in taxable compensation reportable on the Grantee's W-2 in year of vesting.

(e) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connection with any such restriction.

(f) This Market Stock Unit is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(g) Anything herein to the contrary notwithstanding, a Grantee whose Market Stock Units have been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited Market Stock Units reinstated as follows: (i) if such Grantee is re-employed during the Performance Period, all forfeited Market Stock Units shall be reinstated; or (ii) if such Grantee is re-employed after the Performance Period, a cash payment will be made to the Grantee, minus applicable taxes, for the value of the forfeited Market Stock Units on the Vest Date pursuant to procedures established by the Company for this purpose.

(h) It is the intention of the Company and Grantee that this Agreement not result in unfavorable tax consequences to Grantee under Section 409A and the Agreement shall be interpreted as to so comply. Notwithstanding anything to the contrary herein, the Company and Grantee agree to the provisions set forth below in order to comply with the requirements of Section 409A.

(i) If Grantee is a "specified employee" (within the meaning of Section 409A) with respect to the Company, any non-qualified deferred compensation otherwise payable to or in respect of Grantee in connection with Grantee's termination of employment shall be delayed until the earliest date upon which such amounts may be paid without being subject to taxation under Section 409A. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

(ii) Unless deferred pursuant to this agreement, all payments shall be paid to Grantee, to the extent earned, in no event later than the last day of the "applicable 2 ½ month period," as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

(iii) The Company and Grantee agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by the Grantee due to any failure to comply with Section 409A.

(i) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(j) At such times and upon such terms and conditions as the Company shall determine, the Company may permit eligible Grantees to elect to defer the distribution of an Award otherwise payable to the Grantee under this Agreement until termination of the Grantee's Employment or such other date Company shall permit.

(k) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

Exhibit 10.46

AETNA INC.
2010 STOCK INCENTIVE PLAN

PERFORMANCE STOCK UNIT TERMS OF AWARD

Performance Period: [ ] through [ ]
Units Awarded: [ ]
Performance Metric: [ ]
Vesting Period - [ ] month period following the Effective Date (Date of Grant)

Pursuant to its 2010 Stock Incentive Plan (the "Plan"), Aetna Inc. (the "Company") hereby grants Performance Stock Units (PSUs) on the terms and conditions hereinafter set forth. The number of Performance Stock Units awarded is included in the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of the Performance Stock Unit Grant Acknowledgement and Acceptance Form. All capitalized terms used herein which are not otherwise defined herein shall have the meaning specified in the Plan.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) "Change in Control" means the happening of any of the following:

(i) When any "person" as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and as used in Sections 13(d) and 14(d) thereof, including a "group" as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company's then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “Beneficial Owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means the Company's Common Shares, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date" means the date of grant of this award of Performance Stock Units.

(h) “Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such date, on the next day on which the Common Stock is traded.

(i) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(j) "Grantee" means the person to whom this award has been granted.

(k) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively, of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(l) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(m) “Net Shares” means the number of shares of Common Stock which will be deposited in a brokerage account in the Grantee’s name at the Company’s designated broker after shares have been withheld to satisfy applicable tax and withholding requirements upon vesting of the Performance Stock Units.

(n) “Performance Period” means the [ ] month performance period ending [date]. The Performance Period shall run from [date] to [date].

(o) “Performance Stock Units” means the number of shares of Common Stock represented by the number of units awarded or such other amount as may result by operation of Article III of this Agreement.

(p) “Plan” means the Aetna Inc. 2010 Stock Incentive Plan.

(q) "Retirement" means the termination of employment of a Grantee from active service with the Company, any Subsidiary or Affiliate provided the Grantee’s age and completed years of service total 65 or more points at termination of employment.

(r) “Section 409A” means Section 409A of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(s) “Shares of Stock” or “Stock” means the Common Stock.

(t) "Subsidiary" means an entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock of such entity is held by the Company and/or one or more other subsidiaries.

(u) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to the Performance Stock Units by bequest or inheritance or by reason of the death of the Grantee.

(v) “Vest Date” means the last day of the Vesting Period and is the date on which this award of Performance Stock Units shall vest in accordance with the terms of this Agreement and in the Notice of Performance Stock Unit Grant, if at all.

(w) “Vesting Period” means the period beginning on the Effective Date and ending thirty-six months thereafter.

ARTICLE II

VESTING PERIOD

Subject to the terms of this Agreement, the Performance Stock Units will vest, as of the Vest Date, in accordance with the terms of the Plan and this Terms of Award Agreement, or on such earlier date as provided in Article IV. If the Committee determines that the performance goal set forth on Exhibit A is met, on the Vest Date, the Grantee shall vest to one share of Common Stock for each vested Performance Stock Unit net of applicable taxes and withholding (or such greater or lessor amount based on performance, as set forth on Exhibit A). Such Net Shares will be delivered to the Company's designated broker, in a brokerage account established in the Grantee's name after the Vest Date. If the Committee determines that the performance goal set forth on Exhibit A is not met at the minimum level, no shares will vest.

Any social security calculation or other adjustments discovered after the payment of Net Shares will be settled in cash not in Common Stock.

ARTICLE III

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this Plan, then the Committee shall, in such manner as the Committee may deem equitable, adjust the number and kind of shares subject to the award of Performance Stock Units. Additionally, the Committee may make provision for cash payment to a Grantee or the Successor of the Grantee. However, the number of Performance Stock Units shall always be a whole number.

ARTICLE IV

CHANGE IN CONTROL

Notwithstanding any other provision of this Agreement to the contrary, upon the occurrence of a Change in Control, the Performance Stock Units not previously forfeited pursuant to this Terms of Award Agreement shall become immediately vested at a level which equals the greater of the number of Performance Stock Units that would have vested (x) at target-level 100% vesting, or (y) based on the Company's actual year-to-date performance level using the date on which the Change in Control occurs as the end of the Vesting Period. Net Shares will be payable on the Vest Date, provided however, if within the 24 month period following the Change in Control the Company terminates Grantee's employment without cause, the Net Shares will become payable as of such termination of employment date. If an award is considered deferred compensation subject to Section 409A, the award will vest but the Change in Control will not accelerate the payment of the deferred Performance Stock Units unless the Change in Control also meets the definition of change in control set forth in Treasury Regulation Section 1.409A-3(i)(5).

ARTICLE V

TERMINATION OF EMPLOYMENT

(a) Except as provided in (c) below, if, during the Vesting Period, Grantee shall cease to be employed by the Company, any Subsidiaries or Affiliates, for reason of death, Long-term Disability, Retirement or involuntary termination of employment by the Company, the portion of the Performance Stock Units that may vest on the Vest Date, if any, shall be calculated in accordance with the following formula: (i) the number of completed months employed during the Vesting period divided by the number of months in the Vesting Period; multiplied by (ii) the number of Performance Stock Units, that otherwise would have vested. For purposes of this calculation, a month is complete on the day in the month that corresponds to the Effective Date of the grant (e.g., February 12 to March 12).

(b) Except as provided in (a) above, any Performance Stock Unit not vested as of the date Grantee terminates employment shall be forfeited at the time of cessation of employment; provided, however, that if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the Performance Stock Unit in accordance with its terms, then upon the forfeiture of the entire Performance Stock Unit, the Company will pay Grantee an amount equal to the value of a single share of Common Stock, whether or not the forfeited Performance Stock Unit related to more than a single share of Common Stock, calculated as of the cessation of employment, if requested by Grantee, within 30 days of such cessation of employment.

(c) No Performance Stock Unit will vest after the Company has terminated the employment of the Grantee for cause, unless the Committee, in its sole discretion, deems a payment to be warranted under the particular circumstances. In addition, the Performance Stock Units will not vest if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(d) Employment for purposes of determining the vesting rights of the Grantee and the expiration of the grant under this Article V shall mean continuous active full-time salaried employment with the Company, any Subsidiary or Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc. Notwithstanding any period during which Grantee receives salary continuation or severance shall not be considered as part of the continuous employment of the Grantee.

ARTICLE VI

EMPLOYEE COVENANTS

(a) As consideration for this grant of Performance Stock Units, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company, any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement ("Confidential Information"); provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of twelve (12) months following Grantee's termination of employment, directly or indirectly, (x) engage in the ownership (except less than 1% of the outstanding capital stock of any publicly traded company) of or, (y) become an employee of, or (z) act as a consultant or contractor to, any competitor of the Company ("Competitor") in any market in the United States where Company, Affiliate or Subsidiary does business.

a. For purposes of this paragraph "Competitor" shall mean any entity, organization, person or corporation that is involved in the same business as Company, Subsidiary or Affiliate, but in the case of (y) and (z), only to the extent such work, consulting or other activity on behalf of other entity, organization, person or corporation

i. is materially similar to the duties and/or functions that Grantee performed for the Company, Subsidiary or Affiliate in the last 12 months or involves duties and/or functions for Competitor about which Grantee has Confidential Information in the last 12 months. Notwithstanding

1. with respect to sales functions for the Company, Subsidiary or Affiliate that are regionally based or whose focus is geographically limited, the restriction shall only apply where such work, consulting or other activity on behalf of a Competitor overlaps in whole or in part the same geographic area in which the Grantee worked for Company, Subsidiary or Affiliate in the last 12 months;

2. with respect to corporate staff functions, the restriction shall only apply where Competitor is substantially engaged in the business of health insurance, managed health care, population health management, or related products or services.

b. Notwithstanding, if Grantee's employment is terminated by the Company, Subsidiary or Affiliate other than for cause, the length of the noncompetition covenant in this paragraph shall not exceed the length of the severance and/or salary continuation benefits paid by the Company, Subsidiary or Affiliate to Grantee.

c. Grantee acknowledges and agrees that these restrictions:

i. are necessary to protect the Confidential Information and goodwill of the Company, Subsidiary or Affiliate;

ii. are appropriately tailored and limited in time and geographic scope to do so; and

iii. do not impair or limit the Grantee's ability to earn a living.

(iii) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee of the Company, any Subsidiary or Affiliate to be employed or perform services elsewhere;

(iv) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company, any Subsidiary or Affiliate to cease or curtail providing services to the Company, any Subsidiary or Affiliate; and

(v) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved.

(vi) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, for himself or herself or on behalf of or in cooperation with any other person or entity, consult with or in any manner provide advice to, any individual or entity which is a customer of the Company or any Subsidiary or Affiliate of the Company, provided, however, that this limitation shall apply only to consultation or advice relating to any product or service of the Company, or any Subsidiary or Affiliate, or which is in competition with any product or service of the Company, or any Subsidiary or Affiliate, and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved, or about which Grantee has Confidential Information.

In addition:

(vii) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company, any Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(viii) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company.

(ix) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment and relating in any way to the business or contemplated business, products, activities, research or development of the Company, any Subsidiary or Affiliate, or resulting from any work performed by the Grantee for the Company, any Subsidiary or Affiliate (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). To the extent that the foregoing does not apply, the Grantee hereby irrevocably assigns to the Company, and its successors and assigns, for no additional consideration, the Grantee's entire right, title and interest in and to all such works of authorship. Grantee further acknowledges that while employed by the Company, any Subsidiary or Affiliate, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company, and the Grantee hereby assigns all right, title, and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting there from.

(b) If any provision of Article VI (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the Performance Stock Units is Grantee's covenants set forth in Article VI (a) and that the covenants and obligations of Grantee with respect to nondisclosure, non-solicitation and cooperation relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to vest in the Performance Stock or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VI. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine.

(d) The Restrictive Covenants set forth in this Article VI shall supplement and do not supersede the restrictions agreed to by Grantee in any other agreement or contract.

(e) Employment Dispute Arbitration Program - <u>Mandatory Binding Arbitration of Employment Disputes.</u>

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether the Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VI (e) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VI (e) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VI (e) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VI (a) in accordance with applicable law). However, except as provided in Article VI (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement .

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org . THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a

court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VI (e) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VI (e) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(f) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VI, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

ARTICLE VII

OTHER TERMS

(a) Nothing in this Agreement shall interfere with or limit in any way the right of the Company, any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery hereof nor the granting of the Award shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ or continue the employment of the Grantee for any period.

(b) Until the Performance Stock Units have become vested, Grantee shall not have any rights as a stockholder (including the right to payment of dividends) by virtue of this grant of Performance Stock Units.

(c) During the Vesting Period, the Performance Stock Units shall be nontransferable and non-assignable except by will or the laws of descent and distribution.

(d) The award, when vested, will be settled on a net basis. Prior to issuing any Common Shares, the Company will withhold an amount sufficient to satisfy federal, state, local, social security and Medicare withholding tax requirements relating to award. Any social security calculation or other adjustments discovered after net share payment will be settled in cash, not in Shares of Common Stock. Vesting will result in taxable compensation reportable on the Grantee's W-2 in year of vesting.

(e) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connection with any such restriction.

(f) This Performance Stock Unit is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(g) Anything herein to the contrary notwithstanding, a Grantee whose Performance Stock Units have been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited Performance Stock Units reinstated as follows: (i) if such Grantee is re-employed during the Vesting Period, all forfeited Performance Stock Units shall be reinstated; or (ii) if such Grantee is re-employed after the Vesting Period, a cash payment will be made to the Grantee, minus applicable taxes, for the value of the forfeited Performance Stock Units on the Vest Date pursuant to procedures established by the Company for this purpose.

(h) It is the intention of the Company and Grantee that this Agreement not result in unfavorable tax consequences to Grantee under Section 409A and the Agreement shall be interpreted as to so comply. Notwithstanding anything to the contrary herein, the Company and Grantee agree to the provisions set forth below in order to comply with the requirements of Section 409A.

(i) If Grantee is a "specified employee" (within the meaning of Section 409A) with respect to the Company, any non-qualified deferred compensation otherwise payable to or in respect of Grantee in connection with Grantee's termination of employment shall be delayed until the earliest date upon which such amounts may be paid without being subject to taxation under Section 409A. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

(ii) Unless deferred pursuant to this agreement, all payments shall be paid to Grantee, to the extent earned, in no event later than the last day of the "applicable 2 ½ month period," as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

(iii) The Company and Grantee agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by the Grantee due to any failure to comply with Section 409A.

(i) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(j) At such times and upon such terms and conditions as the Company shall determine, the Company may permit eligible Grantees to elect to defer the distribution of an Award otherwise payable to the Grantee under this Agreement until termination of the Grantee's Employment or such other date Company shall permit.

(k) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

Exhibit 10.47

aetna®

AETNA INC.
2010 STOCK INCENTIVE PLAN

EXECUTIVE RESTRICTED STOCK UNIT TERMS OF AWARD

Pursuant to its 2010 Stock Incentive Plan (the "Plan"), Aetna Inc. (the "Company") hereby grants Restricted Stock Units on the terms and conditions hereinafter set forth. The number of Restricted Stock Units awarded and vesting information are included in the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of the Restricted Stock Unit Acknowledgement and Acceptance Form, if applicable. All capitalized terms used herein which are not otherwise defined herein shall have the meaning specified in the Plan.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) "Change in Control" means the happening of any of the following:

(i) When any "person" as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and as used in Sections 13(d) and 14(d) thereof, including a "group" as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company's then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “Beneficial Owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means the Company's Common Shares, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date" means the date of grant of this award of Restricted Stock Units.

(h) “Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such date, on the next day on which the Common Stock is traded.

(i) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(j) "Grantee" means the person to whom this award has been granted.

(k) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively, of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(l) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(m) “Net Shares” means the number of shares of Common Stock which will be deposited in a brokerage account in the Grantee’s name at the Company’s designated broker after shares have been withheld to satisfy applicable tax and withholding requirements upon vesting of the Restricted Stock Units.

(n) “Plan” means the Aetna Inc. 2010 Stock Incentive Plan.

(o) “Restricted Period” means the period during which this award of Restricted Stock Units is not vested.

(p) “Restricted Stock Units” means the number of shares of Common Stock represented by the number of units awarded or such other amount as may result by operation of Article III of this Agreement.

(q) "Retirement" means the termination of employment of a Grantee from active service with the Company, any Subsidiary or Affiliate provided the Grantee’s age and completed years of service total 65 or more points at termination of employment.

(r) “Section 409A” means Section 409A of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(s) “Shares of Stock” or “Stock” means the Common Stock.

(t) "Subsidiary" means an entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock of such entity is held by the Company and/or one or more other subsidiaries.

(u) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to the Restricted Stock Units by bequest or inheritance or by reason of the death of the Grantee.

(v) “Vest Date” means the date on which this award of Restricted Stock Units shall vest in accordance with the terms of this Agreement and as set forth on the website of the designated broker and in the Notice of Restricted Stock Unit Grant, if applicable.

ARTICLE II

RESTRICTED PERIOD

Subject to the terms of this Agreement, the Restricted Stock Units will vest in installments on the Vest Date in accordance with the terms of the Plan and this Terms of Award Agreement, or on such date as provided in Article IV or V. On the Vest Date, the Grantee shall vest to one share of Common Stock for each vested Restricted Stock Unit net of applicable taxes and withholding. Such Net Shares will be delivered to the Company’s designated broker, in a brokerage account established in the Grantee’s name.

ARTICLE III

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this Plan, then the Committee shall, in such manner as the Committee may deem equitable, adjust the number and kind of shares subject to the award of Restricted Stock Units. Additionally, the Committee may make provision for cash payment to a Grantee or the Successor of the Grantee to the extent permitted under Section 409A. However, the number of Restricted Stock Units shall always be a whole number.

ARTICLE IV

CHANGE IN CONTROL

Upon the occurrence of (i) a Change in Control, and (ii) within 24 months thereafter the Company terminates Grantee's Employment without cause, all RSUs, whether or not vested, shall become immediately vested and become payable, provided, however, that, as set forth in the Plan, to the extent the RSUs are considered deferred compensation subject to Section 409A, unless the Change in Control also satisfies the definition of "change in control" under Section 409A, payment shall not be so accelerated but shall occur upon the scheduled Vest Date(s) under Article II.

ARTICLE V

TERMINATION OF EMPLOYMENT

(a) Except as provided in (f) below, if the Grantee shall die during the Restricted Period, the unvested Restricted Stock Units shall become immediately vested and Net Shares, if any, will be deposited with the Company's designated broker in a brokerage account established in Grantee's name.

(b) Except as provided in (f) below, if the Grantee shall begin to receive Long Term Disability benefits during the Restricted Period, the unvested Restricted Stock Units shall continue to vest and Net Shares, if any, will be deposited with the Company's designated broker in a brokerage account established in Grantee's name on the scheduled Vest Date(s) under Article II.

(c) Except as provided in (f) below, if, during the restricted period, Grantee shall cease to be employed by the Company, any Subsidiaries or Affiliates during the Restricted Period, for reason of Retirement or involuntary termination of employment by the Company, a portion of the Restricted Stock Units shall vest in accordance with the following formula: (i) the number of completed months employed after the Effective Date divided by the number of full months in the restricted period; multiplied by (ii) number of Restricted Stock Units, minus any vested Restricted Stock Units. For purposes of this calculation, a month is complete on the day in the following month that corresponds to the Effective Date (e.g., February 13 to March 13). Net shares, if any, will be deposited with the Company's designated broker in a brokerage account established in Grantee's name on the next scheduled Vest Date under Article II and, applicable taxes and withholding will be applied based on the Fair Market Value on that date.

(d) Except as provided in (e) and (f) below, if the Grantee shall, for a reason other than death, Long-Term Disability, Retirement or involuntary termination of employment by the Company, cease to be employed by the Company, any Subsidiaries or Affiliates during the Restricted Period, any unvested Restricted Stock Units shall be forfeited at the time of cessation of employment.

(e) Except as provided in (a) or (b) or (c) above, any Restricted Stock Unit not vested as of the date Grantee terminates employment shall be forfeited at the time of cessation of employment; provided, however, that if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the Restricted Stock Unit in accordance with its terms, then upon the forfeiture of the entire Restricted Stock Unit, the Company will pay Grantee an amount equal to the value of a single share of Common Stock, whether or not the forfeited Restricted Stock Unit related to more than a single share of Common Stock, calculated as of the cessation of employment, if requested by Grantee, within 30 days of such cessation of employment.

(f) No Restricted Stock Unit will vest after the Company has terminated the employment of the Grantee for cause, unless the Committee, in its sole discretion, deems a payment to be warranted under the particular circumstances. In addition, the Restricted Stock Units will not vest if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(g) Employment for purposes of determining the vesting rights of the Grantee and the expiration of the grant under this Article V shall mean continuous full-time salaried employment with the Company, any Subsidiary or an Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), or in receipt of salary continuation or severance pay shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc.

ARTICLE VI

EMPLOYEE COVENANTS

(a) As consideration for this grant of Restricted Stock Units, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company, any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement ("Confidential Information"); provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is

employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of twelve (12) months following Grantee's termination of employment, directly or indirectly, (x) engage in the ownership (except less than 1% of the outstanding capital stock of any publicly traded company) of or, (y) become an employee of, or (z) act as a consultant or contractor to, any competitor of the Company ("Competitor") in any market in the United States where Company, Affiliate or Subsidiary does business.

a. For purposes of this paragraph "Competitor" shall mean any entity, organization, person or corporation that is involved in the same business as Company, Subsidiary or Affiliate, but in the case of (y) and (z), only to the extent such work, consulting or other activity on behalf of other entity, organization, person or corporation

i. is materially similar to the duties and/or functions that Grantee performed for the Company, Subsidiary or Affiliate in the last 12 months or involves duties and/or functions for Competitor about which Grantee has Confidential Information in the last 12 months. Notwithstanding

1. with respect to sales functions for the Company, Subsidiary or Affiliate that are regionally based or whose focus is geographically limited, the restriction shall only apply where such work, consulting or other activity on behalf of a Competitor overlaps in whole or in part the same geographic area in which the Grantee worked for Company, Subsidiary or Affiliate in the last 12 months;

2. with respect to corporate staff functions, the restriction shall only apply where Competitor is substantially engaged in the business of health insurance, managed health care, population health management, or related products or services.

b. Notwithstanding, if Grantee's employment is terminated by the Company, Subsidiary or Affiliate other than for cause, the length of the noncompetition covenant in this paragraph shall not exceed the length of the severance and/or salary continuation benefits paid by the Company, Subsidiary or Affiliate to Grantee.

c. Grantee acknowledges and agrees that these restrictions:

i. are necessary to protect the Confidential Information and goodwill of the Company, Subsidiary or Affiliate;

ii. are appropriately tailored and limited in time and geographic scope to do so; and

iii. do not impair or limit the Grantee's ability to earn a living.

(iii) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee of the Company, any Subsidiary or Affiliate to be employed or perform services elsewhere;

(iv) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company, any Subsidiary or Affiliate to cease or curtail providing services to the Company, any Subsidiary or Affiliate; and

(v) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved.

(vi) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, for himself or herself or on behalf of or in cooperation with any other person or entity, consult with or in any manner provide advice to, any individual or entity which is a customer of the Company or any Subsidiary or Affiliate of the Company, provided, however, that this limitation shall apply only to consultation or advice relating to any product or service of the Company, or any Subsidiary or Affiliate, or which is in competition with any product or service of the Company, or any Subsidiary or Affiliate, and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved, or about which Grantee has Confidential Information

In addition:

(vii) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company, any Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(viii) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company .

(ix) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment and relating in any way to the business or contemplated business, products, activities, research or development of the Company, any Subsidiary or Affiliate, or resulting from any work performed by the Grantee for the Company, any Subsidiary or Affiliate (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). To the extent that the foregoing does not apply, the Grantee hereby irrevocably assigns to the Company, and its successors and assigns, for no additional consideration, the Grantee's entire right, title and interest in and to all such works of authorship. Grantee further acknowledges that while employed by the Company, any Subsidiary or Affiliate, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company, and the Grantee hereby assigns all right, title, and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting therefrom.

(b) If any provision of Article VI (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the Restricted Stock Units is Grantee's covenants set forth in Article VI (a) and that the covenants and obligations of Grantee with respect to nondisclosure, non-solicitation and cooperation relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to vest in the Restricted Stock or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VI. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine.

(d) The Restrictive Covenants set forth in this Article VI shall supplement and do not supersede the restrictions agreed to by Grantee in any other agreement or contract.

(e) Employment Dispute Arbitration Program - Mandatory Binding Arbitration of Employment Disputes.

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether the Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VI (e) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VI (e) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VI (e) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VI (a) in accordance with applicable law). However, except as provided in Article VI (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement .

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org. THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VI (e) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VI (e) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(f) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VI, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

ARTICLE VII

OTHER TERMS

(a) Nothing in this Agreement shall interfere with or limit in any way the right of the Company, any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery hereof nor the granting of the Award shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ or continue the employment of the Grantee for any period.

(b) Until the Restricted Stock Units have become vested, Grantee shall not have any rights as a stockholder (including the right to payment of dividends) by virtue of this grant of Restricted Stock Units.

(c) During the Restricted Period, the Restricted Stock Units shall be nontransferable and non-assignable except by will or the laws of descent and distribution.

(d) The award will be settled on a net basis. Prior to issuing any Common Shares, the Company will withhold an amount sufficient to satisfy federal, state, local, social security and Medicare withholding tax requirements relating to award. Any social security calculation or other adjustments discovered after net share payment will be settled in cash, not in Shares of Common Stock. Vesting will result in taxable compensation reportable on the Grantee's W-2 in year of vesting.

(e) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connection with any such restriction.

(f) This Restricted Stock Unit is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(g) Anything herein to the contrary notwithstanding, a Grantee whose Restricted Stock Units have been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited Restricted Stock Units reinstated as follows: (i) if such Grantee is re-employed during the Restricted Period, all forfeited Restricted Stock Units shall be reinstated; or (ii) if such Grantee is re-employed after the Restricted Period, a cash payment will be made to the Grantee, minus applicable taxes, for the value of the forfeited Restricted Stock Units on the Vest Date pursuant to procedures established by the Company for this purpose.

(h) If any provision of this Agreement would cause Grantee to incur any additional tax or interest under Section 409A, the Company may reform such provision (including an amendment retroactive to the Effective Date to the extent permissible) to comply with Section 409A.

(i) If the Company reasonably anticipates that the Company's tax deduction with respect to the payment upon vesting of the Restricted Stock Units would be limited or eliminated by application of Section 162(m) of the Internal Revenue Code, the Company may elect, in accordance with Section 409A, to delay the payment of such Restricted Stock Units to the earliest date in which the Company anticipates that its tax deduction for such payment will not be limited or eliminated.

(j) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(k) Voluntary Deferral. At such times and upon such terms and conditions as the Company shall determine in accordance with the terms of the Plan and Section 409A, the Company may permit eligible Grantees to elect to defer the distribution of an Award otherwise payable to the Grantee under this Agreement until termination of the Grantee's Employment or such other date Company shall permit.

(l) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

I have read the Restricted Stock Unit Agreement. I accept the Restricted Stock Unit award and agree to be bound by all of its terms and conditions, including mandatory binding arbitration of employment related disputes and, if applicable, any other provisions of Article VI.

Exhibit 10.48

AETNA INC.
2010 STOCK INCENTIVE PLAN

STOCK APPRECIATION RIGHT TERMS OF AWARD

Pursuant to its 2010 Stock Incentive Plan, Aetna Inc. has granted a stock appreciation right on shares of Aetna Inc. Common Stock. The number of shares represented by this right, the Grant Price and vesting information are included on the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of Stock Appreciation Right Grant, if applicable. The Stock Appreciation Right is issued on the terms and conditions hereinafter set forth.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) “Change in Control” means the happening of any of the following:

(i) When any “person” as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”) and as used in Sections 13(d) and 14(d) thereof, including a “group” as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the “beneficial owner” (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company’s then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the “Incumbent Directors”) cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “beneficial owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means shares of the Company's Common Stock, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date” means the date of grant of this Stock Appreciation Right, as approved by the Committee.

(h) “Exercise Date” means the date the Grantee has notified the designated broker to exercise all or a portion of the Stock Appreciation Right.

(i) "Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such day, on the next day on which the Common Stock is traded.

(j) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(k) “Grantee” means the person to whom this Stock Appreciation Right has been granted.

(l) “Grant Price” means the dollar amount per share of Common Stock that is the basis for determining the appreciation in value of the Common Stock.

(m) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as

their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(n) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(o) "Plan" means the Aetna Inc. 2010 Stock Incentive Plan.

(p) "Retirement" means the termination of employment of a Grantee from active service with the Company, a Subsidiary or Affiliate provided the Grantee's age and completed years of service total 65 or more points at termination of employment.

(q) "SAR" means Stock Appreciation Right.

(r) "Shares Granted" means the number of shares of Common Stock represented by the Stock Appreciation Right, or such other amount as may result by operation of Article IV of this Agreement.

(s) "Shares of Stock" or "Stock" means the Common Stock.

(t) "Stock Appreciation Right" or "SAR" means the right granted herein to be paid the excess, as of the Exercise Date, of (i) the Fair Market Value of the shares of Common Stock associated with this Stock Appreciation Right (or the portion thereof that is surrendered on exercise) over (ii) the Grant Price of such Stock Appreciation Right.

(u) "Stock Appreciation Rights Vested" means number of Stock Appreciation Rights exercisable on any given date.

(v) "Subsidiary" means any entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock in such entity is held by the Company and/or one or more other subsidiaries.

(w) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to exercise a SAR by bequest or inheritance or by reason of the death of the Grantee.

(x) "Term" means the period during which the SAR granted hereby may be exercised.

(y) "Vest Date" means the date on which a portion of the SAR becomes exercisable pursuant to the Terms of the Award and, as set forth on the website of the designated broker and in the Notice of Stock Appreciation Right Grant, if applicable.

ARTICLE II

TERM OF SAR AND EXERCISE

(a) Subject to the terms of this Agreement, the term of the SAR shall commence on the first Vest Date and shall terminate, unless sooner terminated by the terms of the Plan or this Terms of Award Agreement, at:

(i) The close of the Company's business on the day preceding the tenth anniversary of the Effective Date, if the Company is open for business on such day; or

(ii) The close of the Company's business on the next preceding day that the Company is open for business.

(b) The SAR is exercisable in installments, each installment to become exercisable as of the Vest Date in accordance with the terms of the Plan and this Terms of Award Agreement. Once an installment is vested, it may be exercised in whole or in part only during the Term of the SAR.

ARTICLE III

METHOD OF SAR EXERCISE

In order to exercise this SAR, Grantee must comply with procedures adopted by the Company from time to time. Under current procedures, the Grantee must exercise the SAR through the Company’s designated broker.

In addition, if the Grantee has been notified that he or she must consult with a member of the Company's Law and Regulatory Affairs Unit prior to engaging in transactions in Aetna stock, Grantee must consult with Law prior to exercising the SAR.

Upon exercise of the SAR, payment (net of federal, state, local, social security and medicare taxes, if applicable) shall be paid in Common Stock. The resulting shares of Common Stock will be deposited in a brokerage account established in Grantee’s name at the designated broker.

ARTICLE IV

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this SAR or the Plan, then the Committee may, in such manner as the Committee may deem equitable, adjust the (i) the number and kind of shares subject to the SAR or (ii) the SAR Grant Price. Additionally, the Committee may make provision for a cash payment to a Grantee or the Successor of the Grantee to the extent permitted under Section 409A. However, the number of Shares of Stock subject to the SAR shall always be a whole number.

ARTICLE V

CHANGE IN CONTROL

Upon the occurrence of (i) a Change in Control, and (ii) within 24 months thereafter, the Company terminates Grantee's Employment without cause, all SARs, whether or not vested, shall become immediately vested and become payable in accordance with the terms of this Agreement.

ARTICLE VI
TERMINATION OF SAR

(a) Except as provided in (d) below, if the Grantee shall die or begin to receive Long Term Disability benefits after the Effective Date, the SAR shall become vested and immediately exercisable and the Grantee or Successor of the Grantee may exercise the SAR until the earlier of:

(i) The expiration of the Term of the SAR; or

(ii) A period not to exceed five years following such death or commencement of Long Term Disability benefits.

(b) Except as provided in (e) below, if Grantee shall, for reason of Retirement, cease to be employed by the Company, its Subsidiaries or Affiliates after the Effective Date, the Grantee will become immediately vested and may immediately exercise any SAR that would have otherwise become vested within one year from the Grantee's termination of employment, and the Grantee or Successor of the Grantee may exercise a vested SAR until the earlier of:

(i) The expiration of the Term of the SAR; or

(ii) A period not to exceed five years following such cessation of employment.

(c) Except as provided in (d) and (e) below, if the Grantee shall, for a reason other than death, Long Term Disability or Retirement, cease to be employed by the Company, its Subsidiaries or Affiliates during the Term of the SAR, the Grantee may exercise a vested SAR until the earlier of:

(i) The expiration of the term of the SAR; or

(ii) A period not to exceed ninety days following such cessation of employment.

(d) Except as provided in (a) or (b) above, any SAR, or portion of a SAR that has not become vested and exercisable at the time of cessation of employment shall terminate immediately upon such cessation of employment and may not be exercised thereafter. Provided, however, if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the SAR in accordance with its terms, then upon the forfeiture of the entire SAR, the Company shall pay Grantee an amount equal to the SAR value on a single share of Common Stock, whether or not the forfeited SAR related to more than a single share of Common Stock, calculated as of the date of termination of employment under the same

method as the Company calculates its SAR expense charge for purposes of its financial statement reporting, if requested by Grantee, within 30 days of such cessation of employment.

(e) No SAR may vest or be exercised after the Company has terminated the employment of the Grantee for cause, except that the Committee may, in its sole discretion, permit the exercise of a vested SAR for a period of up to ninety days in cases where the Committee shall determine such exercise period is warranted under the particular circumstances. In addition, the Company may terminate the SAR if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(f) Employment for purposes of determining the vesting rights of the Grantee and expiration date of the grant under this Article VI shall mean continuous full-time salaried employment with the Company, a Subsidiary or an Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), or in receipt of salary continuation or severance pay shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc.

(g) Except as otherwise herein provided, exercise of the SAR, whether by the Grantee or the Successor of the Grantee, shall be subject to all terms and conditions of this Agreement.

ARTICLE VII
OTHER TERMS

(a) Grantee understands that the Grantee shall not have any rights as stockholder by virtue of the grant of an SAR but only with respect to shares of Common Stock actually issued to the Grantee in accordance with the terms hereof.

(b) Anything herein to the contrary notwithstanding, the Company may postpone the exercise of the SAR or any portion thereof for such time as the Committee in its discretion may deem necessary, in order to permit the Company with reasonable diligence (i) to effect or maintain registration under the Securities Act of 1933, as amended, of the Plan or the shares of Common Stock issuable upon the exercise of the SAR or (ii) to determine that the Plan and such shares are exempt from registration; and the Company shall not be obligated by virtue of this Agreement or any provision of the Plan to recognize the exercise of the SAR or to sell or issue shares of Common Stock in violation of said Act or of the law of any government having jurisdiction thereof. Any such postponement shall not extend the Term of the SAR; and neither the Company nor its Board shall have any obligation or liability to the Grantee, or to the Grantee's Successor, with respect to any shares of Common Stock as to which the SAR shall lapse because of such postponement.

(c) The SAR shall be nontransferable and nonassignable except by will and by the laws of descent and distribution. During the Grantee's lifetime, the SAR may be exercised only by the Grantee.

(d) The SAR is not an incentive stock option as described in the Internal Revenue Code of 1986, as amended, Section 422A (b).

(e) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(f) Anything herein to the contrary notwithstanding, a Grantee whose SAR has been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited SAR reinstated for the original Term pursuant to procedures established by the Company for this purpose.

(g) Nothing in this Agreement shall interfere with a limit in anyway the right of the Company or any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery of this Agreement nor the granting of the SAR shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ Grantee for any period.

(h) This SAR is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(i) The Company shall have the power to withhold, an amount sufficient to satisfy Federal, state and local, social security and medicare withholding tax requirements, if applicable. Any social security calculation or other adjustments discovered after the net share payment will be settled in cash, not in Common Stock.

(j) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connections with any such restriction.

(k) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

ARTICLE VIII

EMPLOYEE COVENANTS

(a) As consideration for the grant of the SAR, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's Employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company, any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement ("Confidential Information"); provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of twelve (12) months following Grantee's termination of employment, directly or indirectly, (x) engage in the ownership (except less than 1% of the outstanding capital stock of any publicly traded company) of or, (y) become an employee of, or (z) act as a consultant or contractor to, any competitor of the Company ("Competitor") in any market in the United States where Company, Affiliate or Subsidiary does business.

a. For purposes of this paragraph "Competitor" shall mean any entity, organization, person or corporation that is involved in the same business as Company, Subsidiary or Affiliate, but in the case of (y) and (z), only to the extent such work, consulting or other activity on behalf of other entity, organization, person or corporation

i. is materially similar to the duties and/or functions that Grantee performed for the Company, Subsidiary or Affiliate in the last 12 months or involves duties and/or functions for Competitor about which Grantee has Confidential Information in the last 12 months. Notwithstanding

1. with respect to sales functions for the Company, Subsidiary or Affiliate that are regionally based or whose focus is geographically limited, the restriction shall only apply where such work, consulting or other activity on behalf of a Competitor overlaps in whole or in part the same geographic area in which the Grantee worked for Company, Subsidiary or Affiliate in the last 12 months;

2. with respect to corporate staff functions, the restriction shall only apply where Competitor is substantially engaged in the business of health insurance, managed health care, population health management, or related products or services.

b. Notwithstanding, if Grantee's employment is terminated by the Company, Subsidiary or Affiliate other than for cause, the length of the noncompetition covenant in this paragraph shall not exceed the length of the severance and/or salary continuation benefits paid by the Company, Subsidiary or Affiliate to Grantee.

c. Grantee acknowledges and agrees that these restrictions:

i. are necessary to protect the Confidential Information and goodwill of the Company, Subsidiary or Affiliate;

ii. are appropriately tailored and limited in time and geographic scope to do so; and

iii. do not impair or limit the Grantee's ability to earn a living.

(iii) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee of the Company, and Subsidiary or Affiliate to be employed or perform services elsewhere;

(iv) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company, any Subsidiary or Affiliate to cease or curtail providing services to the Company, any Subsidiary or Affiliate; and

(v) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved

(vi) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, for himself or herself or on behalf of or in cooperation with any other person or entity, consult with or in any manner provide advice to, any individual or entity which is a customer of the Company or any Subsidiary or Affiliate of the Company, provided, however, that this limitation shall apply only to consultation or advice relating to any product or service of the Company, or any Subsidiary or Affiliate, or which is in competition with any product or service of the Company, or any Subsidiary or Affiliate, and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved, or about which Grantee has Confidential Information.

In addition:

(vii) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company, any Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(viii) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company.

(ix) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment and relating in any way to the business or contemplated business, products, activities, research or development of the Company, any Subsidiary or Affiliate, or resulting from any work performed by the Grantee for the Company, any Subsidiary or Affiliate (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). To the extent that the foregoing does not apply, the Grantee hereby irrevocably assigns to the Company, and its successors and assigns, for no additional consideration, the Grantee's entire right, title and interest in and to all such works of authorship. Grantee further acknowledges that while employed by the Company, any Subsidiary or Affiliate, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company and the Grantee hereby assigns all right, title and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting therefrom.

(b) If any provision of Article VIII (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the SAR is Grantee's covenants set forth in Article VIII(a) and that the covenants and obligations of Grantee with respect to nondisclosure, nonsolicitation, cooperation and intellectual property rights relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to exercise the SAR or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VIII. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine..

(d) The Restrictive Covenants set forth in this Article VIII shall supplement and do not supersede the restrictions agreed to by Grantee in any other agreement or contact.

(e) Employment Dispute Arbitration Program - Mandatory Binding Arbitration of Employment Disputes.

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VIII (e) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VIII (e) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VIII (e) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VIII (a) in accordance with applicable law). However, except as provided in Article VIII (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement.

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org . THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VIII (e) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VIII (e) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(f) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VIII, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

I have read the Stock Appreciation Right Agreement. I accept the Stock Appreciation Right award and agree to be bound by all of its terms and conditions including mandatory binding arbitration of employment related disputes and, if applicable, any other provisions of Article VIII.

Exhibit 13.1

Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and Cautionary Statement Concerning Forward-Looking Statements that are included in this Annual Report.

Overview of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans (see "Liquidity and Capital Resources" later in this document). The consolidated financial statements for the year ended December 31, 2018 reflect Aetna's results subsequent to the Aetna Acquisition Date.

On October 10, 2018, the Company and Aetna entered into a consent decree with the United States Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. for the divestiture of Aetna's standalone Medicare Part D prescription drug plans effective December 31, 2018. On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans. Aetna's standalone Medicare Part D prescription drug plans had an aggregate of approximately 2.3 million members as of December 31, 2018. Aetna will provide administrative services to, and will retain the financial results of, the divested plans through 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care plans, plans offered on public health insurance exchanges and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and

branches for infusion and enteral nutrition services. During the year ended December 31, 2018, the Company's PBM filled or managed approximately 1.9 billion prescriptions on a 30-day equivalent basis.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic ® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, the Retail/LTC segment also provided commercialization services under the name RxCrossroads ® . The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, the Retail/LTC segment operated more than 9,900 retail locations, over 1,100 MinuteClinic ® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2018, the Retail/LTC segment filled approximately 1.3 billion prescriptions on a 30-day equivalent basis. In December 2018, the Company held approximately 26% of the United States retail pharmacy market.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018 . The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates.

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Results of Operations

Summary of Consolidated Financial Results

	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 183,910	$ 180,063	$ 173,377	$ 3,847	2.1 %	$ 6,686	3.9 %
Premiums	8,184	3,558	3,069	4,626	130.0 %	489	15.9 %
Services	1,825	1,144	1,080	681	59.5 %	64	5.9 %
Net investment income	660	21	20	639	3,042.9 %	1	5.0 %
Total revenues	194,579	184,786	177,546	9,793	5.3 %	7,240	4.1 %
Operating Costs:							
Cost of products sold	156,447	153,448	146,533	2,999	2.0 %	6,915	4.7 %
Benefit costs	6,594	2,810	2,179	3,784	134.7 %	631	29.0 %
Goodwill impairments	6,149	181	—	5,968	3,297.2 %	181	— %
Operating expenses	21,368	18,809	18,448	2,559	13.6 %	361	2.0 %
Total operating costs	190,558	175,248	167,160	15,310	8.7 %	8,088	4.8 %
Operating income	4,021	9,538	10,386	(5,517)	(57.8)%	(848)	(8.2)%
Interest expense	2,619	1,062	1,078	1,557	146.6 %	(16)	(1.5)%
Loss on early extinguishment of debt	—	—	643	—	— %	(643)	(100.0)%
Other expense (income)	(4)	208	28	(212)	(101.9)%	180	642.9 %
Income before income tax provision	1,406	8,268	8,637	(6,862)	(83.0)%	(369)	(4.3)%
Income tax provision	2,002	1,637	3,317	365	22.3 %	(1,680)	(50.6)%
Income (loss) from continuing operations	(596)	6,631	5,320	(7,227)	(109.0)%	1,311	24.6 %
Loss from discontinued operations, net of tax	—	(8)	(1)	8	(100.0)%	(7)	700.0 %
Net income (loss)	(596)	6,623	5,319	(7,219)	(109.0)%	1,304	24.5 %
Net (income) loss attributable to noncontrolling interest	2	(1)	(2)	3	(300.0)%	1	(50.0)%
Net income (loss) attributable to CVS Health	$ (594)	$ 6,622	$ 5,317	$ (7,216)	(109.0)%	$ 1,305	24.5 %

Commentary - 2018 compared to 2017

Revenues

- Total revenues increased $9.8 billion or 5.3% in 2018 compared to 2017 . The increase in total revenues was due to a 2.7% increase in Pharmacy Services segment revenue, a 5.8% increase in Retail/LTC segment revenue and the impact of the Aetna Acquisition (primarily reflected in the Health Care Benefits segment) which occurred in November 2018.
- Please see “Segment Analysis” later in this document for additional information about the revenues of the Company’s segments.

Operating expenses (including goodwill impairments)

- Operating expenses increased $8.5 billion or 44.9% in 2018 compared to 2017 . The increase in operating expenses was primarily due to higher operating expenses in the Retail/LTC segment including increased goodwill impairment charges in 2018, the impact of the Aetna Acquisition and an increase in acquisition-related transaction and integration costs. The increase was partially offset by a lack of charges associated with store closures in 2018.
- Operating expenses as a percentage of total revenues was 14.1% in 2018 , an increase of 380 basis points compared to 2017 . The increase in operating expenses as a percentage of total revenues in 2018 was primarily due to the goodwill impairment charges in the Retail/LTC segment in 2018.
- Please see “Segment Analysis” later in this document for additional information about the operating expenses of the Company’s segments.

Operating income

- Operating income decreased $5.5 billion or 57.8% in 2018 compared to 2017 . The decrease was primarily due to the increase in operating expenses described above, continued price compression in the Pharmacy Services segment and reimbursement pressure in the Retail/LTC segment. The decrease was partially offset by increased prescription volume, improved purchasing economics and the addition of Aetna.
- Please see “Segment Analysis” later in this document for additional information about the operating income of the Company’s segments.

Interest expense

- Interest expense increased $1.6 billion during 2018 , primarily due to financing activity associated with the Aetna Acquisition. See Note 8 ‘‘Borrowings and Credit Agreements’’ to the consolidated financial statements for additional information.

Other expense (income)

- Other expense decreased $212 million during 2018, primarily due to 2017 reflecting a $187 million loss on settlement of the Company’s defined benefit pension plans.

Income tax provision

- The Tax Cuts and Jobs Act (the “TCJA”) was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The Company completed its assessment of the TCJA’s final impact in December 2018 and recorded an additional tax benefit of approximately $100 million .
- The Company’s effective income tax rate was 142.4% in 2018 compared to 19.8% in 2017 . The increase in the effective income tax rate was primarily due to the goodwill impairment charges in the Retail/LTC segment in 2018, the majority of which are not deductible for income tax purposes, and an income tax benefit of $1.5 billion in 2017 which reflected the remeasurement of the Company’s net deferred income tax liabilities as a result of the enactment of the TCJA. The increase was partially offset by a lower federal corporate income tax rate in 2018 compared to the prior year as a result of the enactment of the TCJA, which reduced the corporate income tax rate in 2018 to 21% from 35% in 2017.

Loss from discontinued operations

- In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens ‘n Things, which filed for bankruptcy in 2008, and Bob’s stores, which filed for bankruptcy in 2016. The Company’s loss from discontinued operations includes lease-related costs required to satisfy its Linens ‘n Things and Bob’s Stores lease guarantees.
- The Company incurred a loss from discontinued operations, net of tax, of $8 million in 2017 . Results from discontinued operations were immaterial in 2018.
- See “Discontinued Operations” in Note 1 ‘‘Significant Accounting Policies’’ to the consolidated financial statements for additional information about discontinued operations and Note 16 ‘‘Commitments and Contingencies’’ to the consolidated financial statements for additional information about the Company’s lease guarantees.

Commentary - 2017 compared to 2016

Revenues

- Total revenues increased $7.2 billion or 4.1% in 2017 compared to 2016 . The increase in total revenues was due to a 8.9% increase in Pharmacy Services segment revenue, partially offset by a 2.1% decrease in Retail/LTC segment revenue.
- The increase in generic dispensing rates in 2017 negatively affected both the Pharmacy Services and Retail/LTC segment revenues in 2017 compared to 2016 .
- Please see “Segment Analysis” later in this document for additional information about the revenues of the Company’s segments.

Operating expenses (including goodwill impairments)

- Operating expenses increased $542 million , or 2.9% , in 2017 compared to 2016 . The increase in operating expenses primarily relates to (i) higher operating expenses in the Retail/LTC segment including an increase of $181 million in charges associated with the closure of retail stores in connection with the Company’s enterprise streamlining initiative and a $181 million goodwill impairment charge related to the RxCrossroads reporting unit; and (ii) higher operating expenses

in the Pharmacy Services segment due to 2016 reflecting the favorable impact of a reversal of an accrual of $85 million in connection with a legal settlement. The increase was partially offset by lower acquisition-related transaction and integration costs due to the bulk of the integration costs related to the acquisition of Omnicare, Inc. ("Omnicare") being incurred in 2016.

- Operating expenses as a percentage of total revenues was 10.3% in 2017 , a decline of 10 basis points compared to 2016 . The decline in operating expenses as a percentage of total revenues in 2017 was primarily due expense leverage from revenue growth.
- Please see "Segment Analysis" later in this document for additional information about the operating expenses of the Company's segments.

Operating income

- Operating income decreased $848 million or 8.2% in 2017 compared to 2016 . The decrease was primarily driven by the previously announced restricted networks that excluded CVS Pharmacy, continued price compression in the Pharmacy Services segment, reimbursement pressure in the Retail/LTC segment and the increased operating expenses described above.
- Please see "Segment Analysis" later in this document for additional information about the operating income of the Company's segments.

Interest expense

- Interest expense decreased $16 million during 2017 , primarily due to the Company's debt issuance and debt tender offers that occurred in 2016 which resulted in overall more favorable interest rates on the Company's long-term debt. See Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements for additional information.

Other expense (income)

- Other expense increased $180 million during 2017 , primarily due to 2017 reflecting a $187 million loss on settlement of the Company's defined benefit pension plans.

Loss on early extinguishment of debt

- The loss on early extinguishment of debt of $643 million in 2016 relates to the redemption of approximately $4.2 billion aggregate principal amount of certain of the Company's senior notes (see Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements). As a result of the redemption, the Company paid a premium of $583 million in excess of the debt principal, wrote off $54 million of unamortized deferred financing costs and incurred $6 million in fees.

Income tax provision

- The Company's effective income tax rate was 19.8% in 2017 compared to 38.4% in 2016 . The decrease in the effective income tax rate was primarily due to the provisional impact of the TCJA, including the revaluation of net deferred tax liabilities.
- As the result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion in 2017.

Loss from discontinued operations

- Please see the *Commentary - 2018 compared to 2017* section above for additional information about the Company's discontinued operations.
- The Company incurred losses from discontinued operations, net of tax, of $8 million and $1 million in 2017 and 2016 , respectively.

Outlook for 2019

The Company expects 2019 to be a transition year as it integrates the Aetna Acquisition and focuses on key pillars of its growth strategy. The Company believes that it is on track to exceed its 2020 target for synergies from the Aetna Acquisition. The Company also expects that the following challenges may have a disproportionate adverse impact on, and reduce, the operating income of its Pharmacy Services and Retail/LTC segments in 2019 compared to 2018:

- Ongoing pharmacy reimbursement pressure in the Pharmacy Services and Retail/LTC segments and reductions in the traditional offsets to those pressures, including a declining benefit from the introduction of new multi-source generic prescription drugs and lower benefits from generic dispensing rate increases;
- The reimbursement pressure in the Pharmacy Services segment is projected to be exacerbated by the cumulative effect on rebate guarantees of lower brand name drug price inflation and a modest 2019 selling season; and
- The Retail/LTC segment is projected to be impacted by structural and Company specific challenges in the long-term care space as well as the annualization of the Company's 2018 investment of a portion of the savings from the TCJA in wages and benefits.

The Company is taking specific actions designed to address these challenges and position it well in 2020 and beyond. These actions include new product and service initiatives in its Pharmacy Services and Retail/LTC segments, introducing a new PBM client contracting model, accelerating the action plan designed to improve the performance of the LTC business and initiating a new enterprise cost reduction effort. The Company also is continuing to evaluate its assets and the roles they play in enabling the Company's core strategies.

The Company's current expectations described above are forward-looking statements. Please see "Cautionary Statement Concerning Forward-Looking Statements" below for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company evaluates the performance of its operating segments based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The following is a reconciliation of the Company's segments total revenues and operating income (loss) to the consolidated financial statements:

In millions	**Pharmacy Services [1][2]**	**Retail/LTC [2]**	**Health Care Benefits [2]**	**Corporate/ Other**	**Intersegment Eliminations [2]**	**Consolidated Totals**
2018						
Total revenues [3]	$ 134,128	$ 83,989	$ 5,549	$ 606	$ (29,693)	$ 194,579
Operating income (loss) [4][5]	4,699	620	276	(805)	(769)	4,021
2017						
Total revenues [7]	130,601	79,398	—	16	(25,229)	184,786
Operating income (loss) [4][5][7]	4,657	6,558	—	(936)	(741)	9,538
2016						
Total revenues [7]	119,965	81,100	—	18	(23,537)	177,546
Operating income (loss) [4][5][6][7]	4,570	7,437	—	(900)	(721)	10,386

(1) Total revenues of the Pharmacy Services segment include approximately $11.4 billion , $10.8 billion and $10.5 billion of Retail Co-Payments for 2018 , 2017 and 2016 , respectively. See Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information about Retail Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment and the Retail/LTC segment for 2018, 2017 and 2016. Effective November 28, 2018, intersegment eliminations also relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment and/or the Retail/LTC segment.

(3) Corporate/Other segment revenues for 2018 include interest income of $536 million related to the proceeds of the $40 billion principal amount of unsecured floating rate notes and unsecured fixed rate senior notes the Company issued on March 9, 2018 (collectively, the "2018 Notes"). This amount is for the period prior to the close of the Aetna Acquisition, which occurred on November 28, 2018.

(4) Retail/LTC segment operating income for 2018 , 2017 and 2016 includes $7 million , $34 million and $281 million , respectively, of acquisition-related integration costs. The integration costs in 2018 and 2017 are related to the acquisition of Omnicare. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target Corporation ("Target"). Retail/LTC segment operating income for 2018 and 2017 also includes goodwill impairment charges of $6.1 billion related to the LTC reporting unit and $181 million related to the RxCrossroads reporting unit, respectively. In addition, Retail/LTC segment operating income for 2017 and 2016 includes $215 million and $34 million , respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company's enterprise streamlining initiative. Retail/LTC segment operating income for 2018 also includes a $43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment and an $86 million loss on the divestiture of the Company's RxCrossroads subsidiary.

(5) Corporate/Other segment operating loss for 2018 , 2017 and 2016 includes $485 million , $40 million and $10 million, respectively, of divestiture and acquisition-related transaction and integration costs included in operating expenses in the consolidated statements of operations. The transaction and integration costs in 2018 are related to the acquisitions of Aetna and Omnicare. The transaction and integration costs in 2017 are related to the acquisitions of Aetna and Omnicare and the divestiture of RxCrossroads. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.

(6) Pharmacy Services segment operating income for 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

(7) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within total revenues to conform with insurance company presentation which increased total revenues and operating income by $21 million and $20 million in 2017 and 2016 , respectively.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 130,264	$ 126,770	$ 116,639	$ 3,494	2.8 %	$ 10,131	8.7%
Premiums	3,361	3,558	3,069	(197)	(5.5)%	489	15.9%
Services	490	268	255	222	82.8 %	13	5.1%
Net investment income [1]	13	5	2	8	160.0 %	3	150.0%
Total revenues	134,128	130,601	119,965	3,527	2.7 %	10,636	8.9%
Cost of products sold	125,107	121,799	111,949	3,308	2.7 %	9,850	8.8%
Benefit costs	2,805	2,810	2,179	(5)	(0.2)%	631	29.0%
Operating expenses [2]	1,517	1,335	1,267	182	13.6 %	68	5.4%
Operating expenses % of revenues	1.1%	1.0%	1.1%				
Operating income [1]	$ 4,699	$ 4,657	$ 4,570	$ 42	0.9 %	$ 87	1.9%
Operating income % of revenues	3.5%	3.6%	3.8%				
Revenues (by distribution channel): [8]							
Pharmacy network [3][4]	$ 83,261	$ 80,891	$ 73,686	$ 2,370	2.9 %	$ 7,205	9.8%
Mail choice [5]	46,934	45,709	42,783	1,225	2.7 %	2,926	6.8%
Other [4]	3,920	3,996	3,494	(76)	(1.9)%	502	14.4%
Pharmacy claims processed: [6][7]							
Total	1,889.8	1,781.9	1,639.2	107.9	6.1 %	142.7	8.7%
Pharmacy network [3]	1,601.4	1,516.7	1,387.7	84.7	5.6 %	129	9.3%
Mail choice [5]	288.4	265.2	251.5	23.2	8.7 %	13.7	5.4%
Generic dispensing rate: [6][7]							
Total	87.3%	87.0%	85.9%				
Pharmacy network [3]	87.9%	87.7%	86.7%				
Mail choice [5]	83.9%	83.1%	81.4%				
Mail choice penetration rate [6][7]	15.3%	14.9%	15.3%				

(1) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within revenues to conform with insurance company presentation which increased both net investment income and operating income by $5 million and $2 million in 2017 and 2016 , respectively.
(2) Pharmacy Services segment operating expenses in 2016 include the reversal of an accrual of $88 million in connection with a legal settlement.
(3) Pharmacy network revenues, pharmacy network claims processed and pharmacy network generic dispensing rate do not include Maintenance Choice ® activity, which is included within the mail choice category. Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice activity.
(4) Amounts revised for 2017 and 2016 to reflect the reclassification of Medicare Part D premium revenues from pharmacy network revenues to other revenues.
(5) Mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect ® claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program, which permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order..
(6) Includes the adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.
(7) The pharmacy claims processed, generic dispensing rate and mail choice penetration rate in 2016 have been revised to convert 90-day prescriptions to the equivalent of three 30-day prescriptions.
(8) Excludes net investment income.

Commentary - 2018 compared to 2017

Revenues

- Total revenues increased $3.5 billion , or 2.7% , to $134.1 billion in 2018 compared to 2017. The increase was primarily due to increased total pharmacy claims volume, partially offset by continued client pricing pressures.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 8.7% to 288.4 million claims in 2018 compared to 265.2 million claims in 2017 . The increase in mail choice claims was primarily driven by the continued adoption of Maintenance Choice offerings and an increase in specialty pharmacy claims.
  - During 2018 , the average revenue per mail choice claim, on a 30-day equivalent basis, decreased by 5.6% compared to 2017 as a result of price compression.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 5.6% to approximately 1.6 billion claims in 2018 compared to approximately 1.5 billion claims in 2017 . The increase in the pharmacy network claim volume was primarily due to net new business.
  - During 2018 , the average revenue per pharmacy network claim processed, on a 30-day equivalent basis, decreased 2.7% compared to 2017 as a result of continued price compression.
  - The Company's total generic dispensing rate increased to 87.3% in 2018 compared to 87.0% in 2017 . The continued increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate. The Company believes its generic dispensing rate will continue to increase in future periods, albeit at a slower pace. This increase will be affected by, among other things, the number of new brand and generic drug introductions and the Company's success at encouraging plan members to utilize generic drugs when they are available and clinically appropriate.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses, depreciation and amortization related to selling, general and administrative activities and administrative payroll, employee benefits and occupancy costs.
- Operating expenses increased $182 million , or 13.6% , in 2018 compared to 2017 . The year over year increase in operating expenses was primarily due to:
  - Growth in the business, including acquisitions; and
  - The reinstatement of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010' s (as amended, collectively, the "ACA's") health insurer fee ("HIF") in 2018;
  - Partially offset by the realization of partially reserved receivables in 2017 which reduced operating expenses.
- Operating expenses as a percentage of total revenues remained relatively consistent at 1.1% and 1.0% in 2018 and 2017 , respectively.

Operating income

- Operating income increased $42 million , or 0.9% , to $4.7 billion in 2018 compared to 2017 . The increase in operating income was primarily due to increased claims volume and improved purchasing economics, partially offset by continued price compression and the increased operating expenses described above.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Commentary - 2017 compared to 2016

Revenues

- Total revenues increased $10.6 billion , or 8.9% , to $130.6 billion in 2017 compared to 2016 . The increase was primarily due to growth in pharmacy network and specialty pharmacy volume as well as brand name drug price inflation, partially offset by continued price compression and increased generic dispensing.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 5.4% to 265.2 million claims in 2017 compared to 251.5 million claims in 2016 .
  - During 2017 , the Company's average revenue per mail choice claim, on a 30-day equivalent basis, increased by 1.7% compared to 2016 . The increase was primarily due to growth in specialty pharmacy and brand name drug price inflation.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 9.3% to approximately 1.5 billion claims in 2017 compared to approximately 1.4 billion claims in 2016 . The increase was primarily due to increased volume from net new business.
  - During 2017 , the average revenue per pharmacy network claim processed remained flat on a 30-day equivalent basis.
  - The Company's total generic dispensing rate increased to 87.0% in 2017 compared to 85.9% in 2016 . The increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions, and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate.

Operating expenses

- Operating expenses increased $68 million , or 5.4% , in 2017 compared to 2016 . The year over year increase in operating expenses was primarily due to an $88 million reversal of an accrual in connection with a legal settlement in 2016 and an increase in costs associated with the growth of the business. The increase was partially offset by the realization of partially reserved receivables in 2017 which reduced operating expenses.
- Operating expenses as a percentage of revenues remained relatively consistent at 1.0% and 1.1% of revenues in 2017 and 2016 , respectively.

Operating income

- Operating income increased $87 million , or 1.9% , to $4.7 billion in 2017 compared to 2016 . The increase in operating income was primarily due to growth in specialty pharmacy, higher generic dispensing and favorable purchasing economics, partially offset by price compression and the increased operating expenses described above.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Revenues							
Products	$ 83,175	$ 78,522	$ 80,275	$ 4,653	5.9 %	$ (1,753)	(2.2)%
Services	814	876	825	(62)	(7.1)%	51	6.2 %
Total revenues	83,989	79,398	81,100	4,591	5.8 %	(1,702)	(2.1)%
Cost of products sold [1]	59,906	56,066	57,339	3,840	6.8 %	(1,273)	(2.2)%
Operating expenses [2][3][4][5][6]	23,463	16,774	16,324	6,689	39.9 %	450	2.8 %
Operating expenses % of revenues	27.9%	21.1 %	20.1 %				
Operating income [1][2][3][4][5][6]	$ 620	$ 6,558	$ 7,437	$ (5,938)	(90.5)%	$ (879)	(11.8)%
Operating income % of revenues	0.7%	8.3 %	9.2 %				
Revenues (by major goods/service line):							
Pharmacy	$ 64,179	$ 59,528	$ 60,838	$ 4,651	7.8 %	$ (1,310)	(2.2)%
Front Store	19,055	18,769	19,123	286	1.5 %	(354)	(1.9)%
Other	755	1,101	1,139	(346)	(31.4)%	(38)	(3.3)%
Prescriptions filled [7]	1,339.1	1,230.5	1,223.5	108.6	8.8 %	7.0	0.6 %
Revenue increase (decrease):							
Total	5.8%	(2.1)%	12.6 %				
Pharmacy	7.8%	(2.2)%	15.9 %				
Front Store	1.5%	(1.9)%	0.3 %				
Total prescription volume [7]	8.8%	0.6 %	18.6 %				
Same store sales increase (decrease): [8]							
Total	6.0%	(2.6)%	1.9 %				
Pharmacy	7.9%	(2.6)%	3.2 %				
Front Store	0.5%	(2.6)%	(1.5)%				
Prescription volume [7]	9.1%	0.4 %	3.6 %				
Generic dispensing rate	87.5%	87.3 %	85.7 %				

(1) Cost of products sold and operating income for 2017 include $2 million of acquisition-related integration costs related to the acquisition of Omnicare.
(2) Operating expenses and operating income in 2018, 2017 and 2016 include $7 million , $32 million and $235 million , respectively, of acquisition-related integration costs. In 2018 and 2017 , the integration costs related to the acquisition of Omnicare. In 2016 , the integration costs related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.
(3) Operating expenses and operating income for 2018 and 2017 include goodwill impairment charges of $6.1 billion related to the LTC reporting unit and $181 million related to the RxCrossroads reporting unit, respectively.
(4) Operating expenses and operating income for 2017 and 2016 include $215 million and $34 million , respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company's enterprise streamlining initiative.
(5) Operating expenses and operating income for 2018 include a $43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment.
(6) Operating expenses and operating income for 2018 include an $86 million loss on the divestiture of the Company's RxCrossroads subsidiary.
(7) Includes the adjustment to convert 90-day, non-specialty prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.
(8) Same store sales and prescription volume exclude revenues from MinuteClinic, and revenue and prescriptions from stores in Brazil, LTC operations and commercialization services.

Commentary - 2018 compared to 2017

Revenues

- Total revenues increased approximately $4.6 billion , or 5.8% , to $84.0 billion in 2018 compared to 2017 . The increase was primarily driven by increased prescription volume and brand name drug price inflation, partially offset by continued reimbursement pressure and the impact of recent generic introductions.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - Front store same store sales increased 0.5% in 2018 compared to 2017 . Front store sales in 2018 continued to benefit from increases in health product sales.
    - Pharmacy same store sales increased 7.9% in 2018 compared to 2017 . The increase was driven by the 9.1% increase in pharmacy same store prescription volumes on a 30-day equivalent basis due to (i) continued adoption of patient care programs, (ii) collaborations with PBMs, and (iii) the Company's preferred status in a number of Medicare Part D networks during 2018. The increase was also due to the impact of year over year brand name drug price inflation that occurred primarily in the first three months of 2018.
    - Pharmacy revenue continues to be adversely affected by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 87.5% in 2018 compared to 87.3% in 2017 . In addition, pharmacy revenue growth has also been negatively affected by continued reimbursement pressure.
    - 2017 revenues include approximately $0.4 billion related to the Company's RxCrossroads subsidiary which was sold on January 2, 2018.
    - Pharmacy revenue growth has been adversely affected by industry challenges in the LTC business, such as continuing lower occupancy rates at skilled nursing facilities, as well as the deteriorating financial health of many skilled nursing facilities which resulted in a number of customer bankruptcies in 2018.
    - Pharmacy revenue in 2018 continued to benefit from the Company's ability to attract and retain managed care customers and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

Operating expenses (including goodwill impairments)

- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $6.7 billion , or 39.9% , in 2018 compared to 2017 . The increase in operating expenses in 2018 was primarily due to:
    - A goodwill impairment charge of $6.1 billion in 2018 in the LTC reporting unit (see Note 5 ‘‘Goodwill and Other Intangibles’’ to the consolidated financial statements), as compared to a $181 million goodwill impairment charge in the RxCrossroads reporting unit recorded in 2017 in connection with the upcoming sale of RxCrossroads. See the discussion of goodwill under “Critical Accounting Policies” later in this document;
    - An $86 million pre-tax loss on the sale of the RxCrossroads subsidiary in 2018;
    - A $43 million impairment of long-lived assets in 2018; and
    - An increase in operating expenses due to (i) the investment of a portion of the savings from the TCJA in wages and benefits, (ii) increased prescription volume described previously, (iii) incremental costs associated with operating more stores and (iv) other investments in the business to drive revenue growth;
    - Partially offset by lower operating expenses as a result of a lack of charges associated with store closures in 2018, for which the Company incurred $215 million in connection with its enterprise streamlining initiative in 2017; and
    - A decrease in hurricane-related expenses of $25 million in 2018 compared to 2017 .
- Operating expenses as a percentage of total revenues were 27.9% in 2018 compared to 21.1% in 2017 . The increase in operating expenses as a percentage of total revenues was driven by the increased goodwill impairment charges in 2018.

Operating income

- Operating income decreased $5.9 billion , or 90.5% , to approximately $620 million in 2018 compared to 2017 . The decrease in operating income was driven primarily by the increased operating expenses described above.

- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - The Company's pharmacy operating income has been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC Segment. If the reimbursement pressure accelerates, the Company may not be able grow revenues, and its operating income could be adversely affected.
    - The increased use of generic drugs has positively impacted the Company's operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the Company realizes from brand to generic product conversions.

Commentary - 2017 compared to 2016

Revenues

- Total revenues decreased approximately $1.7 billion , or 2.1% , to $79.4 billion in 2017 compared to 2016 . The decrease was primarily due to a decline in same store sales as a result of the previously-announced marketplace changes that restrict CVS Pharmacy from participating in certain networks.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - Front store same store sales declined 2.6% in 2017 compared to 2016 and were negatively impacted approximately 30 basis points due to the absence of leap day in 2017 . The decrease was primarily driven by softer customer traffic and efforts to rationalize promotional strategies, partially offset by an increase in basket size.
    - Pharmacy same store sales declined 2.6% in 2017 compared to 2016 . Pharmacy same store sales were negatively impacted by approximately 390 basis points due to recent generic introductions. Same store prescription volumes increased 0.4% , despite the approximately 420 basis point negative impact from previously-discussed marketplace changes that restrict CVS Pharmacy from participating in certain networks.
    - Pharmacy revenue continues to be negatively impacted by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 87.3% in 2017 compared to 85.7% in 2016 . In addition, pharmacy revenue growth has also been negatively affected by the mix of drugs sold, continued reimbursement pressure and the lack of significant new brand name drug introductions.
    - Pharmacy revenue in 2017 continued to benefit from the Company's ability to attract and retain managed care customers, and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

Operating expenses (including goodwill impairment)

- Operating expenses increased $450 million , or 2.8% in 2017 . The increase in operating expenses in 2017 was due primarily to:
    - An increase of $181 million in charges associated with the closure of retail stores in connection with the Company's enterprise streamlining initiative;
    - A goodwill impairment charge of $181 million related to the RxCrossroads reporting unit, which was subsequently sold on January 2, 2018;
    - Hurricane related costs of $55 million; and
    - Costs associated with new store openings
- Operating expenses as a percentage of total revenues were 21.1% in 2017 compared to 20.1% in 2016 . The increase in 2017 was primarily due to a decline in expense leverage with the loss of business from the previously discussed marketplace changes that restrict CVS Pharmacy from participating in certain networks.

Operating income

- Operating income decreased $879 million , or 11.8% , to approximately $6.6 billion in 2017 compared to 2016 . The decrease in operating income was driven primarily by the increased operating expenses described above and reimbursement pressure.

Health Care Benefits Segment

On November 28, 2018, the Company completed the Aetna Acquisition. The Health Care Benefits segment is the equivalent of the former Aetna Health Care segment.

The following table summarizes the Health Care Benefits segment's performance for the period from November 28, 2018 to December 31, 2018:

In millions	
Revenues:	
Products	$ 164
Premiums	4,819
Services	521
Net investment income	45
Total revenues	5,549
Cost of products sold	147
Benefit costs	3,873
Operating expenses	1,253
Operating income	$ 276

Revenues and operating income for the Health Care Benefits segment include results for the period from November 28, 2018 to December 31, 2018 and therefore are not directly comparable to the former Aetna Health Care segment results for the fourth quarter of 2017.

Health Care Benefits segment medical membership as of December 31, 2018 was as follows:

In thousands	**Insured**	**ASC [1]**	**Total**
Medical membership:			
Commercial	3,871	13,888	17,759
Medicare Advantage	1,758	—	1,758
Medicare Supplement	793	—	793
Medicaid	1,128	663	1,791
Total medical membership	7,550	14,551	22,101

(1) Represents self-insured membership under Administrative Services Contracts.

Medical Membership
Medical membership as of December 31, 2018 remained relatively consistent compared with December 31, 2017, reflecting decreases in Commercial insured and Medicaid products, largely offset by increases in Commercial ASC and Medicare products.

Corporate/Other Segment

Commentary - 2018 compared to 2017

Revenues
- Revenues in 2018 reflect (i) revenues associated with products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, that were acquired in the Aetna Acquisition and (ii) interest income related to the $40 billion of senior notes issued on March 9, 2018 to partially fund the Aetna Acquisition.

Operating expenses

- Operating expenses within the Corporate/Other segment include executive management, corporate relations, legal, compliance, human resources, information technology, finance related costs and acquisition-related transaction and integration costs. After the Aetna Acquisition Date, such operating expenses also include operating costs to support the large case pensions and long-term care insurance products acquired in the Aetna Acquisition.
- Operating expenses increased $437 million , or 45.9% , in 2018 compared to 2017 . The increase was primarily driven by an increase in acquisition-related transaction and integration costs of $454 million in 2018.

Commentary - 2017 compared to 2016

Operating expenses

- Operating expenses within the Corporate/Other segment include executive management, corporate relations, legal, compliance, human resources, information technology, finance related costs and acquisition-related transaction and integration costs.
- Operating expenses increased $34 million , or 3.7% , in 2017 compared to 2016 . The increase was due to (i) ongoing investments in strategic initiatives, (ii) increased employee benefit costs and (iii) increased divestiture and acquisition-related costs, primarily related to $34 million of transaction costs in 2017 associated with the Aetna Acquisition.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2018 , 2017 and 2016 is as follows:

				Change			
	Year Ended December 31,			2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Net cash provided by operating activities	$ 8,865	$ 8,007	$ 10,141	$ 858	11 %	$ (2,134)	(21)%
Net cash used in investing activities	(43,285)	(2,877)	(2,470)	(40,408)	1,405 %	(407)	16 %
Net cash provided by (used in) financing activities	36,819	(6,751)	(6,761)	43,570	(645)%	10	— %
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(4)	1	2	(5)	(500)%	(1)	(50)%
Net increase (decrease) in cash, cash equivalents and restricted cash	$ 2,395	$ (1,620)	$ 912	$ 4,015	(248)%	$ (2,532)	(278)%

Commentary - 2018 compared to 2017

- *Net cash provided by operating activities* increased by $858 million in 2018 due primarily to the timing of client payments and the timing of payments for the Company's Medicare Part D operations.
- *Net cash used in investing activities* increased by $40.4 billion in 2018 largely driven by the Aetna Acquisition in November 2018. In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures remained relatively consistent at approximately $2.0 billion and $1.9 billion in 2018 and 2017 , respectively. During 2018 , approximately 21% of the Company's total capital expenditures were for new store construction, 32% were for store, fulfillment and support facilities expansion and improvements and 47% were for technology and other corporate initiatives.
    - The Company did not complete any sale-leaseback transactions in 2018 compared to $265 million in 2017 . Under the sale-leaseback transactions, the properties generally are sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The specific timing and amount of future sale-leaseback transactions will vary depending on future market conditions and other factors.
- *Net cash provided by financing activities* was $36.8 billion in 2018 compared to net cash used in financing activities of $6.8 billion in 2017 . The cash provided by financing activities in 2018 primarily related to long-term borrowings to partially fund the Aetna Acquisition.

Commentary - 2017 compared to 2016

- *Net cash provided by operating activities* decreased by $2.1 billion , in 2017 due primarily to the timing of payments for the Company's Medicare Part D operations.
- *Net cash used in investing activities* increased by $407 million in 2017 largely driven by an increase in acquisition activity as compared to 2016 . In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures in 2017 totaled approximately $1.9 billion , a decrease of $306 million compared to prior year. The decrease in 2017 capital expenditures is due to the Target integration being completed in 2016. During 2017 , approximately 25% of the Company's total capital expenditures were for new store construction, 30% were for store, fulfillment and support facilities expansion and improvements and 45% were for technology and other corporate initiatives.
    - Proceeds from sale-leaseback transactions totaled $265 million in 2017 compared to $230 million in 2016 .
- *Net cash used in financing activities* was $6.8 billion in both 2017 and 2016 as net borrowings and net payments to shareholders were relatively flat in both years.

Included in net cash used in investing activities for the years ended December 31, 2018 , 2017 and 2016 was the following store development activity [(1)] :

	2018	2017	2016
Total stores (beginning of year)	9,846	9,750	9,665
New and acquired stores [(2)]	148	179	132
Closed stores [(2)]	(27)	(83)	(47)
Total stores (end of year)	9,967	9,846	9,750
Relocated stores [(2)]	34	30	50

(1) Includes retail drugstores, certain onsite pharmacy stores, retail specialty pharmacy stores and pharmacies within Target stores.
(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company had approximately $720 million and $1.3 billion of commercial paper outstanding at weighted average interest rates of 2.8% and 2.0% as of December 31, 2018 and 2017 , respectively. In connection with its commercial paper program, the Company maintains a $1.75 billion 364-day unsecured back-up revolving credit facility, which expires on May 16, 2019, a $1.25 billion , five-year unsecured back-up revolving credit facility, which expires on July 1, 2020, a $1.0 billion , five-year

unsecured back-up revolving credit facility, which expires on May 18, 2022, and a $2.0 billion , five-year unsecured back-up revolving credit facility, which expires on May 17, 2023. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03% , regardless of usage. As of December 31, 2018 and 2017 , there were no borrowings outstanding under any of the back-up credit facilities.

Bridge Loan Facility
On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a $49.0 billion unsecured bridge loan facility commitment. The Company paid $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statements of operations.

On March 9, 2018, the Company issued unsecured senior notes with an aggregate principal amount of $40.0 billion (see "Long-term Borrowings - 2018 Notes" below). At this time, the bridge loan facility commitment was reduced to $4.0 billion , and the Company paid $8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded $173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018 , which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a $4.0 billion unsecured 364-day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the $4.0 billion unsecured 364-day bridge term loan agreement terminated.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the Federal Home Loan Bank of Boston (the "FHLBB"). As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2018 was approximately $790 million . As of December 31, 2018 , there were no outstanding advances from the FHLBB.

Long-term Borrowings

2018 Notes
On March 9, 2018, the Company issued an aggregate of $40.0 billion in principal amount of the 2018 Notes for total proceeds of approximately $39.4 billion, net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes are comprised of the following:

In millions		
3.125% senior notes due March 2020	$	2,000
Floating rate notes due March 2020		1,000
3.35% senior notes due March 2021		3,000
Floating rate notes due March 2021		1,000
3.7% senior notes due March 2023		6,000
4.1% senior notes due March 2025		5,000
4.3% senior notes due March 2028		9,000
4.78% senior notes due March 2038		5,000
5.05% senior notes due March 2048		8,000
Total debt principal	$	40,000

Term Loan Agreement
On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a $5.0 billion term loan agreement. The term loan facility under the term loan agreement consists of a $3.0 billion three-year tranche and a $2.0 billion five-year tranche. The term loan agreement allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings. In connection with the Aetna Acquisition, the Company borrowed $5.0 billion (a $3.0 billion three-year tranche

and a $2.0 billion five-year tranche) under the term loan agreement in November 2018. The Company terminated the $2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. As of December 31, 2018, the Company had $3.0 billion outstanding under the three-year tranche of the term loan agreement.

Aetna Related Debt
Upon the closing of the Aetna Acquisition, the Company assumed long-term debt with a fair value of $8.1 billion with stated interest rates ranging from 2.2% to 6.75%.

2016 Notes
On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the " 2016 Notes ") for total proceeds of approximately $3.5 billion , net of discounts and underwriting fees. The 2016 Notes may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

Early Extinguishment of Long-Term Debt
On May 16, 2016, the Company announced tender offers for (i) any and all of its 5.75% senior notes due 2017, its 6.60% senior notes due 2019 and its 4.75% senior notes due 2020 (collectively, the "Any and All Notes") and (ii) up to $1.5 billion aggregate principal amount of the 4.75% Senior Notes due 2022 issued by its wholly-owned subsidiary Omnicare, the 5.00% Senior Notes due 2024 issued by Omnicare, its 3.875% Senior Notes due 2025, its 6.25% Senior Notes due 2027, its 4.875% Senior Notes due 2035, its 6.125% Senior Notes due 2039 and its 5.75% Senior Notes due 2041 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion. The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. In connection with the purchase of the Notes, the Company paid a premium of $486 million in excess of the debt principal, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on early extinguishment of long-term debt of $542 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. In connection with that redemption, the Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of long-term debt of $101 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

See Note 8 ''Borrowings and Credit Agreements'' and Note 12 ''Shareholders' Equity'' to the consolidated financial statements for additional information about debt issuances, debt repayments, share repurchases and dividend payments.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. As of December 31, 2018 and 2017, the Company had outstanding derivative financial instruments (see Note 1 ''Significant Accounting Policies'' to the consolidated financial statements).

Debt Covenants

The Company's back-up revolving credit facilities, unsecured senior notes, unsecured floating rate notes and term loan agreement (see Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit ratings. The covenants do not materially affect the Company's financial or operating flexibility. As of December 31, 2018 , the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2018 , the Company's long-term debt was rated " Baa2 " by Moody's and " BBB " by Standard & Poor's ("S&P"), and its commercial paper program was rated " P-2 " by Moody's and " A-2 " by S&P. In December 2017, subsequent to the announcement of the proposed acquisition of Aetna, Moody's changed the outlook on the Company's long-term debt to "Under Review" from "Stable." Similarly, S&P placed the Company's long-term debt outlook on "Watch Negative" from "Stable." Upon the issuance of the 2018 Notes on March 9, 2018, S&P lowered its corporate credit rating on the Company's long-term debt to "BBB" from "BBB+" and changed the outlook from "Watch Negative" to "Stable." On November 27, 2018, S&P lowered its rating on the long-term debt of Aetna to "BBB" from "A." On November 28, 2018, upon the completion of the Aetna Acquisition, Moody's lowered its rating on CVS Health Corporation's long-term debt to " Baa2 " from "Baa1." Additionally, Moody's changed the outlook on CVS Health Corporation's long-term debt to "Negative" from "Under Review" and changed the outlook on the long-term debt of Aetna to "Negative" from "Stable." In assessing the Company's credit strength, the Company believes that both Moody's and S&P considered, among other things, the Company's capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody's and/or S&P. The Company's debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Programs

During the year ended December 31, 2018 , the Company did not repurchase any shares of common stock. See Note 12 ''Shareholders' Equity'' to the consolidated financial statements for additional information about share repurchases for the years ended December 31, 2017 and 2016.

Quarterly Cash Dividend

In December 2015, the Company's Board of Directors (the "Board") authorized a 21% increase in our quarterly common stock cash dividend to $0.425 per share effective in 2016. This increase equated to an annual dividend rate of $1.70 per share. In December 2016, the Board authorized an 18% increase in our quarterly common stock cash dividend to $0.50 per share effective in 2017. This increase equated to an annual dividend rate of $2.00 per share. During 2018, the Company maintained its quarterly dividend of $0.50 per share and expects to maintain its quarterly dividend of $0.50 per share throughout 2019.

Off-Balance Sheet Arrangements

In connection with executing operating leases, the Company provides a guarantee of the lease payments. The Company also finances a portion of its new store development through sale-leaseback transactions, which involve selling stores to unrelated parties and then leasing the stores back under leases that generally qualify and are accounted for as operating leases. The Company does not have any retained or contingent interests in the sold stores, and does not provide any guarantees, other than a guarantee of the lease payments, in connection with the transactions. In accordance with generally accepted accounting principles, the Company's operating leases are not reflected on the consolidated balance sheets.

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things (each of which subsequently filed for bankruptcy), and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy these obligations.

As of December 31, 2018 , the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things), with the maximum remaining lease term extending through 2029. Management believes the ultimate disposition of any of the remaining lease guarantees will not have a material adverse effect on the Company's consolidated financial condition or future cash flows. Please see "Results of Operations - Summary of Consolidated Financial Results - Commentary - 2018 compared to 2017 - Loss from discontinued operations" previously in this document for further information regarding the Company's guarantee of certain Linens 'n Things' store lease obligations.

Contractual Obligations

The following table summarizes certain estimated future obligations by period under the Company's various contractual obligations at December 31, 2018 . The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2018 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

	Payments Due by Period				
In millions	**Total**	**2019**	**2020 to 2021**	**2022 to 2023**	**Thereafter**
Operating leases	$ 27,980	$ 2,690	$ 4,943	$ 4,343	$ 16,004
Capital lease obligations	1,241	74	146	146	875
Contractual lease obligations with Target [(1)]	2,074	—	—	—	2,074
Lease obligations for discontinued operations	12	4	8	—	—
Long-term debt	72,903	1,242	16,150	12,699	42,812
Interest payments on long-term debt [(2)]	37,949	3,061	5,595	4,594	24,699
Other long-term liabilities on the consolidated balance sheet [(3)]					
Future policy benefits [(4)]	6,728	575	1,200	952	4,001
Unpaid claims [(4)]	2,742	816	644	413	869
Policyholders' funds [(4)(5)]	1,266	632	127	86	421
Other liabilities	1,705	455	911	100	239
Total	$ 154,600	$ 9,549	$ 29,724	$ 23,333	$ 91,994

(1) The Company leases pharmacy and clinic space from Target. See Note 6 ''Leases'' to the consolidated financial statements for additional information regarding the lease arrangements with Target. Amounts related to the operating and capital leases with Target are reflected within the operating leases and capital lease obligations above. Amounts due after the remaining estimated economic lives of the buildings are reflected herein assuming equivalent stores continue to operate through the term of the arrangements.

(2) Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2018 .

(3) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $3.9 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of the Company's business.

(4) Total payments of future policy benefits, unpaid claims and policyholders' funds include $1.2 billion , $2.7 billion and $339 million , respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.

(5) Customer funds associated with group life and health contracts of approximately $2.3 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt and equity securities supporting experience-rated products of $10 million , before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health as a holding company, since CVS Health is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2018 , the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was approximately $584 million in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and shareholder dividends. In addition, at the Company's discretion, it uses these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes considered advisable.

As of December 31, 2018 , the Company held investments of $531 million that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of the Company's business. See Note 3 ''Investments'' to the consolidated financial statements for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Solvency Regulation

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2018 , the RBC Ratio of each of the Company's primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2018 , at that date, each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Quantitative and Qualitative Disclosures About Market Risk

On November 28, 2018 the Company completed the Aetna Acquisition. As of December 31, 2018 , the Company's earnings and financial condition were exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk and commodity risk. As of December 31, 2017, the Company had outstanding interest rate derivative instruments related to its long-term debt and believed that its exposure to interest rate risk (inherent in the Company's debt securities portfolio) was not material. We refer you to Note 1 ''Significant Accounting Policies'' to the consolidated financial statements.

Evaluation of Interest Rate and Credit Quality Risk

The Company manages interest rate risk by seeking to maintain a tight match between the durations of assets and liabilities when appropriate. The Company manages credit quality risk by seeking to maintain high average credit quality ratings and diversified sector exposure within its debt securities portfolio. In connection with its investment and risk management objectives, the Company also uses derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject the Company to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, the Company expects these instruments to reduce overall risk.

Investments

The Company's investment portfolio supported the following products at December 31, 2018 :

In millions		
Experience-rated products	$	1,063
Remaining products		17,191
Total investments	$	18,254

Investment risks associated with experience-rated products generally do not impact results of operations. The risks associated with investments supporting experience-rated pension and annuity products in the large case pensions business in the Company's Corporate/Other segment are assumed by the contract holders and not by the Company (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals.

The debt securities in the Company's investment portfolio had an average credit quality rating of A at December 31, 2018 , with approximately $3.9 billion rated AAA at December 31, 2018 . The debt securities that were rated below investment grade (that

is, having a credit quality rating below BBB-/Baa3) were $1.1 billion at December 31, 2018 (of which 6% at December 31, 2018 , supported experience-rated products).

At December 31, 2018 , the Company held $373 million of municipal debt securities that were guaranteed by third parties, representing 2% of total investments at December 31, 2018 . These securities had an average credit quality rating of AA- at December 31, 2018 with the guarantee. These securities had an average credit quality rating of A- at December 31, 2018 without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At December 31, 2018 , approximately 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with accounting principles generally accepted in the United States of America). See Note 4 ''Fair Value'' to the consolidated financial statements, which is incorporated by reference herein, for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 3 ''Investments'' to the consolidated financial statements, which is incorporated by reference herein.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in net income, and the amount of the non-credit related component is included in other comprehensive income/loss, unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. Accounting for other-than-temporary impairment ("OTTI") of debt securities is considered a critical accounting estimate. The information under the heading "Critical Accounting Policies - Other-Than-Temporary Impairment of Debt Securities" contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Annual Report is incorporated by reference herein.

Evaluation of Market Valuation Risks

The Company regularly evaluates its risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. The Company also regularly evaluates the appropriateness of investments relative to management-approved investment guidelines (and operates within those guidelines) and the business objectives of its portfolios.

On a quarterly basis, the Company reviews the impact of hypothetical net losses in its investment portfolio on the Company's consolidated near-term financial condition, results of operations and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario and is approximately equal to the historical annual volatility of interest rate movements for intermediate-term available-for-sale debt securities) and an immediate decrease of 15% in prices for domestic equity securities.

Assuming an immediate 100 basis point increase in interest rates and immediate decrease of 15% in the prices for domestic equity securities, the theoretical decline in the fair values of market sensitive instruments at December 31, 2018 is as follows:

- The fair value of long-term debt would decline by $3.9 billion ($4.9 billion pretax). Changes in the fair value of long-term debt do not impact financial condition or results of operations.
- The theoretical reduction in the fair value of investment securities partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of $364 million ($461 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these securities as available for sale. The Company does not record liabilities at fair value.

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, results of operations or cash flows as of December 31, 2018 .

Evaluation of Foreign Currency and Commodity Risk

As of each of December 31, 2018 and 2017 , the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk and commodity price risk is not material.

Evaluation of Operational Risks

The Company also faces certain operational risks, including risks related to information security, including cybersecurity. The Company and its vendors have experienced a variety of cyber attacks, and the Company and its vendors expect to continue to experience cyber attacks going forward. Among other things, the Company has experienced automated attempts to gain access to public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. The Company also has seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, destroy data, disrupt or degrade service, sabotage systems or cause other damage. The impact of the cyber attacks the Company has experienced through December 31, 2018 has not been material to its operations or results of operations. The Board and the Audit Committee of the Board ("the Audit Committee") are regularly informed regarding the Company's information security policies, practices and status.

Critical Accounting Policies

The Company prepares the consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered, support the preparation of the consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Significant accounting policies are discussed in Note 1 ''Significant Accounting Policies'' to the consolidated financial statements. Management believes the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. The Company has discussed the development and selection of these critical accounting policies with the Audit Committee, and the Audit Committee has reviewed the disclosures relating to them.

Revenue Recognition

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Pharmacy Services segment, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client, (ii) the United States Centers for Medicare & Medicaid Services ("CMS") subsidized portion of prescription drugs dispensed to the Company's Silverscript PDP members, (iii) the price paid to the Pharmacy Services segment by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("Retail Co-Payments"), and (iv) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenue.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

The Company recognizes revenue using the net method for contracts under which the Company acts as an agent or does not control the prescription drug prior to transfer to the client.

The Company records revenue net of manufacturers' rebates that are earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues as identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's results of operations or financial condition.

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual performance refund amounts has not been material to the Company's results of operations or financial condition.

The Pharmacy Services segment participates in the federal government's Medicare Part D program as a PDP through the Company's SilverScript subsidiary. Revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium,

which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

In addition to these premiums, the Pharmacy Services segment receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under a risk-sharing feature of the Medicare Part D program design, referred to as the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to the third party payer for pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts have not been material to the Company's results of operations or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's results of operations or financial condition. Sales taxes are not included in revenue.

Loyalty Program

The Company's customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed rewards are reflected as a contract liability.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of the revenue from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment

Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise. A significant difference in the actual level of retroactivity compared to estimated levels would have a significant effect on the Company's results of operations.

Additionally, premium revenue subject to the ACA's minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. The Company estimates minimum MLR rebates payable by projecting MLRs for certain markets, as defined by the ACA, for each state in which each of its insurance entities operates. The claims and premiums used in estimating such rebates are modified for certain adjustments allowed by the ACA and include a statistical credibility adjustment for those states with a number of members that is not statistically credible.

Furthermore, the ACA's permanent risk adjustment program transfers funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable or payable for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue. In this analysis, the Company considers the estimate of the average risk of members of other qualified plans in comparable markets the most critical assumption. The Company estimates its ultimate risk adjustment receivable or payable using management's best estimates, which are based on various data sources, including but not limited to market risk data compiled by third party sources as well as pricing and other regulatory inputs. See Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information on the ACA's risk adjustment program.

Other-Than-Temporary Impairments of Debt Securities

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in results of operations, and the amount of the non-credit related component is included in other comprehensive income, unless the Company intends to sell the debt security or it is more likely than not that it will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

Among the factors considered in evaluating whether a decline in fair value is other-than-temporary are whether the decline results from a change in the quality of the debt security itself, whether the decline results from a downward movement in the market as a whole, and the prospects for realizing the carrying value of the debt security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, the Company determines whether it intends to sell the debt security or if it is more likely than not that it will be required to sell the debt security before recovery of its amortized cost basis. If either case is true, the Company recognizes an OTTI, and the cost basis/carrying amount of the debt security is written down to fair value.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from projections and the risk that facts and circumstances factored into the Company's assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Vendor Allowances and Purchase Discounts

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's results of operations or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract.

There have not been any material changes in the way the Company accounts for vendor allowances and purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method.

The value of ending inventory is reduced for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each store and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. The accounting for inventory contains uncertainty since management must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, a number of factors are considered which include, but are not limited to, historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

The total reserve for estimated inventory losses covered by this critical accounting policy was $328 million as of December 31, 2018 . Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $33 million as of December 31, 2018 .

Although management believes that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from such estimates, and such differences could be material.

Goodwill and Identifiable Intangible Assets

Identifiable intangible assets
Identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/relationships, covenants not to compete, technology, provider networks, value of business acquired and favorable leases. These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

Recoverability of definite-lived intangible assets
The Company evaluates the recoverability of definite-lived intangible assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. These long-lived assets are grouped and evaluated for impairment at the lowest level at which individual cash flows can be identified. When evaluating these long-lived assets for potential impairment, the Company first compares the carrying amount of the asset group to the asset group's estimated future cash flows (undiscounted and without interest charges). If the estimated future cash flows are less than that carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges).

The long-lived asset impairment loss calculation contains uncertainty since management must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, the Company considers historical results and current operating trends and consolidated sales, profitability and cash flow results and forecasts. These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

There were no material impairment losses for definite-lived intangible assets recognized in any of the three years ended December 31, 2018, 2017 or 2016.

Recoverability of indefinitely-lived intangible assets
Indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that their carrying value may not be recoverable. Indefinitely-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized and the asset is written down to its estimated fair value.

The indefinitely-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including, but not limited to, general economic conditions, availability of market information as well as the profitability of the Company.

There were no material impairment losses recognized on indefinitely-lived intangible assets recognized in any of the three years ended December 31, 2018, 2017 or 2016.

Recoverability of goodwill
Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is calculated by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include, but are not limited to, the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes;

discount rates; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends; consolidated revenues, profitability and cash flow results and forecasts; and industry trends. These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, market capitalization, efforts of customers and payers to reduce costs including their prescription drug costs and/or increase member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

2018 goodwill impairment tests
As discussed in Note 5 ''Goodwill and Other Intangibles'' to the consolidated financial statements, during 2018, the LTC reporting unit continued to experience industry wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare and when the 2017 annual goodwill impairment test was performed. These challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a projected deterioration in the financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, higher risk-free interest rates and lower market multiples of peer group companies contributed to the amount of the second quarter 2018 goodwill impairment charge.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill. The results of these impairment tests indicated that there was no impairment of goodwill. The results of the annual goodwill impairment tests showed the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair value of the LTC reporting unit exceeded its carrying value by approximately 2%.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. The updated projections continue to reflect industry wide challenges including lower occupancy rates in skilled nursing facilities, the significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, an interim goodwill impairment test was performed during the fourth quarter of 2018. The results of that impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion goodwill impairment charge in the fourth quarter of 2018. In addition to the lower financial projections, lower market multiples of peer group companies also contributed to the amount of the fourth quarter 2018 goodwill impairment charge. The fair value of the LTC reporting unit was determined using a methodology consistent with the methodology described above for the analyses performed during the second and third quarters of 2018.

As of December 31, 2018 , the remaining goodwill balance in the LTC reporting unit is approximately $431 million .

Although the Company believes the financial projections used to determine the fair value of the LTC reporting unit in the fourth quarter of 2018 are reasonable and achievable, the LTC reporting unit may continue to face challenges that may affect the Company's ability to grow its business at the rate estimated when such goodwill impairment test was performed. These challenges and some of the key assumptions included in the Company's financial projections to determine the estimated fair value of the LTC reporting unit include client retention rates, occupancy rates in skilled nursing facilities, the financial health of skilled nursing facility customers, facility reimbursement pressures, the Company's ability to execute its senior living initiative, the Company's ability to make acquisitions and integrate those businesses into its LTC operations in an orderly manner, as well as the Company's ability to extract cost savings from labor productivity and other initiatives. The Company has made a number of additions and changes to its LTC management team to better respond to these challenges. The estimated fair value of the LTC reporting unit also is dependent on earnings multiples of market participants in the pharmacy industry, as well as the risk-free interest rate environment, which impacts the discount rate used in the discounted cash flow valuation method. If the Company

does not achieve its forecasts, it is reasonably possible in the near term that the goodwill of the LTC reporting unit could be deemed to be impaired again by a material amount.

2017 and 2016 goodwill impairment tests
The Company recorded $181 million in goodwill impairment charges in 2017 related to the RxCrossroads reporting unit. During the third quarter of 2017, the Company performed its required annual impairment test of goodwill. The goodwill impairment tests showed that the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair values of the LTC and RxCrossroads reporting units exceeded their carrying values by approximately 1% and 6%, respectively. On January 2, 2018, the Company sold its RxCrossroads reporting unit to McKesson Corporation for $725 million .

The Company did not record any goodwill impairment charges during 2016 .

Health Care Costs Payable

At December 31, 2018 , 80% of health care costs payable are estimates of the ultimate cost of (i) services rendered to members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. See Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information on the Company's reserving methodology.

The Company has considered the pattern of changes in its completion factors when determining the completion factors used in its estimates of IBNR as of December 31, 2018 . However, based on historical claim experience, it is reasonably possible that the Company's estimated weighted average completion factors may vary by plus or minus 16 basis points from the Company's assumed rates, which could impact health care costs payable by approximately plus or minus $194 million pretax.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2018 , the Company increased its assumed health care cost trend rates for the most recent three months by 3.5% from health care cost trend rates recently observed. However, based on historical claim experience, it is reasonably possible that the Company's estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus $299 million pretax.

Income Taxes

Income taxes are accounted for using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain. Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company's tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although management believes that its estimates are reasonable and are based on the best available information at the time the provision is prepared, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in the consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement. Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision. Significant judgment is required in determining uncertain tax positions. The Company has established

accruals for uncertain tax positions using its judgment and adjusts these accruals, as warranted, due to changing facts and circumstances.

Business Combinations

The Company accounts for business combinations using the acquisition method of accounting which requires that the assets acquired and liabilities assumed be recorded at the date of the acquisition at their respective fair values. The excess of purchase price over the fair value of assets acquired and liabilities assumed is recorded as goodwill. Determining the fair value of identifiable assets, particularly intangible assets, and liabilities acquired also requires management to make estimates, which are based on all available information and in some cases assumptions with respect to the timing and amount of future revenues and expenses associated with an asset. The most critical assumptions used in determining the fair value of intangible assets include customer attrition, membership growth and revenue growth. In determining the estimated fair value for intangible assets, the Company typically utilizes the income approach, which discounts the projected future net cash flow using an appropriate discount rate that reflects the risks associated with such projected future cash flows. Determining the useful life of an intangible asset also requires judgment, as different types of intangible assets will have different useful lives and certain assets are considered to have indefinite useful lives.

New Accounting Pronouncements

See Note 1 ‘‘Significant Accounting Policies’’ to the consolidated financial statements for a description of new accounting pronouncements applicable to the Company.

Holders of Common Stock

As of February 19, 2019, there were 27,266 registered holders of the Company’s common stock according to the records maintained by the Company’s transfer agent.

Cautionary Statement Concerning Forward-Looking Statements

The Private Securities Litigation Reform Act of 1995 (the “Reform Act”) provides a safe harbor for forward-looking statements made by or on behalf of the Company. In addition, the Company and its representatives may, from time to time, make written or verbal forward-looking statements, including statements contained in the Company’s filings with the United States Securities and Exchange Commission (the “SEC”) and in its reports to stockholders, press releases, webcasts, conference calls, meetings and other communications. Generally, the inclusion of the words “anticipate,” “believe,” “estimate,” “expect,” “intend,” “project,” “should,” “will” and similar expressions identify statements that constitute forward-looking statements. All statements addressing operating performance of CVS Health Corporation or any subsidiary, events or developments that the Company projects, expects or anticipates will occur in the future, including statements relating to corporate strategy; revenue growth; adjusted revenue growth, earnings or earnings per common share growth; adjusted operating income or adjusted earnings per common share growth; free cash flow; debt ratings; inventory levels; inventory turn and loss rates; store development; relocations and new market entries; retail pharmacy business, sales results and/or trends and operations; PBM business, sales results and/or trends and operations; specialty pharmacy business, sales trends and operations; LTC pharmacy business, sales results and/or trends and operations; Health Care Benefits business, sales results and/or trends, medical cost trends, medical membership growth, medical benefit ratios and operations; the Company’s ability to attract or retain customers and clients; Medicare Part D competitive bidding, enrollment and operations; new product development; and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future results of operations or events, are forward-looking statements within the meaning of the Reform Act.

The forward-looking statements are and will be based upon management’s then-current views and assumptions regarding future events and operating performance, and are applicable only as of the dates of such statements. The Company undertakes no obligation to update or revise any forward-looking statements, whether as a result of new information, future events, or otherwise.

By their nature, all forward-looking statements involve risks and uncertainties. Actual results may differ materially from those contemplated by the forward-looking statements for a number of reasons as described in the Company's SEC filings, including those set forth in the Risk Factors section within the CVS Health Corporation's 2018 Annual Report on Form 10-K, and including, but not limited to:

- *Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.*
- *Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.*
- *Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.*
- *We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our future performance.*
- *We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.*
- *Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.*
- *Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.*
- *Gross margins in the industries in which we operate may decline.*
- *Our results of operations are affected by the health of the economy in general and in the geographies we serve.*
- *We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.*
- *We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.*
- *We are exposed to risks relating to the solvency of our customers and of other insurers.*
- *We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs that we purchase and sell.*
- *We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.*
- *Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.*
- *Product liability, product recall or personal injury issues could damage our reputation.*
- *We face challenges in growing our Medicare Advantage and Medicare Part D membership.*
- *We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.*
- *A change in our Health Care Benefits product mix may adversely affect our profit margins.*
- *We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's results of operations. There can be no assurance that the future health care and other benefit costs of our Insured Health Care Benefits products will not exceed our projections.*
- *A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.*
- *The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.*
- *Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.*
- *Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges.*

Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.

- *We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and results of operations and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.*
- *Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our results of operations.*
- *Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.*
- *If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.*
- *Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.*
- *We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and results of operations.*
- *We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.*
- *We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.*
- *Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.*
- *Our results of operations may be adversely affected by changes in laws and policies governing employers and by union organizing activity.*
- *We must develop and maintain a relevant omni-channel experience for our retail customers.*
- *We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.*
- *In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.*
- *Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.*
- *If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.*
- *Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.*

- *We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.*
- *Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.*
- *We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.*
- *Our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and results of operations.*
- *We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.*
- *The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, results of operations and cash flows.*
- *Our business success and results of operations depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.*
- *Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.*
- *We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:*
  - *Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;*
  - *Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and*
  - *Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.*
- *Goodwill and other intangible assets could, in the future, become impaired.*
- *We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, cash flows, financial condition and results of operations.*
- *Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our results of operations and/or our financial condition.*
- *We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.*
- *The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.*
- *We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.*
- *Our future results may be adversely impacted if we do not effectively manage our expanded operations following completion of the Aetna Acquisition.*
- *We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.*
- *The Aetna integration process could disrupt our ongoing businesses and/or operations.*
- *Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.*
- *We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.*

- *We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.*
- *We may be unable to successfully integrate companies we acquire.*
- *As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.*

The foregoing list is not exhaustive. There can be no assurance that the Company has correctly identified all the risks that affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. Should any risks or uncertainties develop into actual events, these developments could have a material adverse effect on the Company's businesses, results of operations, cash flows and/or financial condition. For these reasons, you are cautioned not to place undue reliance on the Company's forward-looking statements.

Management's Report on Internal Control Over Financial Reporting

Management is responsible for establishing and maintaining adequate internal control over financial r eporting. The Company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the Company's consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2018 .

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company ' s system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by the Company's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

On November 28, 2018, the Company completed its acquisition of Aetna Inc. ("Aetna"). Management's assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018 excludes Aetna from that assessment as permitted under SEC rules. Aetna's operations are included in the Company's consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and represented 21% of the Company's consolidated total assets as of December 31, 2018 and 3% of the Company's consolidated total revenues for the year ended December 31, 2018.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2018 .

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by the Board of Directors and ratified by the Company's shareholders. They were engaged to render an opinion regarding the fair presentation of the Company ' s consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their accompanying reports are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

February 28, 2019

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, CVS Health Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on the COSO criteria.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Aetna Inc., which is included in the 2018 consolidated financial statements of the Company and constituted 21% of total assets as of December 31, 2018 and 3% of revenues for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Aetna Inc.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes and our report dated February 28, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP
Boston, Massachusetts
February 28, 2019

Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2018	2017	2016
Revenues:			
Products	$ 183,910	$ 180,063	$ 173,377
Premiums	8,184	3,558	3,069
Services	1,825	1,144	1,080
Net investment income	660	21	20
Total revenues	194,579	184,786	177,546
Operating costs:			
Cost of products sold	156,447	153,448	146,533
Benefit costs	6,594	2,810	2,179
Goodwill impairments	6,149	181	—
Operating expenses	21,368	18,809	18,448
Total operating costs	190,558	175,248	167,160
Operating income	4,021	9,538	10,386
Interest expense	2,619	1,062	1,078
Loss on early extinguishment of debt	—	—	643
Other expense (income)	(4)	208	28
Income before income tax provision	1,406	8,268	8,637
Income tax provision	2,002	1,637	3,317
Income (loss) from continuing operations	(596)	6,631	5,320
Loss from discontinued operations, net of tax	—	(8)	(1)
Net income (loss)	(596)	6,623	5,319
Net (income) loss attributable to noncontrolling interests	2	(1)	(2)
Net income (loss) attributable to CVS Health	$ (594)	$ 6,622	$ 5,317
Basic earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.48	$ 4.93
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.47	$ 4.93
Weighted average basic shares outstanding	1,044	1,020	1,073
Diluted earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.45	$ 4.91
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.44	$ 4.90
Weighted average diluted shares outstanding	1,044	1,024	1,079
Dividends declared per share	$ 2.00	$ 2.00	$ 1.70

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income (Loss)

In millions	**For the Years Ended December 31, 2018**	**2017**	**2016**
Net income (loss)	$ (596)	$ 6,623	$ 5,319
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains	97	—	—
Foreign currency translation adjustments	(29)	(2)	38
Net cash flow hedges	330	(10)	2
Pension and other postretirement benefits	(124)	152	13
Other comprehensive income	274	140	53
Comprehensive income (loss)	(322)	6,763	5,372
Comprehensive (income) loss attributable to noncontrolling interests	2	(1)	(2)
Comprehensive income (loss) attributable to CVS Health	$ (320)	$ 6,762	$ 5,370

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2018	At December 31, 2017
Assets:		
Cash and cash equivalents	$ 4,059	$ 1,696
Investments	2,522	111
Accounts receivable, net	17,631	13,181
Inventories	16,450	15,296
Other current assets	4,581	945
Total current assets	45,243	31,229
Long-term investments	15,732	112
Property and equipment, net	11,349	10,292
Goodwill	78,678	38,451
Intangible assets, net	36,524	13,630
Separate accounts assets	3,884	—
Other assets	5,046	1,417
Total assets	$ 196,456	$ 95,131
Liabilities:		
Accounts payable	$ 8,925	$ 8,863
Pharmacy claims and discounts payable	12,302	10,355
Health care costs payable	5,210	5
Policyholders' funds	2,939	—
Accrued expenses	10,711	6,581
Other insurance liabilities	1,937	23
Short-term debt	720	1,276
Current portion of long-term debt	1,265	3,545
Total current liabilities	44,009	30,648
Long-term debt	71,444	22,181
Deferred income taxes	7,677	2,996
Separate accounts liabilities	3,884	—
Other long-term insurance liabilities	8,119	334
Other long-term liabilities	2,780	1,277
Total liabilities	137,913	57,436
Commitments and contingencies (Note 16)		
Shareholders' equity:		
CVS Health shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,720 shares issued and 1,295 shares outstanding at December 31, 2018 and 1,712 shares issued and 1,014 shares outstanding at December 31, 2017 and capital surplus	45,440	32,096
Treasury stock, at cost: 425 shares at December 31, 2018 and 698 shares at December 31, 2017	(28,228)	(37,796)
Retained earnings	40,911	43,556
Accumulated other comprehensive income (loss)	102	(165)
Total CVS Health shareholders' equity	58,225	37,691
Noncontrolling interests	318	4
Total shareholders' equity	58,543	37,695
Total liabilities and shareholders' equity	$ 196,456	$ 95,131

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2018	2017	2016
Cash flows from operating activities:			
Cash receipts from customers	$ 186,519	$ 176,594	$ 172,310
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(148,821)	(146,469)	(140,312)
Insurance benefits paid	(7,057)	(2,810)	(2,199)
Cash paid to other suppliers and employees	(17,234)	(15,348)	(15,478)
Interest and investment income received	644	21	20
Interest paid	(2,803)	(1,072)	(1,140)
Income taxes paid	(2,383)	(2,909)	(3,060)
Net cash provided by operating activities	8,865	8,007	10,141
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	817	61	91
Purchases of investments	(692)	(137)	(80)
Purchases of property and equipment	(2,037)	(1,918)	(2,224)
Proceeds from sale-leaseback transactions	—	265	230
Acquisitions (net of cash acquired)	(42,226)	(1,181)	(524)
Proceeds from sale of subsidiary and other assets	832	—	—
Other	21	33	37
Net cash used in investing activities	(43,285)	(2,877)	(2,470)
Cash flows from financing activities:			
Net repayments of short-term debt	(556)	(598)	1,874
Proceeds from issuance of long-term debt	44,343	—	3,455
Repayments of long-term debt	(5,522)	—	(5,943)
Purchase of noncontrolling interest in subsidiary	—	—	(39)
Payment of contingent consideration	—	—	(26)
Derivative settlements	446	—	—
Repurchase of common stock	—	(4,361)	(4,461)
Dividends paid	(2,038)	(2,049)	(1,840)
Proceeds from exercise of stock options	242	329	296
Payments for taxes related to net share settlement of equity awards	(97)	(71)	(72)
Other	1	(1)	(5)
Net cash provided by (used in) financing activities	36,819	(6,751)	(6,761)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(4)	1	2
Net increase (decrease) in cash, cash equivalents and restricted cash	2,395	(1,620)	912
Cash, cash equivalents and restricted cash at the beginning of the period	1,900	3,520	2,608
Cash, cash equivalents and restricted cash at the end of the period	$ 4,295	$ 1,900	$ 3,520

In millions	For the Years Ended December 31, 2018	2017	2016
Reconciliation of net income (loss) to net cash provided by operating activities:			
Net income (loss)	$ (596)	$ 6,623	$ 5,319
Adjustments required to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	2,718	2,479	2,475
Goodwill impairments	6,149	181	—
Losses on settlements of defined benefit pension plans	—	187	—
Stock-based compensation	280	234	222
Loss on early extinguishment of debt	—	—	643
Deferred income taxes	87	(1,334)	18
Other noncash items	339	53	135
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(1,139)	(941)	(243)
Inventories	(1,153)	(514)	(742)
Other assets	(3)	(338)	(8)
Accounts payable and pharmacy claims and discounts payable	2,489	1,710	2,189
Health care costs payable and other insurance liabilities	(471)	—	(19)
Other liabilities	165	(333)	152
Net cash provided by operating activities	$ 8,865	$ 8,007	$ 10,141

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

In millions	Number of shares outstanding: Common Shares	Number of shares outstanding: Treasury Shares [1]	Attributable to CVS Health: Common Stock and Capital Surplus [2]	Attributable to CVS Health: Treasury Stock [1]	Attributable to CVS Health: Retained Earnings	Attributable to CVS Health: Accumulated Other Comprehensive Income (Loss)	Attributable to CVS Health: Total CVS Health Shareholders' Equity	Non Controlling Interests	Total Equity
Balance at December 31, 2015	**1,699**	**(598)**	**$ 30,965**	**$ (28,917)**	**$ 35,506**	**$ (358)**	**$ 37,196**	**$ 7**	**$ 37,203**
Net income [3]	—	—	—	—	5,317	—	5,317	1	5,318
Other comprehensive income (Note 13)	—	—	—	—	—	53	53	—	53
Stock option activity, stock awards, related tax benefits and other	6	—	525	—	—	—	525	—	525
Purchase of treasury shares, net of ESPP issuances	—	(46)	145	(4,566)	—	—	(4,421)	—	(4,421)
Common stock dividends	—	—	—	—	(1,840)	—	(1,840)	—	(1,840)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(4)	(4)
Balance at December 31, 2016	1,705	(644)	31,635	(33,483)	38,983	(305)	36,830	4	36,834
Net income	—	—	—	—	6,622	—	6,622	1	6,623
Other comprehensive income (Note 13)	—	—	—	—	—	140	140	—	140
Stock option activity, stock awards and other	7	—	461	—	—	—	461	—	461
Purchase of treasury shares, net of ESPP issuances	—	(54)	—	(4,313)	—	—	(4,313)	—	(4,313)
Common stock dividends	—	—	—	—	(2,049)	—	(2,049)	—	(2,049)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(1)	(1)
Balance at December 31, 2017	1,712	(698)	32,096	(37,796)	43,556	(165)	37,691	4	37,695
Adoption of new accounting standards (Note 1)	—	—	—	—	(6)	(7)	(13)	—	(13)
Net loss	—	—	—	—	(594)	—	(594)	(2)	(596)
Other comprehensive income (Note 13)	—	—	—	—	—	274	274	—	274
Common shares issued to acquire Aetna	—	274	12,923	9,561	—	—	22,484	—	22,484
Stock option activity, stock awards and other	8	—	421	—	—	—	421	—	421
Purchase of treasury shares, net of ESPP issuances	—	(1)	—	7	—	—	7	—	7
Common stock dividends	—	—	—	—	(2,045)	—	(2,045)	—	(2,045)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(13)	(13)
Acquisition of noncontrolling interests	—	—	—	—	—	—	—	329	329
Balance at December 31, 2018	**1,720**	**(425)**	**$ 45,440**	**$ (28,228)**	**$ 40,911**	**$ 102**	**$ 58,225**	**$ 318**	**$ 58,543**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2018, 2017 and 2016. Treasury stock includes $29 million related to shares held in trust for the year ended December 31, 2018 and $31 million related to shares held in trust for each of the years ended December 31, 2017 and 2016. See Note 1 ''Significant Accounting Policies'' for additional information.

(2) Common stock and capital surplus includes the par value of common stock of $17 million as of December 31, 2018, 2017 and 2016.

(3) Net income attributable to noncontrolling interests for the year ended December 31, 2016 excludes $1 million attributable to a redeemable noncontrolling interest. See Note 1 ''Significant Accounting Policies'' for additional information.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below. The consolidated financial statements for the year ended December 31, 2018 reflect Aetna's results subsequent to the Aetna Acquisition Date.

Pharmacy Services Segment ("PSS")
PSS provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. PSS' clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. PSS operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment ("RLS")
RLS sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic ® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, RLS also provided commercialization services under the name RxCrossroads ® . The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, RLS operated more than 9,900 retail locations, over 1,100 MinuteClinic ® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies.

Health Care Benefits Segment ("HCBS")
HCBS is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018 . HCBS has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. HCBS offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. HCBS' customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC."

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying consolidated financial statements of CVS Health Corporation and its subsidiaries have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents

Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash.

Restricted cash

As of December 31, 2018 and 2017 , the Company had $230 million and $190 million , respectively, of restricted cash held in a trust in an insurance captive to satisfy collateral requirements associated with the assignment of certain insurance policies. Such amounts are included in other assets on the consolidated balance sheets. Additionally, as of December 31, 2018 and 2017 , the Company had $6 million and $14 million , respectively, of restricted cash held in escrow accounts in connection with certain recent acquisitions. Such amounts are included in other current assets on the consolidated balance sheets.

Investments

Debt Securities
Debt securities consist primarily of United States Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current within the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 ''Fair Value'' for additional information on how the Company estimates the fair value of these investments.

The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments.

Debt securities are regularly reviewed to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in the

fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in net income, and the amount of the non-credit related component is included in other comprehensive income/loss, unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

Equity Securities
Equity securities with readily available fair values are measured at fair value with changes in fair value recognized in net income.

Mortgage Loans
Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of impairment reserves. A mortgage loan may be impaired when it is a problem loan (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure), a potential problem loan (i.e., high probability of default) or a restructured loan. For impaired loans, a specific impairment reserve is established for the difference between the recorded investment in the loan and the estimated fair value of the collateral. The Company applies its loan impairment policy individually to all loans in its portfolio.

The impairment evaluation described above also considers characteristics and risk factors attributable to the aggregate portfolio. An additional allowance for loan losses is established if it is probable that there will be a credit loss on a group of similar mortgage loans. The following characteristics and risk factors are considered when evaluating if a credit loss is probable on a group of similar mortgage loans: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Full or partial impairments of loans are recorded at the time an event occurs affecting the legal status of the loan, typically at the time of foreclosure or upon a loan modification giving rise to forgiveness of debt. Interest income on a potential problem loan or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships are accounted for using the equity method of accounting. Under this method, the carrying value of the investments are based on the value of the Company's equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund managers, these investments are generally reported on up to a three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.
- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.
- Privately-placed equity securities, which are carried on the consolidated balance sheets at cost less impairments, plus or minus subsequent adjustments for observable price changes. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), a subsidiary of the Company is required to purchase and hold shares of the FHLBB. These shares are restricted and carried at cost.

Net Investment Income
Net investment income on the Company's investments is recorded when earned and is reflected in net income in the consolidated results of operations (other than net investment income on assets supporting experience-rated products). Experience-rated products are products in the large case pensions business where the contract holder, not the Company, assumes investment and other risks, subject to, among other things, minimum guarantees provided by the Company. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact the Company's net income in the consolidated results of operations (as long as the contract's minimum guarantees are not triggered). Net investment income on assets supporting large case pensions' experience-rated products is included in net investment income in the consolidated statements of operations and is credited to contract holders' accounts through a charge to benefit costs.

Realized capital gains and losses on investments (other than realized capital gains and losses on investments supporting experience-rated products) are included as a component of net investment income in the consolidated statements of operations. Realized capital gains and losses are determined on a specific identification basis. Purchases and sales of debt and equity securities and alternative investments are reflected on the trade date. Purchases and sales of mortgage loans and investment real estate are reflected on the closing date.

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Unrealized capital gains and losses on investments (other than unrealized capital gains and losses on investments supporting experience-rated products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive income. Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts, which are reflected in policyholders' funds on the consolidated balance sheets.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Accounts Receivable

Accounts receivable are stated net of allowances for doubtful accounts, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net consists of the following at December 31 :

In millions	**2018**	**2017**
Trade receivables	$ 6,896	$ 7,895
Vendor and manufacturer receivables	7,655	5,109
Premium receivables	2,259	31
Other receivables	821	146
Total accounts receivable, net	$ 17,631	$ 13,181

The activity in the allowance for doubtful accounts receivable for the years ended December 31 is as follows:

In millions	**2018**	**2017**	**2016**
Beginning balance	$ 307	$ 286	$ 161
Additions charged to bad debt expense	256	177	221
Write-offs charged to allowance	(70)	(156)	(96)
Ending balance	$ 493	$ 307	$ 286

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to reduce its required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated results of operations or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2018 , the Company's reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits and Pharmacy Services segments are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. Acquisition costs for certain long-duration insurance contracts are deferred and are recorded as other current assets or other assets on the consolidated balance sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations. At December 31, 2018 , the balance of deferred acquisition costs was $22 million , comprised primarily of commissions paid on Medicare Supplement products within the Health Care Benefits segment.

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 5 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consists of the following at December 31 :

In millions	2018	2017
Land	$ 1,872	$ 1,707
Building and improvements	3,785	3,343
Fixtures and equipment	13,028	11,963
Leashold improvements	5,384	4,793
Software	2,800	2,484
Total property and equipment	26,869	24,290
Accumulated depreciation and amortization	(15,520)	(13,998)
Property and equipment, net	$ 11,349	$ 10,292

The amount of property and equipment under capital leases at December 31 is as follows:

In millions	**2018**	**2017**
Property and equipment under capital leases	$ 582	$ 588
Accumulated amortization of property and equipment under capital leases	(163)	(140)
Property and equipment under capital leases, net	$ 419	$ 448

Depreciation expense (which includes the amortization of property and equipment under capital leases) totaled $1.7 billion in each of the years ended December 31, 2018 , 2017 and 2016 .

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded as goodwill. Goodwill is not amortized, but is subject to impairment reviews annually, or more frequently if necessary. When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess. See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill and goodwill impairments.

Intangible Assets

The Company’s definite-lived intangible assets are amortized over their estimated useful-life based upon the pattern of future cash flows attributable to the asset. Other than value of business acquired (“VOBA”), definite-lived intangible assets are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. The Company groups and evaluates definite-lived intangible assets for impairment at the lowest level at which individual cash flows can be identified whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group’s estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group’s carrying value that exceeds the asset group’s estimated future cash flows (discounted and with interest charges). There were no material impairment losses recognized on definite-lived intangible assets in any of the three years ended December 31, 2018 , 2017 or 2016 .

Indefinitely-lived intangible assets are not amortized but are tested for impairment annually, or more frequently if necessary. Indefinitely-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinitely-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinitely-lived intangible assets in any of the three years ended December 31, 2018 , 2017 or 2016 .

See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about intangible assets.

Separate Accounts

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals and net investment income (including net realized and net unrealized capital gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements primarily related to the Health Care Benefits segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the consolidated results of operations in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR from the Aetna Acquisition Date through December 31, 2018 .

The Company analyzes historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." The Company uses completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. The Company estimates completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents the Company's estimate of claims remaining to be paid as of the financial statement date and is included in the Company's health care costs payable. The completion factors the Company uses reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in Insured membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using the Company's completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, the Company uses a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. The Company applies its actuarial judgment and places a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

The Company's health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including the Company's ability to manage benefit costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of the Company's business. The health status of the Company's Insured members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and the Company's health care cost trend rate.

For each reporting period, the Company uses an extensive degree of judgment in the process of estimating its health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period the Company recognizes the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. The Company believes its estimate of health care costs payable is reasonable and adequate to cover its obligations at December 31, 2018 ; however, actual claim payments may differ from the Company's estimates. A worsening (or improvement) of the Company's health care cost trend rates or changes in completion factors from those that the Company assumed in estimating health care costs payable at December 31, 2018 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, the Company re-examines previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that the Company's estimates of health care costs payable could develop either favorably (that is, its actual benefit costs for the period were less than estimated) or unfavorably. The changes in the Company's estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For a roll forward of the Company's health care costs payable, see Note 7 "Health Care Costs Payable." The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid claims
Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the United States Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR from the Aetna Acquisition Date through December 31, 2018 . As of December 31, 2018 , unpaid claims balances of $816 million and $1.9 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

Future policy benefits
Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts, long-duration group life and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 3.5% to 11.3% from the Aetna Acquisition Date through December 31, 2018 . The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-duration long-term care contracts represent the Company's estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. The assumed interest rate on such contracts was 5.1% from the Aetna Acquisition Date through December 31, 2018 . The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2018 , future policy benefits

balances of $536 million and $6.2 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. The Company established a premium deficiency reserve of $16 million as of December 31, 2018 related to Medicaid products in the Health Care Benefits segment.

Policyholders' Funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts and customer funds associated with certain health contracts. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus credited interest thereon, net of experience-rated adjustments. From the Aetna Acquisition Date through December 31, 2018 , interest rates for pension and annuity investment contracts ranged from 3.5% to 13.4% . Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also holds funds for health savings accounts ("HSAs") on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $2.1 billion at December 31, 2018 and are reflected in other current assets with a corresponding liability in policyholder funds.

Policyholders' Funds liabilities that are expected to be paid within twelve months from the balance sheet date are classified as current on the consolidated balance sheets. Policyholders' Funds liabilities that are expected to be paid greater than twelve months from the balance sheet date are included in other long-term liabilities on the consolidated balance sheets.

Self-Insurance Liabilities

The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience. At December 31, 2018 and 2017 , self-insurance liabilities totaled $865 million and $696 million , respectively, and were recorded as accrued expenses on the consolidated balance sheets.

Facility Opening and Closing Costs

New facility opening costs, other than capital expenditures, are charged directly to expense when incurred. When the Company closes a facility, the present value of estimated unrecoverable costs, including the remaining lease obligation less estimated sublease income and the book value of abandoned property and equipment, are charged to expense.

In December 2016, the Company announced an enterprise streamlining initiative designed to reduce costs and enhance operating efficiencies to allow the Company to be more competitive in the current health care environment. During the year ended December 31, 2017 , in connection with that enterprise streamlining initiative, the Company closed 71 retail stores and recorded charges of $215 million within operating expenses in the Retail/LTC segment. The charges are primarily comprised of provisions for the present value of noncancelable lease obligations. The noncancelable lease obligations associated with stores closed during the year ended December 31, 2017 extend through the year 2039. During the year ended December 31, 2018 , the Company did not recognize any significant charges related to facility closing costs.

The long-term portion of the lease obligations associated with all outstanding facility closings was $269 million and $306 million as of December 31, 2018 and 2017 , respectively, and was recorded in other long-term liabilities on the consolidated balance sheets.

Contingent Consideration

In December 2015, the Company acquired the pharmacy and clinic businesses of Target for approximately $1.9 billion , plus contingent consideration of up to $60 million based on future prescription growth over a three year period through December 31, 2019. As of December 31, 2018, no liability for any potential contingent consideration has been recorded based on historical and projected prescription growth through 2019.

Redeemable Noncontrolling Interest

As a result of the acquisition of Omnicare, Inc. ("Omnicare") in 2015, the Company obtained a 73% ownership interest in a limited liability company ("LLC"). Due to the change in control in Omnicare, the noncontrolling member of the LLC had the contractual right to put its membership interest to the Company at fair value. Consequently, the noncontrolling interest in the LLC was recorded as a redeemable noncontrolling interest at fair value. During 2016, the noncontrolling member of the LLC exercised its option to sell its ownership interest and the Company purchased the noncontrolling interest in the LLC for approximately $39 million .

Below is a summary of the changes in redeemable noncontrolling interest for the year ended December 31, 2016 :

In millions		
Beginning balance	$	39
Net income attributable to noncontrolling interest		1
Distributions		(2)
Purchase of noncontrolling interest		(39)
Reclassification to capital surplus in connection with purchase of noncontrolling interest		1
Ending balance	$	—

Foreign Currency Translation and Transactions

For local currency functional currency, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenue and expense are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in income.

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in any of the periods presented.

Revenue Recognition

The following is a discussion of the Company's revenue recognition policies by segment under the new revenue recognition accounting standard. See "New accounting pronouncements recently adopted - Revenue from Contracts with Customers" below for further discussion regarding the adoption of the new revenue recognition accounting standard. The new revenue recognition accounting standard does not relate to contracts within the scope of *Accounting Standards Codification 944 Financial Services - Insurance* . As a result, the majority of revenues within the Health Care Benefits segment and certain revenues within the Pharmacy Services segment are not within the scope of the new accounting standard.

Pharmacy Services Segment
PSS sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each

prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to PSS, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the United States Centers for Medicare & Medicaid Services ("CMS") subsidized portion of prescription drugs dispensed to the Company's Silverscript PDP members, (iii) the price paid to PSS by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("Retail Co-Payments"), and (iv) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenue.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to in exchange for those prescription drugs. The following revenue recognition policies have been established for PSS:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which PSS acts as an agent or does not control the prescription drugs prior to transfer to the client, revenue is recognized using the net method.

Drug discounts

PSS records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. PSS estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. PSS adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues as identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's results of operations or financial condition.

Guarantees

PSS also adjusts revenues for refunds owed to the client resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's results of operations or financial condition.

Medicare Part D

PSS' revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

PSS' revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor,

and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, PSS receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to the third party payer for pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's results of operations or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's results of operations or financial condition. Sales taxes are not included in revenue.

Loyalty Program

The Company's customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed rewards are reflected as a contract liability.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of the revenue from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors are typically not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment

Premium Revenue

HCBS premiums are recognized as income in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (as amended, collectively, the "ACA's") minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services and Product Revenue

HCBS services and product revenue relates to contracts that can include various combinations of products, services, or series of services, which are generally capable of being distinct and accounted for as separate performance obligations. HCBS' services and product revenue consists of the following components:

- ASC fees are received in exchange for performing certain claim processing and member services for HCBS' ASC medical members. ASC fee revenue is recognized over the period the service is provided. Some of the administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, HCBS is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period HCBS estimates obligations under the terms of these guarantees and records its estimate as an offset to service revenues.
- Workers' compensation administrative services consist of fee-based managed care services. Workers' compensation administrative services revenue is recognized once the service is provided.
- Specialty and home delivery pharmacy product revenue is recognized when the prescription is delivered to an ASC member. Specialty and home delivery pharmacy product revenue reflects the price of the prescription on a gross basis (ASC member co-payments and plan sponsor reimbursements).

Accounting for Medicare Part D

HCBS offers Medicare Part D prescription drug insurance coverage under contracts with the CMS. HCBS' revenue recognition policy for Medicare Part D is consistent with the policy detailed in the " *Medicare Part D"* section of PSS' revenue recognition policy described above.

Disaggregation of Revenue
The following table disaggregates the Company's revenue by major source in each segment for the year ended December 31, 2018 :

In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Major goods/services lines:						
Pharmacy	$ 130,195	$ 64,179	$ 164	$ —	$ (29,693)	$ 164,845
Front Store	—	19,055	—	—	—	19,055
Premiums	3,361	—	4,819	4	—	8,184
Net investment income	13	—	45	602	—	660
Other	559	755	521	—	—	1,835
Total	$ 134,128	$ 83,989	$ 5,549	$ 606	$ (29,693)	$ 194,579

Pharmacy Services distribution channel:	
Mail choice [1]	$ 46,934
Pharmacy network [2]	83,261
Other	3,933
Total	$ 134,128

(1) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect ® claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice ® program, which permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order.
(2) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice activity, which is included within the mail choice category.

Contract Balances
Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, for example ExtraBucks ® Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31:

In millions	**2018**	**2017**
Trade receivables (included in accounts receivable, net)	$ 6,896	$ 7,895
Contract liabilities (included in accrued expenses)	67	53

During the year ended December 31, 2018 , the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	
Balance at December 31, 2017	$ 53
Adoption of ASU 2014-09	17
Loyalty program earnings and gift card issuances	332
Redemption and breakage	(335)
Balance at December 31, 2018	$ 67

Cost of products sold

The Company accounts for cost of products sold as follows:

Pharmacy Services Segment
PSS' cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through its mail service dispensing pharmacies and indirectly through its retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of its mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from PSS' mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor allowances and purchase discounts" below) and (ii) the cost of prescription drugs sold (including Retail Co-Payments) through PSS' retail pharmacy network under contracts where it is the principal, net of any volume-related or other discounts.

Retail/LTC Segment
RLS' cost of products sold includes: the cost of merchandise sold during the reporting period, including prescription drug costs, and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

Health Care Benefits Segment
HCBS' cost of products sold includes the cost of the prescription and certain administrative costs incurred for dispensing the prescription to ASC members by HCBS' specialty and home delivery pharmacy operations.

See Note 17 ''Segment Reporting'' for additional information about the cost of products sold of the Company's segments.

Vendor allowances and purchase discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment
PSS receives purchase discounts on products purchased. PSS' contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for PSS to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices, or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days after the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to PSS' results of operations. PSS accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. PSS also receives additional discounts under its wholesaler contracts if it exceeds contractually defined annual purchase volumes. In addition, PSS receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of "cost of products sold".

Retail/LTC Segment
Vendor allowances received by RLS reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments also is initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

Health Care Reform

Health Insurer Fee
Since January 1, 2014, the ACA imposes an annual premium-based health insurer fee ("HIF") for each calendar year payable in September which is not deductible for tax purposes. The Company is required to estimate a liability for the HIF at the beginning of the calendar year in which the fee is payable with a corresponding deferred asset that is amortized ratably to operating expenses over the calendar year. The Company records the liability for the health insurer fee in accrued expenses and records the deferred asset in other current assets. In 2018 and 2016, operating expenses include $157 million and $56 million , respectively, related to the Company's share of the HIF. There was no expense related to the HIF in 2017 and there will be no expense for HIF in 2019, since the HIF was suspended for each of those periods.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Advertising costs

Advertising costs are expensed when the related advertising takes place. Advertising costs, net of vendor funding (included in operating expenses), were $364 million , $230 million and $216 million in 2018 , 2017 and 2016 , respectively.

Stock-based compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as an expense over the applicable requisite service period of the stock award (generally 3 to 5 years) using the straight-line method.

Income taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.

The Tax Cuts and Jobs Act (the "TCJA") was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion for year ended December 31, 2017. The Company completed its assessment of the TCJA's final impact in December 2018 and recorded an additional tax benefit of approximately $100 million in the year ended December 31, 2018.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and recent results of operations. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit ("OPEB") Plans

The Company sponsors defined benefit pension plans ("pension plans") and OPEB plans for its employees and retirees. The Company recognizes the funded status of its pension plans and OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plans benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other long-term liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets. Nearly all of the Company's net benefit costs for the Company's defined benefit pension and postretirement plans do not contain a service cost component as most of these defined benefit plans have been frozen for an extended period of time. Non-service components of pension and postretirement benefit cost are included in other expense (income) in the consolidated statements of operations.

Earnings per common share

Earnings per share is computed using the two-class method. The Company calculates basic earnings per share based on the weighted average number of common shares outstanding for the period. See Note 14 ''Earnings Per Share'' for additional information.

Shares held in trust

The Company maintains grantor trusts, which held approximately one million shares of its common stock at December 31, 2018 and 2017 , respectively. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Variable Interest Entities

The Company has investments in (i) a generic pharmaceutical sourcing entity, (ii) certain hedge fund and private equity investments and (iii) real estate partnerships that are considered VIE's. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary
In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50% . The Red Oak arrangement has an initial term of 10 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company 39 quarterly payments beginning in October 2014. As milestones are met, the quarterly payments increase. The Company received from Cardinal approximately $183 million during each of the years ended December 31, 2018 and 2017 and $163 million during the year ended December 31, 2016 . The payments reduce the Company's carrying value of inventory and are recognized in cost of products sold when the related inventory is sold. Revenues associated with Red Oak expenses reimbursed by Cardinal for the years ended December 31, 2018 , 2017 and 2016 , as well as amounts due to or due from Cardinal at December 31, 2018 and 2017 were immaterial.

Variable Interest Entities - Other Variable Interest Holder
In November 2018, the Company completed the Aetna Acquisition. Aetna has involvement with VIEs where the Company has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.

- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these investments because the nature of the Company's involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheet and recognizes its share of each VIE's income or losses in earnings. The Company's maximum exposure to loss from these VIEs is limited to its investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which the Company does not consider significant.

The total amount of other variable interest holder VIE assets included in long-term investments on the consolidated balance sheet at December 31, 2018 was as follows:

In millions		
Hedge fund investments	$	270
Private equity investments		524
Real estate partnerships		275
Total	$	1,069

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. PSS and RLS utilize this clinical health information network in providing services to their respective client plan members and retail customers. The Company expensed fees for the use of this network of approximately $45 million , $35 million and $39 million in the years ended December 31, 2018 , 2017 and 2016 , respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company approximately $135 million , $139 million and $140 million for pharmaceutical inventory purchases during the years ended December 31, 2018 , 2017 and 2016 , respectively. Additionally, the Company performs certain collection functions for Heartland and then passes those customer cash collections back to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

Discontinued Operations

In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Bob's Stores and Linens 'n Things each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations primarily includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its lease guarantees. See "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' for more information.

Results from discontinued operations were immaterial for the year ended December 31, 2018. Below is a summary of the results of discontinued operations for the years ended December 31 , 2017 and 2016:

In millions	**2017**	**2016**
Loss from discontinued operations	$ (13)	$ (2)
Income tax benefit	5	1
Loss from discontinued operations, net of tax	$ (8)	$ (1)

New accounting pronouncements recently adopted

Revenue from Contracts with Customers
In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers* (Topic 606) ("Topic 606"). ASU 2014-09 outlines a single comprehensive model for

companies to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance. In March 2016, the FASB issued ASU 2016-08, *Principal Versus Agent Considerations (Reporting* Revenue *Gross Versus Net)* which amends the principal-versus-agent implementation guidance and in April 2016 the FASB issued ASU 2016-10, *Identifying Performance Obligations and Licensing,* which amends the guidance in those areas in the new revenue recognition standard.

The Company adopted the new standard as of January 1, 2018 using the modified retrospective method and applied the new standard to all contracts. Therefore, the comparative financial information has not been restated and continues to be reported under the accounting standards in effect for the applicable period. While the adoption of the new standard did not result in any material adjustments to the Company's revenue or net income, one difference was identified between the previous accounting guidance and the new accounting guidance in RLS related to the accounting for the Company's ExtraBucks ® Rewards customer loyalty program. This program was previously accounted for under a cost deferral method, while under the new standard this program is accounted for under a revenue deferral method. The cumulative effect of applying the new guidance to all contracts was recorded as an adjustment to retained earnings as of the adoption date.

As a result of applying the modified retrospective method to adopt the new standard, the following adjustments were made to accounts on the consolidated balance sheet as of January 1, 2018:

		Impact of Change in Accounting Policy	
In millions	**As Reported December 31, 2017**	**Adjustments**	**Adjusted January 1, 2018**
Consolidated Balance Sheet:			
Accrued expenses	$ 6,581	$ 17	$ 6,598
Deferred income taxes	2,996	(4)	2,992
Total liabilities	57,436	13	57,449
Retained earnings	43,556	(13)	43,543
Total CVS Health shareholders' equity	37,691	(13)	37,678
Total shareholders' equity	37,695	(13)	37,682

The following tables compare the reported consolidated balance sheet, statements of operations, and statement of cash flows amounts to the pro forma amounts had the previous revenue accounting guidance remained in effect:

		Impact of Change in Accounting Policy	
In millions	**As Reported As of/For the Year Ended December 31, 2018**	**Adjustments**	**Balances Without Adoption of Topic 606**
Consolidated Statement of Operations:			
Revenues:			
Products	$ 183,910	$ 3	$ 183,913
Total revenues	194,579	3	194,582
Operating costs:			
Cost of products sold	156,447	2	156,449
Total operating costs	190,558	2	190,560
Operating income	4,021	1	4,022
Income before income tax provision	1,406	1	1,407
Income tax provision	2,002	—	2,002
Loss from continuing operations	(596)	1	(595)
Net loss	(596)	1	(595)
Net loss attributable to CVS Health	(594)	1	(593)
Consolidated Balance Sheet:			
Accrued expenses	10,711	(18)	10,693
Total current liabilities	44,009	(18)	43,991
Deferred income taxes	7,677	4	7,681
Total liabilities	137,913	(14)	137,899
Retained earnings	40,911	14	40,925
Total CVS Health shareholders' equity	58,225	14	58,239
Total shareholders' equity	58,543	14	58,557
Consolidated Statement of Cash Flow:			
Reconciliation of net loss to net cash provided by operating activities:			
Net loss	(596)	1	(595)
Other liabilities	165	(1)	164

Recognition and Measurement of Financial Assets and Financial Liabilities
In January 2016, the FASB issued ASU 2016-01, *Financial Instruments - Overall* (Subtopic 825-10): *Recognition and Measurement of Financial Assets and Financial Liabilities* . This ASU requires equity investments, except those under the equity method of accounting or those that result in the consolidation of an investee, to be measured at fair value with changes in fair value recognized in net income. However, an entity may choose to measure equity investments that do not have readily determinable fair values at cost minus impairment, if any, plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issuer. This simplifies the impairment assessment of equity investments previously held at cost. Entities are required to apply the guidance retrospectively, with the exception of the amendments related to equity investments without readily determinable fair values, which must be applied on a prospective basis. Effective January 1, 2018, the Company adopted this new accounting guidance. The adoption of this new guidance did not have a material impact on the Company's financial condition or results of operations.

Classification of Certain Cash Receipts and Cash Payments in the Consolidated Statements of Cash Flows
In August 2016, the FASB issued ASU 2016-15, *Classification of Certain Cash Receipts and Cash Payments* . This ASU is intended to add or clarify guidance on the classification of certain cash receipts and payments in the statement of cash flows and

to eliminate the diversity in practice related to such classifications. Effective January 1, 2018, the Company adopted this new accounting guidance. The adoption of this new guidance did not have a material impact on the Company's financial condition or results of operations.

Statement of Cash Flows - Restricted Cash
In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows* , which amends Accounting Standard Codification Topic 230. This ASU requires entities to show the changes in the total of cash, cash equivalents, restricted cash and restricted cash equivalents in the statement of cash flows. As a result, entities no longer are required to present transfers between cash and cash equivalents and restricted cash and restricted cash equivalents in the statement of cash flows. When cash, cash equivalents, restricted cash and restricted cash equivalents are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Entities will also have to disclose the nature of their restricted cash and restricted cash equivalent balances. The guidance is required to be applied retrospectively. Effective January 1, 2018, the Company adopted this new accounting guidance.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets as of December 31 to total cash, cash equivalents and restricted cash in the consolidated statements of cash flows:

In millions	**2018**	**2017**	**2016**
Cash and cash equivalents	$ 4,059	$ 1,696	$ 3,371
Restricted cash (included in other current assets)	6	14	—
Restricted cash (included in other assets)	230	190	149
Total cash, cash equivalents and restricted cash at the end of the period in the statement of cash flows	$ 4,295	$ 1,900	$ 3,520

See "Restricted cash" above for further discussion of the nature of the Company's restricted cash and restricted cash equivalent balances.

The following is a reconciliation of the effect on the relevant line items in the consolidated statement of cash flows for the years ended December 31, 2017 and 2016 as a result of adopting this new accounting guidance:

In millions	**As Previously Reported**	**Adjustments**	**As Revised**
Year Ended December 31, 2017			
Acquisitions (net of cash acquired)	$ (1,236)	$ 55	$ (1,181)
Net cash used in investing activities	(2,932)	55	(2,877)
Net decrease in cash, cash equivalents and restricted cash [(1)]	(1,675)	55	(1,620)
Cash, cash equivalents and restricted cash at the beginning of the period [(1)]	3,371	149	3,520
Cash, cash equivalents and restricted cash at the end of the period [(1)]	1,696	204	1,900
Year Ended December 31, 2016			
Acquisitions (net of cash acquired)	(524)	—	(524)
Net cash used in investing activities	(2,470)	—	(2,470)
Net decrease in cash, cash equivalents and restricted cash [(1)]	912	—	912
Cash, cash equivalents and restricted cash at the beginning of the period [(1)]	2,459	149	2,608
Cash, cash equivalents and restricted cash at the end of the period [(1)]	3,371	149	3,520

(1) Prior to the adoption of ASU 2016-18, these financial statement captions excluded restricted cash. The financial statement captions have been renamed to reflect the inclusion of restricted cash subsequent to the adoption of ASU 2016-18 on January 1, 2018.

Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income
In February 2018, the FASB issued ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income ("ASU 2018-02")* . This ASU permits entities to reclassify tax effects stranded in accumulated other comprehensive income as a result of the TCJA to retained

earnings. The guidance states that because the adjustment of deferred income taxes due to the reduction of the historical corporate income tax rate to the newly enacted corporate income tax rate was required to be included in income from continuing operations, the tax effects of items within accumulated other comprehensive income ("stranded tax effects") are not reflected at the appropriate tax rate. During the first quarter of 2018, the Company elected to early adopt this new standard and decreased accumulated other comprehensive income and increased retained earnings in the period of adoption by $7 million due to the change in the United States federal corporate income tax rate enacted in December 2017. See Note 13 ''Other Comprehensive Income (Loss)'' for the impact of the adoption of this guidance on accumulated other comprehensive income for the year ended December 31, 2018 .

New accounting pronouncements not yet adopted

Leases
In February 2016, the FASB issued ASU 2016-02, *Leases* (Topic 842). Lessees will be required to recognize a right-of-use asset and a lease liability for virtually all of their leases (other than leases that meet the definition of a short-term lease). The liability will be equal to the present value of future lease payments. The asset will be based on the liability, subject to adjustment, such as for initial direct costs. For income statement purposes, a dual model was retained, requiring leases to be classified as either operating or finance leases. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). Lessor accounting is similar to the current model, but updated to align with certain changes to the lessee model (e.g., certain definitions, such as initial direct costs, have been updated) and the new revenue recognition standard. The Company adopted this new accounting guidance on January 1, 2019 on a modified retrospective basis. The adoption of this new guidance resulted in an increase in both assets and liabilities of approximately $20 billion as of January 1, 2019. The adoption of this new guidance is not expected to have a material impact on the Company's results of operations or cash flows.

Accounting for Interest Associated with the Purchase of Callable Debt Securities
In March 2017, the FASB issued ASU 2017-08, *Accounting for Interest Associated with the Purchase of Callable Debt Securities (* Topic 310 *).* Under this ASU, premiums on callable debt securities are amortized to the earliest call date rather than to the contractual maturity date. Callable debt securities held at a discount will continue to be amortized to the contractual maturity date. The Company adopted this new accounting guidance on January 1, 2019 on a modified retrospective basis and recorded an immaterial cumulative effect adjustment from accumulated other comprehensive income to retained earnings on the consolidated balance sheet.

Measurement of Credit Losses on Financial Instruments
In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This ASU requires the use of a forward-looking expected loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. The ASU also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract
In August 2018, the FASB issued ASU 2018-15, *Intangibles - Goodwill and other - Internal-Use Software* (Topic 350-40): *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract.* The new standard requires a customer in a cloud computing arrangement that is a service contract to follow internal-use software guidance in Topic 350-40 to determine which implementation costs to capitalize as assets. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. Early adoption is permitted. The Company is currently evaluating the effect the implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the FASB issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Insurance Contracts* (Topic 944). The ASU requires the Company to review cash flow assumptions for its long-duration insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income. The Company is also required to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount the Company's liability for future policy benefits will be based on an estimate of the yield for an upper-medium-grade fixed-income instrument. In addition, the new guidance changes the amortization method for deferred acquisition costs and requires additional disclosures regarding the long duration insurance contract

liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2020. The Company is currently evaluating the effect the implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

2. Acquisition of Aetna

On the Aetna Acquisition Date, the Company acquired 100% of the outstanding shares and voting interests of Aetna for a combination of cash and stock. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion . Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion . The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans. Aetna is a leading health care benefits company that offers a broad range of traditional, voluntary, and consumer-directed health insurance products and related services. The majority of Aetna's operations are included in a new segment, Health Care Benefits. The Health Care Benefits segment is the equivalent of the former Aetna Health Care Segment. The remainder of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Corporate/Other segment. The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care.

The fair value of the consideration transferred on the date of acquisition consisted of the following:

In millions		
Cash	$	48,089
Common stock (274.4 million shares) [(1)]		22,117
Fair value of replacement equity awards for pre-combination services (9.9 million shares) [(2)]		367
Effective settlement of pre-existing relationship [(3)]		(807)
Total consideration transferred	$	69,766

(1) The fair value of the Company's common stock issued as consideration was calculated based on the 327.6 million Aetna common shares outstanding as of November 28, 2018 multiplied by (i) the merger agreement per share exchange ratio and (ii) the volume weighted average price of CVS Health common stock on November 28, 2018 of $80.59 .

(2) The fair value of the replacement equity awards issued by the Company was determined as of the Aetna Acquisition Date. The fair value of the awards attributed to pre-combination services of $367 million is included in the consideration transferred and the fair value of the awards attributed to post-combination services of $232 million has been, or will be, included in the Company's post-combination financial statements as compensation costs.

(3) The purchase price included $807 million of effectively settled liabilities the Company owed to Aetna from their pre-existing pharmacy services relationship.

The transaction has been accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. The following table summarizes the estimated fair values of the assets acquired and liabilities assumed at the date of acquisition:

In millions	
Cash and cash equivalents	$ 6,565
Accounts receivable [1]	4,089
Other current assets	3,896
Investments (current and long-term)	17,991
Goodwill	46,684
Intangible assets	23,746
Other long-term assets	8,282
Total assets acquired	111,253
Health care costs payable	5,359
Other current liabilities	10,026
Debt (current and long-term)	8,098
Deferred income taxes	4,574
Other long-term liabilities	13,101
Total liabilities assumed	41,158
Noncontrolling interests	329
Total consideration transferred	$ 69,766

(1) The fair value of premium receivables acquired is $2.4 billion , with the gross contractual amount being $2.8 billion . The Company expects $424 million of premium receivables to be uncollectible. The fair value of other receivables acquired is $1.7 billion , with the gross contractual amount being $1.8 billion . The Company expects $84 million of other receivables to be uncollectible.

The assessment of fair value is preliminary and is based on information that was available to management at the time the consolidated financial statements were prepared. The most significant open items included the valuation of certain intangible assets and investments, the accounting for income taxes and the accounting for contingencies as management is awaiting additional information to complete its assessment of these matters. Measurement period adjustments will be recorded in the period in which they are determined, as if they had been completed at the acquisition date. The finalization of the Company's purchase accounting assessment could result in changes in the valuation of assets acquired and liabilities assumed, which could be material.

Goodwill

Goodwill represents future economic benefits expected to arise from the Company's expanded presence in the health care industry, the assembled workforce acquired, expected purchasing, medical cost and revenue synergies, as well as operating efficiencies and cost savings. The preliminarily valuation of goodwill was allocated to the Company's business segments as follows:

In millions	
Health Care Benefits	$ 44,484
Pharmacy Services	1,500
Retail/LTC	700
Total goodwill	$ 46,684

Approximately $165 million of goodwill is deductible for income tax purposes.

Intangible Assets
The following table summarizes the preliminary fair values and weighted average useful lives for intangible assets acquired in the Aetna Acquisition, each of which is subject to change as the Company finalizes its purchase accounting:

In millions, except weighted average useful life		**Gross Fair Value**	**Weighted Average Useful Life (years)**
Customer relationships [(1)]	$	13,630	14.4
Standalone Medicare Part D prescription drug plan customer relationship (held for sale)		101	N/A
Technology		1,060	3.0
Provider networks [(1)]		4,200	20.0
Value of Business Acquired		590	20.0
Trademark (definite-lived)		65	5.0
Trademark (indefinitely-lived)		4,100	N/A
Total intangible assets	$	23,746	15.1

(1) The amortization period for the Company's customer relationships and provider networks includes an assumption of renewal or extension of these arrangements. At the acquisition date, the periods prior to the next renewal or extension for provider networks primarily ranged from one to three years, and the period prior to the next renewal or extension for customer relationships was one year. Any costs related to the renewal or extension of these contracts are expensed as incurred.

Deferred income taxes
The purchase price allocation includes net deferred tax liabilities of $4.6 billion , primarily relating to deferred tax liabilities established on the identifiable acquired intangible assets.

Consolidated results of operations
The Company's consolidated results of operations for the year ended December 31, 2018 , include $5.6 billion of revenues and $146 million of income before income tax provision associated with the results of operations of Aetna from the Aetna Acquisition Date to December 31, 2018 .

During the year ended December 31, 2018 and 2017 , the Company incurred transaction costs of $147 million and $34 million , respectively, associated with the Aetna Acquisition that were recorded within operating expenses.

Unaudited pro forma financial information
The following unaudited pro forma information presents a summary of the Company's combined results of operations for the years ended December 31, 2018 and 2017 as if the Aetna acquisition and the related financing transactions had occurred on January 1, 2017 . The following pro forma financial information is not necessarily indicative of the results of operations as they would have been had the acquisition been effected on the assumed date, nor is it necessarily an indication of trends in future results for a number of reasons, including, but not limited to, differences between the assumptions used to prepare the pro forma information, basic shares outstanding and dilutive equivalents, cost savings from operating efficiencies, potential synergies, and the impact of incremental costs incurred in integrating the businesses.

		Year Ended December 31,		
In millions, except per share data		**2018**		**2017**
Total revenues	$	243,398	$	236,000
Income from continuing operations		1,123		6,813
Basic earnings per share from continuing operations attributable to CVS Health	$	0.87	$	5.25
Diluted earnings per share from continuing operations attributable to CVS Health	$	0.86	$	5.21

The pro forma results for the years ended December 31, 2018 and 2017 include adjustments related to the following purchase accounting and acquisition-related items:

- Elimination of intercompany transactions between CVS Health and Aetna;

- Elimination of estimated foregone interest income associated with (i) cash assumed to have been used to partially fund the Aetna Acquisition and (ii) adjusting the amortized cost of Aetna's investment portfolio to fair value as of the completion of the Aetna Acquisition;
- Elimination of historical intangible asset, deferred acquisition cost and capitalized software amortization expense and addition of amortization expense based on the current preliminary values of identified intangible assets;
- Additional interest expense from (i) the long-term debt issued to partially fund the Aetna Acquisition and (ii) the amortization of the fair value adjustment to assumed long-term debt.
- Additional depreciation expense related to the adjustment of Aetna's property and equipment to fair value;
- Adjustments to align CVS Health's and Aetna's accounting policies;
- Elimination of transaction related costs; and
- Tax effects of the adjustments noted above.

3. Investments

On November 28, 2018, the Company completed the Aetna Acquisition. Prior to the Aetna Acquisition Date, the Company's short term investments balance was comprised of certificates of deposit with initial maturities of greater than three months when purchased that mature in less than one year from the balance sheet date. These investments totaled $111 million as of December 31, 2017 and were classified as available for sale. In addition, the Company had $112 million of additional long-term investments as of December 31, 2017 which primarily consisted of cost method and equity method investments. Since the total amount of investments prior to the Aetna Acquisition was not material to the consolidated financial statements, the Company will include additional disclosures for investments on a prospective basis starting from the Aetna Acquisition Date.

Total investments at December 31, 2018 were as follows:

In millions	**Current**	**Long-term**	**Total**
Debt securities available for sale	$ 2,359	$ 12,896	$ 15,255
Mortgage loans	145	1,216	1,361
Other investments	18	1,620	1,638
Total investments	$ 2,522	$ 15,732	$ 18,254

At December 31, 2018 , the Company held investments of $531 million related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. The conversion occurred prior to the Aetna Acquisition. These investments are included in the total investments of large case pensions supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of the Company's business and only support future policy benefits obligations under that group annuity contract.

Debt Securities

Debt securities available for sale at December 31, 2018 were as follows:

In millions	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2018				
Debt securities:				
U.S. government securities	$ 1,662	$ 26	$ —	$ 1,688
States, municipalities and political subdivisions	2,370	30	(1)	2,399
U.S. corporate securities	6,444	61	(16)	6,489
Foreign securities	2,355	31	(3)	2,383
Residential mortgage-backed securities	567	10	—	577
Commercial mortgage-backed securities	594	11	—	605
Other asset-backed securities	1,097	3	(15)	1,085
Redeemable preferred securities	30	—	(1)	29
Total debt securities [1]	$ 15,119	$ 172	$ (36)	$ 15,255

(1) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated results of operations. At December 31, 2018 , debt securities with a fair value of $916 million , gross unrealized capital gains of $12 million and gross unrealized capital losses of $2 million were included in total debt securities, but support experience-rated products.

The fair value of debt securities at December 31, 2018 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	Amortized Cost	Fair Value
Due to mature:		
Less than one year	$ 901	$ 902
One year through five years	5,489	5,521
After five years through ten years	2,973	2,999
Greater than ten years	3,498	3,566
Residential mortgage-backed securities	567	577
Commercial mortgage-backed securities	594	605
Other asset-backed securities	1,097	1,085
Total	$ 15,119	$ 15,255

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2018 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the United States Government. At December 31, 2018 , the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 4.8 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2018 , these securities had an average credit quality rating of AAA and a weighted average duration of 6.3 years.

The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2018 , these securities had an average credit quality rating of AA and a weighted average duration of 1.3 years.

Summarized below are the debt securities the Company held at December 31, 2018 that were in an unrealized capital loss position:

In millions, except number of securities	**Number of Securities**	**Fair Value**	**Unrealized Losses**
Debt securities:			
U.S. government securities	8	$ 26	$ —
States, municipalities and political subdivisions	54	86	1
U.S. corporate securities	1,399	1,431	16
Foreign securities	243	314	3
Residential mortgage-backed securities	45	1	—
Other asset-backed securities	516	528	15
Redeemable preferred securities	14	23	1
Total debt securities	2,279	$ 2,409	$ 36

Since Aetna's investment portfolio was measured at fair value as of the Aetna Acquisition Date, each of the securities in the table above were in an unrealized loss position for less than 12 months. The Company reviewed the securities in the table above and concluded that they are performing assets generating investment income to support the needs of the Company's businesses. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. As of December 31, 2018 , the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2018 were as follows:

	Supporting experience-rated products		**Supporting remaining products**		**Total**	
In millions	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Due to mature:						
Less than one year	$ 21	$ —	$ 308	$ —	$ 329	$ —
One year through five years	36	2	557	5	593	7
After five years through ten years	47	—	492	9	539	9
Greater than ten years	49	—	370	5	419	5
Residential mortgage-backed securities	—	—	1	—	1	—
Other asset-backed securities	4	—	524	15	528	15
Total	$ 157	$ 2	$ 2,252	$ 34	$ 2,409	$ 36

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. From the Aetna Acquisition Date through December 31, 2018 , the Company had the following activity in its mortgage loan portfolio:

In millions	
New mortgage loans	$ 4
Mortgage loans fully-repaid	27
Mortgage loans foreclosed	—

The Company assesses mortgage loans on a regular basis for credit impairments, and annually assign a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, property condition, market trends, creditworthiness of the borrower and deal structure. The vast majority of the Company's mortgage loans fall into categories 2 to 4.

- *Category 1* - Represents loans of superior quality
- *Categories 2 to 4* - Represents loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represents loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the most recent assessments at December 31, 2018 , the Company's mortgage loans were given the following credit quality indicators:

In millions, except credit ratings indicator		
1	$	42
2 to 4		1,301
5 and 6		18
7		—
Total	$	1,361

At December 31, 2018 scheduled mortgage loan principal repayments were as follows:

In millions		
2019	$	145
2020		109
2021		269
2022		228
2023		83
Thereafter		527
Total	$	1,361

Net Investment Income

Sources of net investment income for the year ended December 31, 2018 were as follows:

In millions		
Debt securities	$	637
Mortgage loans		6
Other investments		17
Gross investment income		660
Investment expenses		(3)
Net investment income (excluding net realized capital gains or losses)		657
Net realized capital gains		3
Net investment income [(1)]	$	660

(1) Net investment income in 2018 includes $4 million related to investments supporting experience-rated products.

The Company's net investment income was $21 million and $20 million in 2017 and 2016 , respectively, relating to interest income on debt securities. The Company did not have any material realized capital gains or losses during 2017 or 2016.

The portion of unrealized capital gains and losses recognized during the year ended December 31, 2018 related to investments in equity securities held as of December 31, 2018 was not material.

Excluding amounts related to experience-rated products, proceeds from the sale of available for sale debt securities and the related gross realized capital gains and losses from the Aetna Acquisition Date through December 31, 2018 were as follows: [1]

In millions		
Proceeds from sales	$	389
Gross realized capital gains		2
Gross realized capital losses		(2)

(1) The proceeds from sales and gross realized capital gains and losses exclude the impact of the sales of short-term debt securities which primarily relate to the Company's investments in mutual funds. These investments were excluded from the disclosed amounts because they represent an immaterial amount of aggregate gross realized capital gains or losses and have a high volume of sales activity.

4. Fair Value

The preparation of the Company's consolidated financial statements in accordance with GAAP requires certain assets and liabilities to be reflected at their fair value, and others on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income (loss) attributable to CVS Health or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of United States Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The Company reviews these prices to ensure they are based on observable market inputs that include, but are not limited to, quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable but not prices (for example, interest rates and credit risks). The Company also reviews the

methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of these prices at December 31, 2018 . The Company's Level 2 debt securities were not material as of December 31, 2017 .

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company obtained one non-binding broker quote for each of these Level 3 debt securities and did not adjust any of these quotes at December 31, 2018 . The total fair value of broker quoted debt securities was $50 million at December 31, 2018 . The Company did not have any Level 3 debt securities as of December 31, 2017. Examples of these broker quoted Level 3 debt securities include certain United States and foreign corporate securities and certain of the Company's commercial mortgage-backed securities as well as other asset-backed securities. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain United States and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would result in a change in the fair value measurement, which may be significant. The Company did not have any Level 3 equity securities as of December 31, 2017.

Derivative Financial Instruments - The fair values of derivative financial instruments are determined using quoted prices in markets that are not active or inputs that are observable for the asset or liability and therefore they are classified as Level 2 in the fair value hierarchy. The fair value of these instruments are recorded in other current assets or accrued expenses, as applicable. The Company did not have any material outstanding derivative financial instruments as of December 31, 2018.

Financial assets and liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2018 and 2017 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2018				
Assets:				
Debt securities:				
U.S. government securities	$ 1,597	$ 91	$ —	$ 1,688
States, municipalities and political subdivisions	—	2,399	—	2,399
U.S. corporate securities	—	6,422	67	6,489
Foreign securities	—	2,380	3	2,383
Residential mortgage-backed securities	—	577	—	577
Commercial mortgage-backed securities	—	605	—	605
Other asset-backed securities	—	1,085	—	1,085
Redeemable preferred securities	—	22	7	29
Total debt securities	1,597	13,581	77	15,255
Equity securities	19	—	54	73
Total	$ 1,616	$ 13,581	$ 131	$ 15,328
December 31, 2017				
Assets:				
Debt securities:				
U.S. corporate securities	$ —	$ 1	$ —	$ 1
Foreign securities	—	110	—	110
Total debt securities	—	111	—	111
Equity securities	—	—	—	—
Derivative financial instruments	—	5	—	5
Total assets	$ —	$ 116	$ —	$ 116
Liabilities:				
Derivative financial instruments	$ —	$ 23	$ —	$ 23

There were no transfers between Levels 1 and 2 during the years ended December 31, 2018 and 2017 . The change in the balance of Level 3 financial assets during 2018 relates to investments acquired in the Aetna Acquisition, which occurred on November 28, 2018. There were no transfers into or out of Level 3 from November 28, 2018 to December 31, 2018.

Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2018 and 2017 were as follows:

In millions	Carrying Value	Estimated Fair Value			
		Level 1	Level 2	Level 3	Total
December 31, 2018					
Assets:					
Mortgage loans	$ 1,361	$ —	$ —	$ 1,366	$ 1,366
Equity securities [1]	140	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	382	—	—	357	357
Long-term debt	72,709	71,252	—	—	71,252

In millions	Carrying Value	Estimated Fair Value			
		Level 1	Level 2	Level 3	Total
December 31, 2017					
Assets:					
Equity securities [1]	$ 47	N/A	N/A	N/A	N/A
Liabilities:					
Long-term debt	25,726	26,756	—	—	26,756

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies. See Note 1 ‘‘Significant Accounting Policies’’ for additional information regarding the valuation of cost-method investments.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

As part of the Aetna Acquisition, the Company acquired Separate Accounts assets related to large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders’ equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 4 “Fair Value.” Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts’ interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value (“NAV”) per share/unit on the valuation date.

Separate Accounts financial assets as of December 31, 2018 were as follows:

In millions	Level 1	Level 2	Level 3	Total
Debt securities	$ 782	$ 2,500	$ 4	$ 3,286
Equity securities	—	3	—	3
Common/collective trusts	—	404	—	404
Total [1]	$ 782	$ 2,907	$ 4	$ 3,693

(1) Excludes $191 million of cash and cash equivalents and accounts receivable at December 31, 2018 .

During 2018 , the Company had an immaterial amount of Level 3 Separate Accounts financial assets and an immaterial amount of gross transfers of Separate Accounts financial assets into or out of Level 3. During 2018 , there were no transfers of Separate Accounts financial assets between Levels 1 and 2. The Company held no Separate Accounts financial assets as of December 31, 2017 .

Offsetting Financial Assets and Liabilities

Subsequent to the Aetna Acquisition Date, certain financial assets and liabilities are offset in the Company's consolidated balance sheets or are subject to master netting arrangements or similar agreements with the applicable counterparty. Financial assets, including derivative assets, subject to offsetting and enforceable master netting arrangements were $13 million as of December 31, 2018.

5. Goodwill and Other Intangibles

Goodwill

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2018 and 2017 :

In millions	Pharmacy Services	Retail/LTC	Health Care Benefits	Total
Balance at December 31, 2016	$ 21,637	$ 16,612	$ —	$ 38,249
Acquisitions	182	203	—	385
Foreign currency translation adjustments	—	(2)	—	(2)
Impairments	—	(181)	—	(181)
Balance at December 31, 2017	21,819	16,632	—	38,451
Acquisitions	1,569	735	44,484	46,788
Foreign currency translation adjustments	—	(14)	—	(14)
Divestiture of RxCrossroads subsidiary	—	(398)	—	(398)
Impairments	—	(6,149)	—	(6,149)
Balance at December 31, 2018	$ 23,388	$ 10,806	$ 44,484	$ 78,678

Cumulative goodwill impairments as of December 31, 2018 and 2017 were $6.1 billion and $181 million , respectively.

The changes in the carrying amount of goodwill during the years ended December 31, 2018 and 2017 reflect the following activity:

Aetna Acquisition
On November 28, 2018, the Company completed the Aetna Acquisition. The majority of the preliminary valuation of goodwill associated with the Aetna Acquisition was recorded in the Health Care Benefits segment. The Company also allocated a portion of such goodwill to the Retail/LTC and Pharmacy Services segments related to the fair value of identified synergies that are expected to directly benefit those segments. See Note 2 ''Acquisition of Aetna'' for further discussion regarding the Aetna Acquisition.

LTC
During 2018, the LTC reporting unit continued to experience industry wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare and when the 2017 annual goodwill impairment test was performed. These challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a projected deterioration in the financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, higher risk-free interest rates and lower market multiples of peer group companies contributed to the amount of the second quarter 2018 goodwill impairment charge.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill or trade names.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. The updated projections continue to reflect industry wide challenges including lower occupancy rates in skilled nursing facilities, significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, an interim goodwill impairment test was performed during the fourth quarter of 2018. The results of that impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion goodwill impairment charge in the fourth quarter of 2018. In addition to the lower financial projections, lower market multiples of peer group companies also contributed to the amount of the fourth quarter 2018 goodwill impairment charge. The fair value of the LTC reporting unit was determined using a methodology consistent with the methodology described above for the analyses performed during the second and third quarters of 2018.

As of December 31, 2018 , the remaining goodwill balance in the LTC reporting unit is approximately $431 million .

RxCrossroads
During 2017, the Company began pursuing various strategic alternatives for its RxCrossroads reporting unit. In connection with this effort, the Company performed an interim goodwill impairment test in the second quarter of 2017. The results of that impairment test showed that the fair value of the RxCrossroads reporting unit was lower than the carrying value, resulting in a $135 million pre-tax goodwill impairment charge in the second quarter of 2017.

The TCJA was enacted on December 22, 2017 and reduced the United States federal corporate income tax rate from 35% to 21% effective January 1, 2018 (see Note 10 ‘‘Income Taxes’’). As a result, the RxCrossroads deferred income tax liabilities were reduced by $47 million and an income tax benefit of $47 million was recorded in the 2017 statement of operations. The reduction in the deferred income tax liabilities increased the carrying value of the RxCrossroads reporting unit by $47 million which triggered an additional goodwill impairment charge in the RxCrossroads reporting unit of $46 million during the fourth quarter of 2017.

On January 2, 2018, the Company sold its RxCrossroads subsidiary to McKesson Corporation for $725 million , at which time the remaining goodwill of this reporting unit was removed from the consolidated balance sheet.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31 :

In millions, except weighted average life	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Life (years)
2018				
Trademarks (indefinitely-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	26,213	(6,349)	19,864	14.8
Technology	1,060	(31)	1,029	3.0
Provider networks	4,200	(19)	4,181	20.0
Value of Business Acquired	590	(7)	583	20.0
Favorable leases and other	1,177	(808)	369	17.1
Total	$ 43,738	$ (7,214)	$ 36,524	15.3
2017				
Trademark (indefinitely-lived)	$ 6,398	$ —	$ 6,398	N/A
Customer contracts/relationships and covenants not to compete	12,341	(5,536)	6,805	15.3
Favorable leases and other	1,190	(763)	427	16.2
Total	$ 19,929	$ (6,299)	$ 13,630	15.4

Amortization expense for intangible assets totaled $1.0 billion , $817 million and $795 million for the years ended December 31, 2018 , 2017 and 2016 , respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2019	$ 2,563
2020	2,350
2021	2,253
2022	1,879
2023	1,844

6. Leases

The Company leases most of its retail and mail order dispensing pharmacy locations, and certain distribution centers and corporate offices under noncancelable operating leases, typically with initial terms of 15 to 25 years and with options that permit renewals for additional periods. The Company also leases certain equipment and other assets under noncancelable operating leases, typically with initial terms of 3 to 10 years.

In December 2015, in connection with the acquisition of the pharmacy and clinic businesses of Target, the Company entered into lease agreements with Target for the pharmacy and clinic space within Target stores. Given that the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings being leased, the Company concluded for accounting purposes that the lease term was the remaining economic life of the buildings. Consequently, most of the individual Target pharmacy and clinic leases are capital leases.

Minimum rent on operating leases is expensed on a straight-line basis over the term of the lease. In addition to minimum rental payments, certain leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred.

The following table is a summary of the Company's net rental expense for operating leases for the years ended December 31:

In millions	**2018**	**2017**	**2016**
Minimum rentals	$ 2,528	$ 2,455	$ 2,418
Contingent rentals	28	29	35
Rental expense	2,556	2,484	2,453
Less: sublease income	(21)	(24)	(24)
Total rental expense, net	$ 2,535	$ 2,460	$ 2,429

The following table is a summary of the future minimum lease payments under capital and operating leases as of December 31, 2018 :

In millions	**Capital Leases**	**Operating Leases [1]**
2019	$ 74	$ 2,690
2020	73	2,544
2021	73	2,399
2022	73	2,233
2023	73	2,110
Thereafter	875	16,004
Total future lease payments [2]	1,241	$ 27,980
Less: imputed interest	(599)	
Present value of capital lease obligations	$ 642	

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $164 million due in the future under noncancelable subleases.
(2) The Company leases pharmacy and clinic space from Target. Amounts related to such capital and operating leases are reflected above. Amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.1 billion are not reflected herein since the estimated economic life of the buildings is shorter than the contractual term of the lease arrangement.

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the above table. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. There were no sale-leaseback transactions in 2018. Proceeds from sale-leaseback transactions totaled $265 million and $230 million in 2017 and 2016 , respectively.

7. Health Care Costs Payable

On November 28, 2018 , the Company completed the Aetna Acquisition. Prior to the Aetna Acquisition, the Company's health care costs payable balance was immaterial and related to unpaid pharmacy claims for its stand-alone Medicare Part D PDPs within the Pharmacy Services segment. Accordingly, the Company will include disclosures for health care costs payable for the year ended December 31, 2018. Since the health care costs payable liability related to the Pharmacy Services segment is immaterial, the Company's disclosures will be presented on a consolidated basis and will not be disaggregated between the Pharmacy Services and Health Care Benefits segments.

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements and accruals for state assessments within the Health Care Benefits segment. See Note 1 ''Significant Accounting Policies'' for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company's estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company's liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company's inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company's different claim processing systems and would not

be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency was not included in the disclosures included below.

The following table shows the components of the change in health care costs payable during 2018:

In millions	
Health care costs payable, beginning of the period	$ 5
Less: Reinsurance recoverables	—
Health care costs payable, beginning of the period, net	5
Acquisitions, net	5,357
Add: Components of incurred health care costs	
Current year	6,594
Prior years	(42)
Total incurred health care costs [(1)]	6,552
Less: Claims paid	
Current year	6,464
Prior years	260
Total claims paid	6,724
Add: Premium deficiency reserve	16
Health care costs payable, end of period, net	5,206
Add: Reinsurance recoverables	4
Health care costs payable, end of period	$ 5,210

(1) Total incurred health care costs for the year ended December 31, 2018 in the table above exclude (i) $16 million related to a premium deficiency reserve for the 2019 coverage year related to Medicaid products, (ii) $4 million of benefit costs recorded in the Health Care Benefits segment that are included in Other Insurance Liabilities on the consolidated balance sheet and (iii) $22 million of benefit costs recorded in the Corporate/Other segment that are included in Other Insurance Liabilities on the consolidated balance sheet.

At December 31, 2018 , the Company's liabilities for IBNR plus expected development on reported claims totaled approximately $ 4.1 billion . Substantially all of the Company's liabilities for IBNR plus expected development on reported claims at December 31, 2018 related to the current calendar year.

Due to the proximity of the Aetna Acquisition Date to December 31, 2018 , the Company did not include disclosures related to incurred and paid claim development from November 28, 2018 to December 31, 2018 . The Company will begin including disclosures related to incurred and paid claim development for the year ended December 31, 2019.

8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31 :

In millions	**2018**	**2017**
Short-term debt		
Commercial paper	$ 720	$ 1,276
Long-term debt		
1.9% senior notes due July 2018	—	2,250
2.25% senior notes due December 2018	—	1,250
2.2% senior notes due March 2019	375	—
2.25% senior notes due August 2019	850	850
3.125% senior notes due March 2020	2,000	—
Floating rate notes due March 2020	1,000	—
2.8% senior notes due July 2020	2,750	2,750
3.35% senior notes due March 2021	3,000	—
Floating rate notes due March 2021	1,000	—
4.125% senior notes due May 2021	550	550
2.125% senior notes due June 2021	1,750	1,750
4.125% senior notes due June 2021	500	—
5.45% senior notes due June 2021	600	—
3-Year tranche loan due November 2021	3,000	—
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	—
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	6,000	—
2.8% senior notes due June 2023	1,300	—
4% senior notes due December 2023	1,250	1,250
3.375% senior notes due August 2024	650	650
3.5% senior notes due November 2024	750	—
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	5,000	—
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
6.25% senior notes due June 2027	372	372
4.3% senior notes due March 2028	9,000	—
4.875% senior notes due July 2035	652	652
3.25% senior exchange debentures due December 2035	—	1
6.625% senior notes due June 2036	771	—
6.75% senior notes due December 2037	533	—
4.78% senior notes due March 2038	5,000	—
6.125% senior notes due September 2039	447	447
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	—
4.125% senior notes due November 2042	500	—
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	—
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	—
5.05% senior notes due March 2048	8,000	—
Capital lease obligations	642	670
Other	19	43
Total debt principal	74,265	27,170

Debt premiums	302	28
Debt discounts and deferred financing costs	(1,138)	(196)
	73,429	27,002
Less:		
Short-term debt (commercial paper)	(720)	(1,276)
Current portion of long-term debt	(1,265)	(3,545)
Long-term debt	$ 71,444	$ 22,181

The following is a summary of the Company's required principal debt repayments due during each of the next five years and thereafter, as of December 31, 2018 :

In millions		
2019	$	1,985
2020		5,775
2021		10,427
2022		4,178
2023		8,581
Thereafter		43,319
Total	$	74,265

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company had approximately $720 million and $1.3 billion of commercial paper outstanding at weighted average interest rates of 2.8% and 2.0% as of December 31, 2018 and 2017 , respectively. In connection with its commercial paper program, the Company maintains a $1.75 billion 364 -day unsecured back-up revolving credit facility, which expires on May 16, 2019, a $1.25 billion , five -year unsecured back-up revolving credit facility, which expires on July 1, 2020, a $1.0 billion , five -year unsecured back-up revolving credit facility, which expires on May 18, 2022, and a $2.0 billion , five -year unsecured back-up revolving credit facility, which expires on May 17, 2023. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03% , regardless of usage. As of December 31, 2018 and 2017 , there were no borrowings outstanding under any of the back-up credit facilities.

Bridge Loan Facility
On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a $49.0 billion unsecured bridge loan facility commitment. The Company paid $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statements of operations.

On March 9, 2018, the Company issued an aggregate of $40.0 billion principal amount of unsecured floating rate notes and unsecured fixed rate senior notes, collectively the "2018 Notes". At this time, the bridge loan facility commitment was reduced to $4.0 billion , and the Company paid $8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded $173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018 , which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a $4.0 billion unsecured 364 -day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the $4.0 billion unsecured 364 -day bridge term loan agreement terminated.

Terminated Revolving Credit Facility
On January 3, 2017, the Company entered into a $2.5 billion revolving credit facility. The credit facility allowed for borrowings at various rates that were dependent, in part, on the Company's debt ratings and required the Company to pay a weighted average quarterly facility fee of approximately 0.03% , regardless of usage. The Company terminated this credit facility in May 2017.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2018 was approximately $790 million . As of December 31, 2018 , there were no outstanding advances from the FHLBB.

Long-term Borrowings

2018 Notes
On March 9, 2018, the Company issued the 2018 Notes with an aggregate principal amount of $40.0 billion , for total proceeds of approximately $39.4 billion , net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes are comprised of the following:

In millions		
3.125% senior notes due March 2020	$	2,000
Floating rate notes due March 2020		1,000
3.35% senior notes due March 2021		3,000
Floating rate notes due March 2021		1,000
3.7% senior notes due March 2023		6,000
4.1% senior notes due March 2025		5,000
4.3% senior notes due March 2028		9,000
4.78% senior notes due March 2038		5,000
5.05% senior notes due March 2048		8,000
Total debt principal	$	40,000

Beginning in December 2017 through March 31, 2018, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of long-term debt to fund the Aetna Acquisition.

In connection with the issuance of the 2018 Notes, the Company terminated all outstanding cash flow hedges. In connection with the hedge transactions, the Company received a net amount of $446 million from the hedge counterparties upon termination, which was recorded as a gain, net of tax, of $331 million in accumulated other comprehensive income and will be reclassified as a reduction of interest expense over the life of the 2018 Notes. See Note 13 ‘‘Other Comprehensive Income (Loss)’’ for additional information. The Company expects to reclassify approximately $18 million , net of tax, in gains associated with these cash flow hedges into net income within the next 12 months.

Term Loan Agreement
On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a $5.0 billion term loan agreement. The term loan facility under the term loan agreement consists of a $3.0 billion three -year tranche and a $2.0 billion five -year tranche. The term loan agreement allows for borrowings at various rates that are dependent, in part, on the Company’s debt ratings. In connection with the Aetna Acquisition, the Company borrowed $5.0 billion (a $3.0 billion three -year tranche and a $2.0 billion five -year tranche) under term loan agreement in November 2018. The Company terminated the $2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. As of December 31, 2018, the Company had $3.0 billion outstanding under the three -year tranche of the term loan agreement.

Aetna Related Debt
On the Aetna Acquisition Date, the Company assumed long-term debt with a fair value of $8.1 billion , with stated interest rates ranging from 2.2% to 6.75% . The long-term debt assumed is included in the summary of borrowings table above.

2016 Notes
On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the “ 2016 Notes ”) for total proceeds of approximately $3.5 billion , net of discounts and underwriting fees. The 2016 Notes may be redeemed, in whole at any time, or in part from time to time, at the Company’s option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

Early Extinguishment of Long-Term Debt
On May 16, 2016, the Company announced tender offers for (i) any and all of its 5.75% senior notes due 2017, its 6.60% senior notes due 2019 and its 4.75% senior notes due 2020 (collectively, the “Any and All Notes”) and (ii) up to $1.5 billion aggregate

principal amount of the 4.75% Senior Notes due 2022 issued by its wholly-owned subsidiary Omnicare, the 5.00% Senior Notes due 2024 issued by Omnicare, its 3.875% Senior Notes due 2025, its 6.25% Senior Notes due 2027, its 4.875% Senior Notes due 2035, its 6.125% Senior Notes due 2039 and its 5.75% Senior Notes due 2041 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion . The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. In connection with the purchase of the Notes, the Company paid a premium of $486 million in excess of the debt principal, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on early extinguishment of long-term debt of $542 million , which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. In connection with that redemption, the Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of long-term debt of $101 million , which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

Debt Covenants

The back-up revolving credit facilities, unsecured senior notes, unsecured floating rate notes and term loan agreement contain customary restrictive financial and operating covenants. These covenants do not include a requirement for the acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit rating. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2018 , the Company was in compliance with all of its debt covenants.

9. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2018 , the Company sponsors several active 401(k) savings plans that cover all employees who meet plan eligibility requirements. The Company makes matching contributions consistent with the provisions of the respective plans.

At the participant's option, account balances, including the Company's matching contribution, can be invested without restriction among various investment options under each plan. Two of the defined contribution plans offer the Company's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health 401(k) Plan or Aetna 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under the above defined contribution plans were $334 million , $314 million and $295 million in 2018, 2017 and 2016, respectively. The Company's contributions for the year ended December 31, 2018 include contributions to the Aetna Inc. 401(k) plan subsequent to the Aetna Acquisition Date.

Defined Benefit Pension Plans

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna sponsors a tax-qualified pension plan that was frozen in 2010. Aetna also sponsors a non-qualified supplemental pension plan that was frozen in 2007. Aetna's pension plan benefit obligations and the fair value of plan assets were remeasured as of the Aetna Acquisition Date.

Prior to the Aetna Acquisition, during the year ended December 31, 2017 , the Company settled the pension obligations of its existing two tax-qualified defined benefit pension plans by irrevocably transferring pension liabilities to an insurance company through the purchase of group annuity contracts and through lump sum distributions. These purchases, funded with pension plan assets, resulted in pre-tax settlement losses of $187 million in the year ended December 31, 2017 , related to the recognition of accumulated deferred actuarial losses. The settlement losses were recorded in other expense in the consolidated statement of operations. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans as described in the "Other Postretirement Benefits" section below.

Pension Benefit Obligations and Plan Assets
The following tables outline the change in benefit obligations and plan assets over the specified periods:

In millions	**2018**	**2017**
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 131	$ 844
Acquired benefit obligations	5,685	—
Interest cost	25	20
Actuarial loss (gain)	41	(31)
Benefit payments	(41)	(35)
Settlements	—	(667)
Benefit obligation, end of year	$ 5,841	$ 131

In millions	**2018**	**2017**
Change in plan assets:		
Fair value of plan assets, beginning of year	$ —	$ 624
Fair value of plan assets acquired	5,709	—
Actual return on plan assets	(17)	32
Employer contributions	12	46
Benefit payments	(41)	(35)
Settlements	—	(667)
Fair value of plan assets, end of year	5,663	—
Funded status	$ (178)	$ (131)

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2018 and 2017 for the pension plans consisted of the following:

In millions	**2018**	**2017**
Accrued benefit assets reflected in other assets	$ 147	$ —
Accrued benefit liabilities reflected in accrued expenses	(25)	(21)
Accrued benefit liabilities reflected in other long-term liabilities	(300)	(110)
Net liabilities	$ (178)	$ (131)

Net Periodic Benefit Costs
The components of net periodic benefit cost for the years ended December 31 are shown below:

In millions	**2018**	**2017**	**2016**
Components of net periodic benefit cost:			
Interest cost	$ 25	$ 20	$ 27
Expected return on plan assets	(33)	(20)	(32)
Amortization of net actuarial loss	2	21	32
Settlement losses	—	187	—
Net periodic benefit cost	$ (6)	$ 208	$ 27

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligations and net benefit costs as further detailed below.

Discount Rates - The discount rate for the acquired Aetna plans is determined using a yield curve as of the annual measurement date. Each yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve. The weighted average discount rate for the Aetna pension plans was 4.4% in 2018 .

The Company settled the pension obligations of its existing tax-qualified plans during 2017. The discount rates for determining plan benefit obligations (excluding the terminated qualified plan) were approximately 4.0% , 3.5% and 4.0% in 2018 , 2017 and 2016 , respectively. The discount rate for the terminated qualified plan was 3.1% in 2016.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan by plan basis. The expected long-term rate of return for the acquired Aetna plans was 6.6% in 2018. See "Pension Plan Assets" below for additional details regarding the Aetna pension plan assets as of December 31, 2018.

The Company settled the pension obligations of its existing tax-qualified plans during 2017. The expected long-term rate of return for these plans ranged from 4.0% to 5.5% in both 2017 and 2016 .

Net Actuarial Losses/Gains - Based on the mortality experience of the acquired Aetna pension plans, in 2018 the Company utilized the RP-2014WC Mortality Table with a generation projection of future mortality improvements using Scale MP-2018 for the acquired Aetna plans.

Pension Plan Assets
As of December 31, 2017, the assets in the Company's prior qualified defined benefit pension plans had been fully liquidated to settle all plan obligations through the purchase of group annuity contracts and through lump sum distributions. On November 28, 2018, the Company completed the Aetna Acquisition. At December 31, 2018, the assets of the Aetna pension plan (the "Aetna Pension Plan") primarily include debt and equity securities held in separate accounts, as well as common/collective trusts and real estate investments. The valuation methodologies used to price these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Assets of the Aetna pension plan also include investments in other assets that are carried at fair value. The following is a description of the valuation methodology used to price real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which includes, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Aetna Pension Plan assets with changes in fair value measured on a recurring basis at December 31, 2018 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Debt securities:				
U.S. government securities	$ 511	$ 38	$ —	$ 549
States, municipalities and political subdivisions	—	147	—	147
U.S. corporate securities	—	1,671	5	1,676
Foreign securities	—	177	—	177
Residential mortgage-backed securities	—	339	—	339
Commercial mortgage-backed securities	—	70	—	70
Other asset-backed securities	—	162	—	162
Redeemable preferred securities	—	6	—	6
Total debt securities	511	2,610	5	3,126
Equity securities:				
U.S. Domestic	744	—	—	744
International	356	—	—	356
Domestic real estate	30	—	—	30
Total equity securities	1,130	—	—	1,130
Other investments:				
Real estate	—	—	425	425
Common/collective trusts (1)	—	253	—	253
Derivatives	—	2	—	2
Total other investments	—	255	425	680
Total pension investments (2)	$ 1,641	$ 2,865	$ 430	$ 4,936

(1) The assets in the underlying funds of common/collective trusts consist of $109 million of equity securities and $144 million of debt securities.
(2) Excludes $98 million of cash and cash equivalents, $465 million of private equity limited partnership investments and $164 million of hedge fund limited partnership investments as the amounts are carried at fair value.

The change in the balance of pension plan assets during 2018 relates to investments acquired in the Aetna Acquisition, which occurred on November 28, 2018. There was an immaterial amount of transfers into or out of Level 3 from November 28, 2018 to December 31, 2018.

The Aetna Pension Plan invests in a diversified mix of assets intended to maximize long-term returns while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing Aetna Pension Plan's liability characteristics. Complementary investment styles and techniques are utilized by multiple professional investment firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2018 , target investment allocations for the Aetna Pension Plan were: 31% in equity securities, 57% in debt securities, 6% in real estate, 3% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the Aetna Pension Plan's Benefit Finance Committee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows
The Company generally contributes to its tax-qualified pension plans based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the non-qualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed $12 million , $46 million and $25 million to the pension plans during 2018 , 2017 and 2016 , respectively. No contributions are required for the Aetna Pension Plan in 2019. The Company expects to make an immaterial amount of contributions for all other pension plans in 2019. The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension plan benefit obligation as of December 31, 2018 :

In millions		
2019	$	375
2020		387
2021		411
2022		387
2023		391
2024-2028		1,916

Multiemployer Pension Plans
The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following aspects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. Total Company contributions to multiemployer pension plans were $18 million , $17 million and $15 million in 2018 , 2017 and 2016 , respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. On November 28, 2018, the Company completed the Aetna Acquisition. Aetna also sponsors OPEB plans that provide certain health care and life insurance benefits for retired employees. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2018 and 2017 , the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $228 million and $25 million , respectively. Net periodic benefit costs related to these other postretirement benefits were $2 million in 2018 , and $1 million in both 2017 and 2016 .

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the other postretirement benefit obligation as of December 31, 2018 :

In millions		
2019	$	17
2020		17
2021		17
2022		16
2023		16
2024-2028		76

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to

certain employees who meet eligibility requirements. Total Company contributions to multiemployer health and welfare plans were $58 million , $58 million and $52 million in 2018 , 2017 and 2016 , respectively.

10. Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31:

In millions	**2018**	**2017**	**2016**
Current:			
Federal	$ 1,480	$ 2,594	$ 2,803
State	499	464	511
	1,979	3,058	3,314
Deferred:			
Federal	22	(1,435)	5
State	1	14	(2)
	23	(1,421)	3
Total	$ 2,002	$ 1,637	$ 3,317

The TCJA was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective on January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion for year ended December 31, 2017. The Company completed its assessment of the TCJA's final impact in December 2018 and recorded an additional tax benefit of approximately $100 million in the year ended December 31, 2018.

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31:

	2018	**2017**	**2016**
Statutory income tax rate	21.0 %	35.0 %	35.0 %
State income taxes, net of federal tax benefit	27.7	4.1	4.1
Effect of the Tax Cuts and Jobs Act	(7.1)	(18.3)	—
Health insurer fee	2.2	—	0.2
Goodwill impairments	89.5	0.8	—
Sale of subsidiary	5.0	—	—
Other	4.1	(1.8)	(0.9)
Effective income tax rate	142.4 %	19.8 %	38.4 %

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31:

In millions	**2018**	**2017**
Deferred income tax assets:		
Lease and rents	$ 277	$ 291
Inventory	28	31
Employee benefits	243	246
Allowance for doubtful accounts	243	187
Retirement benefits	130	40
Net operating loss and capital loss carryforwards	529	101
Deferred income	104	93
Insurance reserves	467	—
Investments	11	—
Other	242	18
Valuation allowance	(520)	(77)
Total deferred income tax assets	1,754	930
Deferred income tax liabilities:		
Depreciation and amortization	(9,431)	(3,926)
Total deferred income tax liabilities	(9,431)	(3,926)
Net deferred income tax liabilities	$ (7,677)	$ (2,996)

The increase in net deferred income tax liabilities is mainly due to the Aetna Acquisition. As of December 31, 2018, the Company has net operating and capital loss carryovers of approximately $529 million . The Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and recent results of operations. The Company established a valuation allowance of $520 million because it does not consider it more likely than not that these deferred tax assets will be recovered.

A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows:

In millions	**2018**	**2017**	**2016**
Beginning balance	$ 344	$ 307	$ 338
Additions based on tax positions related to the current year	1	62	68
Additions based on tax positions related to prior years	324	32	70
Reductions for tax positions of prior years	(5)	(28)	(100)
Expiration of statutes of limitation	(2)	(10)	(22)
Settlements	(1)	(19)	(47)
Ending balance	$ 661	$ 344	$ 307

The increase in the balance of unrecognized tax benefits in 2018 compared to 2017 and 2016 is mainly due to the Aetna Acquisition.

The Company and most of its subsidiaries are subject to United States federal income tax as well as income tax of numerous state and local jurisdictions. The Company is a participant in the Compliance Assurance Process, which is a program made available by the Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax return. The IRS has substantially completed its examinations of the Company's 2015, 2016 and 2017 consolidated United States federal income tax returns. The IRS is currently examining the Company's 2018 consolidated United States federal income tax return.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2018 , no examination has resulted in any proposed adjustments that would result in a material change to the Company's results of operations, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2012. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2019, but the change in the balance of the Company's uncertain tax positions is projected to be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in the income tax provision. The Company accrued interest expense of approximately $19 million , $11 million and $10 million in 2018 , 2017 and 2016 , respectively. The Company had approximately $80 million and $34 million accrued for interest and penalties as of December 31, 2018 and 2017 , respectively.

As of December 31, 2018 , the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $597 million , after considering the federal benefit of state income taxes.

11. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of the Company's Board of Directors (the "Board"). The ICP allows for a maximum of 32 million shares of CVS Health common stock to be reserved and available for grants. Prior to the acquisition of Aetna in 2018, the ICP was the only compensation plan under which the Company granted stock options, restricted stock and other stock-based awards to its employees, with the exception of the Company's Employee Stock Purchase Plan ("ESPP"). As of December 31, 2018 , there were approximately 26 million shares of CVS Health common stock available for future grants under the ICP.

As of the Aetna Acquisition Date, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health common stock reserved and available for issuance pursuant to future awards. As of December 31, 2018 , there were approximately 32 million shares of CVS Health common stock available for future grants under the SIP.

Stock-based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for each of the respective periods:

In millions	**2018**	**2017**	**2016**
Stock options and stock appreciation rights ("SARs") (1)(2)	$ 70	$ 65	$ 79
Restricted stock units and performance stock units (2)	210	169	143
Total stock-based compensation	$ 280	$ 234	$ 222

(1) Includes the ESPP.
(2) Stock-based compensation for the year ended December 31, 2018 includes $14 million and $27 million associated with accelerated vesting of SARs and restricted stock replacement awards, respectively, issued to Aetna employees who were terminated subsequent to the acquisition.

ESPP

The ESPP provides for the purchase of up to 30 million shares of common stock. Under the ESPP, beginning in 2016, eligible employees could purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. Prior to 2016, the purchase price was equal

to 85% of the lower of the fair market value on the first day or the last day of the offering period. During 2018 , approximately two million shares of common stock were purchased under the provisions of the ESPP at an average price of $61.40 per share. As of December 31, 2018 , approximately 9 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for each of the respective periods:

	2018	2017	2016
Dividend yield [1]	1.45%	1.24%	0.88%
Expected volatility [2]	28.02%	22.70%	20.64%
Risk-free interest rate [3]	1.87%	0.86%	0.45%
Expected life (in years) [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 12.26	$ 13.01	$ 14.98

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is based on the historical volatility of the Company's daily stock market prices over the previous six month period.
(3) The risk-free interest rate is based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).
(4) The expected life is based on the semi-annual purchase period.

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are set at the time of grant by the MP&D Committee. For each restricted stock unit and performance share stock granted, employees receive one share of common stock, net of taxes, at the end of the vesting period. Compensation cost is recorded based on the market price of the Company's common stock on the grant date and is recognized on a straight-line basis over the requisite service period. On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna performance stock unit and restricted stock unit awards as of the Aetna Acquisition Date were converted into replacement CVS Health restricted stock awards.

As of December 31, 2018 , there was $491 million of total unrecognized compensation cost related to Company restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.01 years. The total fair value of restricted shares vested during 2018 , 2017 and 2016 was $262 million , $175 million and $218 million , respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2018 :

Units in thousands	Units	Weighted Average Grant Date Fair Value
Unvested at beginning of year	5,014	$ 86.92
Granted	10,185	$ 73.18
Vested	(3,757)	$ 68.85
Forfeited	(437)	$ 76.92
Unvested at end of year	11,005	$ 76.18

Stock Options and SARs

All stock option grants are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model and stock-based compensation is recognized on a straight-line basis over the requisite

service period. Stock options granted generally become exercisable over a four -year period from the grant date. Stock options generally expire seven years after the grant date.

On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna SARs outstanding as of the Aetna Acquisition Date were converted into replacement CVS Health SARs. The replacement SARs granted will be settled in CVS Health common stock, net of taxes, based on the appreciation of the stock price on the exercise date over the market price on the date of grant. The fair value of SARs is estimated using the Black-Scholes option pricing model and stock-based compensation is recognized on a straight-line basis over the requisite service period. SARs generally become exercisable over a three -year period from the grant date. SARs generally expire ten years after the grant date.

The following table is a summary of stock option and SAR activity that occurred for the years ended December 31, 2018 , 2017 and 2016 :

In millions	**2018**	**2017**	**2016**
Cash received from stock options exercised (including ESPP)	$ 242	$ 329	$ 296
Payments for taxes for net share settlement of equity awards	97	71	72
Intrinsic value of stock options and SARs exercised	79	176	244
Fair value of stock options and SARs vested	324	341	298

The fair value of each stock option and SAR is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2018	**2017**	**2016**
Dividend yield [1]	2.76%	2.56%	1.62%
Expected volatility [2]	21.27%	18.39%	17.22%
Risk-free interest rate [3]	2.77%	1.77%	1.24%
Expected life (in years) [4]	4.8	4.1	4.2
Weighted-average grant date fair value	$ 24.55	$ 9.43	$ 13.00

(1) The dividend yield is based on annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is estimated using the Company's historical volatility over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.
(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.
(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option holder exercise experience.

As of December 31, 2018 , unrecognized compensation expense related to unvested stock options and SARs totaled $58 million , which the Company expects to be recognized over a weighted-average period of 1.2 years. After considering anticipated forfeitures, the Company expects approximately 11 million of the unvested stock options and SARs to vest over the requisite service period.

The following table is a summary of the Company's stock option and SAR activity for the year ended December 31, 2018

In thousands, except weighted average exercise price and remaining contractual term	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at December 31, 2017	20,530	$ 75.32		
Granted	7,144	$ 51.06		
Exercised	(2,993)	$ 44.62		
Forfeited	(908)	$ 86.97		
Expired	(864)	$ 81.79		
Outstanding at December 31, 2018	22,909	$ 71.15	4.08	$ 165,245
Exercisable at December 31, 2018	11,436	$ 72.69	2.23	$ 73,784
Vested at December 31, 2018 and expected to vest in the future	22,532	$ 71.18	4.05	$ 163,596

12. Shareholders' Equity

Share Repurchases

The following share repurchase programs have been authorized by the Board:

In billions Authorization Date	Authorized	Remaining as of December 31, 2018
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2014 Repurchase Program was completed during the second quarter of 2017. The 2016 Repurchase Program can be modified or terminated by the Board at any time.

2018 Activity
During the year ended December 31, 2018 , the Company did not repurchase any shares of common stock pursuant to the 2016 Repurchase Program.

2017 Activity
Pursuant to the authorization under the 2014 Repurchase Program, in August 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion . Upon payment of the $3.6 billion purchase price in January 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares, which were placed into treasury stock in January 2017. The ASRs were accounted for as an initial treasury stock transaction for $2.9 billion and a forward contract for $0.7 billion . In April 2017, the Company received an additional 9.9 million shares of common stock, representing the remaining 20% of the $3.6 billion notional amount of the ASRs, thereby concluding the ASRs. The additional 9.9 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in April 2017.

During the year ended December 31, 2017, the Company repurchased an aggregate of 55.4 million shares of common stock for approximately $4.4 billion under the 2014 and 2016 Repurchase Programs.

2016 Activity
Pursuant to the authorization under the 2014 Repurchase Program, in December 2015, the Company entered into a $725 million fixed dollar ASR with Barclays. Upon payment of the $725 million purchase price in December 2015, the Company received a number of shares of its common stock equal to 80% of the $725 million notional amount of the ASR or approximately 6.2

million shares, which were placed into treasury stock in December 2015. The ASR was accounted for as an initial treasury stock transaction for $580 million and a forward contract for $145 million . The forward contract was classified as an equity instrument and was recorded within capital surplus on the consolidated balance sheet. In January 2016, the Company received an additional 1.4 million shares of common stock, representing the remaining 20% of the $725 million notional amount of the ASR, thereby concluding the ASR. The additional 1.4 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in January 2016.

During the year ended December 31, 2016, the Company repurchased an aggregate of 47.5 million shares of common stock for approximately $4.5 billion under the 2014 Repurchase Program.

Dividends

The quarterly cash dividend declared by the Board was $0.50 per share in 2018 and 2017. CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna's insurance business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. The Company's HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP.

The combined statutory net income for the year ended December 31, 2018 (which includes Aetna and its subsidiaries from November 28, 2018 to December 2018) was not material. The combined statutory capital and surplus at December 31, 2018 of the Company's insurance and HMO subsidiaries was approximately $11.1 billion . From November 28, 2018 to December 31, 2018 , the Company's insurance and HMO subsidiaries paid $909 million of gross dividends to the Company.

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2018 , these amounts were as follows:

In millions		
Estimated minimum statutory surplus required by regulators	$	5,358
Investments on deposit with regulatory bodies		630
Estimated maximum dividend distributions permitted in 2019 without prior regulatory approval		584

Noncontrolling Interests

At December 31, 2018 , noncontrolling interests were $318 million primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders ' equity.

13. Other Comprehensive Income (Loss)

Shareholders' equity included the following activity in accumulated other comprehensive income (loss) in 2018 , 2017 and 2016 :

	At December 31,		
In millions	**2018**	**2017**	**2016**
Net unrealized investment gains (losses):			
Beginning of year balance	$ —	$ —	$ —
Other comprehensive income before reclassifications *($132 pretax)*	97	—	—
Amounts reclassified from accumulated other comprehensive income *($1 pretax)* (1)	—	—	—
Other comprehensive income	97	—	—
End of year balance	97	—	—
Foreign currency translation adjustments:			
Beginning of year balance	(129)	(127)	(165)
Other comprehensive income (loss)	(29)	(2)	38
Other comprehensive income (loss)	(29)	(2)	38
End of year balance	(158)	(129)	(127)
Net cash flow hedges:			
Beginning of year balance	(15)	(5)	(7)
Adoption of new accounting standard (4)	(3)	—	—
Other comprehensive income (loss) before reclassifications *($465, $(18) and $0 pretax)*	344	(11)	—
Amounts reclassified from accumulated other comprehensive loss *($(19), $2 and $3 pretax)* (2)	(14)	1	2
Other comprehensive income (loss)	330	(10)	2
End of year balance	312	(15)	(5)
Pension and OPEB plans:			
Beginning of year balance	(21)	(173)	(186)
Adoption of new accounting standard (4)	(4)	—	—
Other comprehensive loss before reclassifications *($(178), $0 and $0 pretax)*	(132)	—	—
Amounts reclassified from accumulated other comprehensive loss *($11, $249 and $21 pretax)* (3)	8	152	13
Other comprehensive income (loss)	(124)	152	13
End of year balance	(149)	(21)	(173)
Total beginning of year accumulated other comprehensive loss	(165)	(305)	(358)
Adoption of new accounting standard (4)	(7)	—	—
Total other comprehensive income	274	140	53
Total end of year accumulated other comprehensive income (loss)	$ 102	$ (165)	$ (305)

(1) Amounts reclassified from accumulated other comprehensive income for debt securities are included in net investment income within the consolidated statements of operations.
(2) Amounts reclassified from accumulated other comprehensive loss for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations.
(3) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other (income) expense in the consolidated statements of operations.
(4) See Note 1 ''Significant Accounting Policies'' for additional information on the adoption of ASU 2018-02 during the first quarter of 2018.

14. Earnings Per Share

Earnings (loss) per share is computed using the two-class method. For periods in which the Company reports net income, diluted earnings per share is determined by using the weighted average number of common and dilutive common equivalent shares outstanding during the period, unless the effect is antidilutive. Due to the loss from continuing operations attributable to CVS Health in the year ended December 31, 2018 , 3 million potentially dilutive common equivalent shares were excluded from

the calculation of diluted earnings per share, as the impact of these shares was antidilutive. In addition, options to purchase 13.2 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the year ended December 31, 2018 because the exercise prices of the options were greater than the average market price of the common shares and, therefore, the effect would be antidilutive. For the same reason, options to purchase 10.4 million and 6.7 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the years ended December 31, 2017 and 2016 , respectively.

The following is a reconciliation of basic and diluted earnings (loss) per share from continuing operations for the years ended December 31:

In millions, except per share amounts	**2018**	**2017**	**2016**
Numerator for earnings per share calculation:			
Income (loss) from continuing operations	$ (596)	$ 6,631	$ 5,320
Income allocated to participating securities	(3)	(24)	(27)
Net (income) loss attributable to noncontrolling interests	2	(1)	(2)
Income (loss) from continuing operations attributable to CVS Health	$ (597)	$ 6,606	$ 5,291
Denominator for earnings per share calculation:			
Weighted average shares, basic	1,044	1,020	1,073
Effect of dilutive securities	—	4	6
Weighted average shares, diluted	1,044	1,024	1,079
Earnings (loss) per share from continuing operations:			
Basic	$ (0.57)	$ 6.48	$ 4.93
Diluted	$ (0.57)	$ 6.45	$ 4.91

15. Reinsurance

The Company utilizes reinsurance agreements primarily to reduce required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans to a subsidiary of WellCare, effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare has ceded to Aetna 100% of the insurance risk related to the divested standalone Medicare Part D prescription drug plans for the 2019 PDP plan year.

In January 2019, the Company entered into two four -year reinsurance agreements with an unrelated reinsurer that allowed it to reduce required capital and provided collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2018 were as follows:

In millions	
Reinsurer	
Hartford Life and Accident Insurance Company	$ 3,470
Lincoln Life & Annuity Company of New York	424
Constitution Life	320
VOYA Retirement Insurance and Annuity Company	186
All Other	141
Total	$ 4,541

Direct, assumed and ceded premiums earned for the year ended December 31, 2018 were as follows:

In millions		
Direct	$	8,365
Assumed		38
Ceded		(219)
Net premiums	$	8,184

The impact of reinsurance on benefit costs for the year ended December 31, 2018 was as follows:

In millions		
Direct	$	6,773
Assumed		32
Ceded		(211)
Net benefit costs	$	6,594

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. These contracts were entered into to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements for certain portions of its group term life insurance and group accidental death and dismemberment insurance businesses and certain portions of the Health Care Benefits segment's Medicare Advantage and group Commercial Insured businesses. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2018 .

16. Commitments and Contingencies

Guarantees

The Company has the following significant guarantee arrangements at December 31, 2018 :

- ASC Claim Funding Accounts - The Company has arrangements with certain banks for the processing of claim payments for its ASC customers. The banks maintain accounts to fund claims of the Company's ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, the Company guarantees that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million . The Company can limit its exposure to these guarantees by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.
- Separate Accounts Assets - Certain Separate Accounts assets associated with the large case pensions business in the Corporate/Other segment represent funds maintained as a contractual requirement to fund specific pension annuities that the Company has guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $1.4 billion at December 31, 2018 . See Note 1 ''Significant Accounting Policies'' for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2018 exceeded the value of the guaranteed benefit obligation. As a result, the Company was not required to maintain any additional liability for its related guarantees at December 31, 2018 .

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed

to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of December 31, 2018, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, Aetna recorded a discounted estimated liability and expense of $231 million pretax for its estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The Company did not record an asset for expected premium tax offsets for its in force business at December 31, 2018, as the amount was not material. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's results of operations, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The total guaranty fund assessments liability as of December 31, 2018 was $90 million and was recorded in accrued expenses on the consolidated balance sheet.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. The Company is defending itself against these claims.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The *Corcoran* plaintiffs have appealed the District Court's decision to the Ninth Circuit. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, moved for judgment on the pleadings, filed a counterclaim and moved the case to Mississippi Circuit Court. The Company's motion for judgment on the pleadings remains pending. The Company is defending itself against these claims.

Manufacturer's Rebate Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning manufacturer's rebates that the Company has negotiated.

Bewley, et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants' motions. The Company is defending itself against these claims.

Klein , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation* . The Company is defending itself against these claims.

In April 2017, the Company received a CID from the Attorney General of Washington requesting documents and information regarding pricing and rebates for insulin products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin pricing. The Office of the Attorney General of Washington has notified the Company that information provided in response to the Washington Attorney General's CID will be shared with the Attorneys General of California, Florida, Minnesota, New Mexico, the District of Columbia and Mississippi. In July 2017, the Company received a CID from the Attorney General of Minnesota requesting documents and information regarding pricing and rebates for insulin and epinephrine products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin and epinephrine pricing. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. Fewer than 100 similar cases that name the Company as a defendant in some capacity are pending in state courts. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). For several of these audits, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served Omnicare with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Company pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Company pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, Omnicare received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, Omnicare also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the arbitrator awarded the claimant hospitals approximately $150 million . The Company is defending itself against the claimant hospitals' claims and has appealed the arbitrator's decision.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's results of operations, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's results of operations, cash flows or financial condition.

Other Legal and Regulatory Proceedings .

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in the Company's Commercial Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's results of operations. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the

Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company currently has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information for which results of operations are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services, Retail/LTC and Health Care Benefits segments' performance based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The chief operating decision maker does not use total assets by segment to make decisions regarding resources. Therefore the total asset disclosure by segment has not been included. See Note 1 ''Significant Accounting Policies'' for a description of the Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other segments and related significant accounting policies.

In 2018 , 2017 and 2016 , approximately 9.8% , 12.3% and 11.7% , respectively, of the Company's consolidated revenues were from Aetna, a Pharmacy Services segment client. On November 28, 2018, the Company completed the Aetna Acquisition. Subsequent to the Aetna Acquisition, transactions with Aetna will continue to be reported within the Pharmacy Services segment, but are eliminated in the Company's consolidated financial statements.

Effective for the first quarter of 2019, the Company will realign the composition of its segments to correspond with changes to its operating model. As a result of this realignment, the Company's Silverscript PDP will move from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company will move Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment.

In millions	Pharmacy Services [1][2]	Retail/ LTC [2]	Health Care Benefits [2]	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2018:						
Revenues from customers	$ 134,115	$ 83,989	$ 5,504	$ 4	$ (29,693)	$ 193,919
Net investment income [3]	13	—	45	602	—	660
Total revenues	134,128	83,989	5,549	606	(29,693)	194,579
Operating income (loss) [4][5]	4,699	620	276	(805)	(769)	4,021
Depreciation and amortization	712	1,698	170	138	—	2,718
Additions to property and equipment	326	1,350	46	401	—	2,123
2017:						
Revenues from customers	130,596	79,398	—	—	(25,229)	184,765
Net investment income	5	—	—	16	—	21
Total revenues [7]	130,601	79,398	—	16	(25,229)	184,786
Operating income (loss) [4][5][7]	4,657	6,558	—	(936)	(741)	9,538
Depreciation and amortization	712	1,651	—	116	—	2,479
Additions to property and equipment	311	1,398	—	340	—	2,049
2016:						
Revenues from customers	119,963	81,100	—	—	(23,537)	177,526
Net investment income	2	—	—	18	—	20
Total revenues [7]	119,965	81,100	—	18	(23,537)	177,546
Operating income (loss) [4][5][6][7]	4,570	7,437	—	(900)	(721)	10,386
Depreciation and amortization	714	1,642	—	119	—	2,475
Additions to property and equipment	295	1,732	—	252	—	2,279

(1) Total revenues of PSS include approximately $11.4 billion , $10.8 billion and $10.5 billion of Retail Co-Payments for 2018 , 2017 and 2016 , respectively. See Note 1 ‘‘Significant Accounting Policies’’ for additional information about Retail Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between PSS and RLS for 2018, 2017 and 2016. Effective November 28, 2018, intersegment eliminations also relate to intersegment revenue generating activities that occur between HCBS, PSS and/or RLS.

(3) Corporate/Other segment net investment income for 2018 includes interest income of $536 million related to the proceeds of the $40 billion 2018 Notes. This amount is for the period prior to the close of the Aetna Acquisition, which occurred on November 28, 2018.

(4) RLS operating income for 2018 , 2017 and 2016 includes $7 million , $34 million and $281 million , respectively, of acquisition-related integration costs. The integration costs in 2018 and 2017 are related to the acquisition of Omnicare. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target. RLS operating income for 2018 and 2017 also includes goodwill impairment charges of $6.1 billion related to the LTC reporting unit and $181 million related to the RxCrossroads reporting unit, respectively. In addition, RLS operating income for 2017 and 2016 includes $215 million and $34 million , respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company’s enterprise streamlining initiative. RLS operating income for 2018 also includes a $43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment and an $86 million loss on the divestiture of the Company’s RxCrossroads subsidiary.

(5) Corporate/Other segment operating loss for 2018 , 2017 and 2016 includes $485 million , $40 million and $10 million , respectively, of divestiture and acquisition-related transaction and integration costs included in operating expenses in the consolidated statements of operations. The transaction and integration costs in 2018 are related to the acquisitions of Aetna and Omnicare. The transaction and integration costs in 2017 are related to the acquisitions of Aetna and Omnicare and the divestiture of RxCrossroads. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.

(6) PSS operating income for 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

(7) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within total revenues to conform with insurance company presentation which increased total revenues and operating income by $21 million and $20 million in 2017 and 2016, respectively.

In conjunction with the Company's implementation of a new enterprise resource planning system in the first quarter of 2018, the Company changed the manner in which certain shared functional costs are allocated to its reportable segments.

Additionally, in connection with the Aetna Acquisition on November 28, 2018, the Company reclassified interest income from interest expense, net to net investment income within revenues to conform with insurance company presentation. Segment financial information for the years ended December 31, 2017 and 2016 , have been retrospectively adjusted to reflect this change to the Company's cost allocation methodology and net investment income presentation as shown below:

	Year Ended December 31, 2017				
In millions	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Revenues, as previously reported	$ 130,596	$ 79,398	$ —	$ (25,229)	$ 184,765
Adjustments	5	—	16	—	21
Revenues, as adjusted	$ 130,601	$ 79,398	$ 16	$ (25,229)	$ 184,786
Cost of products sold [1]	$ 121,746	$ 56,081	$ —	$ (24,417)	$ 153,410
Adjustments	53	(15)	—	—	38
Cost of products sold	$ 121,799	$ 56,066	$ —	$ (24,417)	$ 153,448
Benefit costs [1]	$ 2,810	$ —	$ —	$ —	$ 2,810
Adjustments	—	—	—	—	—
Benefit costs	$ 2,810	$ —	$ —	$ —	$ 2,810
Operating expenses, as previously reported	$ 1,285	$ 16,848	$ 966	$ (71)	$ 19,028
Adjustments	50	(74)	(14)	—	(38)
Operating expenses, as adjusted	$ 1,335	$ 16,774	$ 952	$ (71)	$ 18,990
Operating income (loss), as previously reported	$ 4,755	$ 6,469	$ (966)	$ (741)	$ 9,517
Adjustments	(98)	89	30	—	21
Operating income (loss), as adjusted	$ 4,657	$ 6,558	$ (936)	$ (741)	$ 9,538

(1) The total of cost of products sold and benefit costs previously was reported as cost of revenues.

	Year Ended December 31, 2016				
In millions	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Revenues, as previously reported	$ 119,963	$ 81,100	$ —	$ (23,537)	$ 177,526
Adjustments	2	—	18	—	20
Revenues, as adjusted	$ 119,965	$ 81,100	$ 18	$ (23,537)	$ 177,546
Cost of products sold [1]	$ 111,883	$ 57,362	$ —	$ (22,755)	$ 146,490
Adjustments	66	(23)	—	—	43
Cost of products sold	$ 111,949	$ 57,339	$ —	$ (22,755)	$ 146,533
Benefit costs [1]	$ 2,179	$ —	$ —	$ —	$ 2,179
Adjustments	—	—	—	—	—
Benefit costs	$ 2,179	$ —	$ —	$ —	$ 2,179
Operating expenses, as previously reported	$ 1,225	$ 16,436	$ 891	$ (61)	$ 18,491
Adjustments	42	(112)	27	—	(43)
Operating expenses, as adjusted	$ 1,267	$ 16,324	$ 918	$ (61)	$ 18,448
Operating income (loss), as previously reported	$ 4,676	$ 7,302	$ (891)	$ (721)	$ 10,366
Adjustments	(106)	135	(9)	—	20
Operating income (loss), as adjusted	$ 4,570	$ 7,437	$ (900)	$ (721)	$ 10,386

(1) The total of cost of products sold and benefit costs previously was reported as cost of revenues.

18. Quarterly Financial Information (Unaudited)

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2018:					
Total revenues [1]	$ 45,743	$ 46,922	$ 47,490	$ 54,424	$ 194,579
Operating income (loss) [1]	1,996	(1,373)	2,574	824	4,021
Income (loss) from continuing operations	998	(2,562)	1,390	(422)	(596)
Net income (loss) attributable to CVS Health	998	(2,563)	1,390	(419)	(594)
Per common share data:					
Basic earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Diluted earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Dividends per common share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of $50 million , $214 million and $221 million was made for the first, second and third quarters of 2018, respectively, to increase revenues and increase interest expense.

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2017:					
Total revenues [1]	$ 44,520	$ 45,689	$ 46,186	$ 48,391	$ 184,786
Operating income [1]	1,799	2,121	2,504	3,114	9,538
Income from continuing operations	962	1,097	1,285	3,287	6,631
Net income attributable to CVS Health	952	1,098	1,285	3,287	6,622
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 0.93	$ 1.07	$ 1.26	$ 3.23	$ 6.48
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.23	$ 6.47
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.22	$ 6.45
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.22	$ 6.44
Dividends per common share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of $6 million , $4 million , $5 million and $6 million was made for the first, second, third and fourth quarters of 2017, respectively, to increase revenues and increase interest expense.

Five-Year Financial Summary

In millions, except per share amounts	2018 [2]	2017	2016	2015	2014
Statement of operations data:					
Total revenues [1]	$ 194,579	$ 184,786	$ 177,546	$ 153,311	$ 139,382
Operating income [1]	4,021	9,538	10,386	9,496	8,837
Income (loss) from continuing operations	(596)	6,631	5,320	5,230	4,645
Net income (loss) attributable to CVS Health	(594)	6,622	5,317	5,237	4,644
Per common share data:					
Basic earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.48	$ 4.93	$ 4.65	$ 3.98
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —	$ 0.01	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.47	$ 4.93	$ 4.66	$ 3.98
Diluted earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.45	$ 4.91	$ 4.62	$ 3.96
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —	$ 0.01	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.44	$ 4.90	$ 4.63	$ 3.96
Dividends per common share	$ 2.00	$ 2.00	$ 1.70	$ 1.40	$ 1.10
Balance sheet and other data:					
Total assets	$ 196,456	$ 95,131	$ 94,462	$ 92,437	$ 73,202
Long-term debt	$ 71,444	$ 22,181	$ 25,615	$ 26,267	$ 11,630
Total shareholders' equity	$ 58,543	$ 37,695	$ 36,834	$ 37,203	$ 37,963
Number of stores (at end of year)	9,967	9,846	9,750	9,681	7,866

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of $21 million, $20 million, $21 million and $15 million was made for years ended December 31, 2017, 2016, 2015 and 2014, respectively, to increase revenues and increase interest expense.

(2) On November 28, 2018, the Company acquired Aetna. Aetna's operations are included in the Company's consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and the period then ended. See Note 2 ''Acquisition of Aetna'' of Notes to Consolidated Financial Statements for additional information.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 28, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2007.

Boston, Massachusetts
February 28, 2019

Exhibit 21.1

Subsidiaries of CVS Health Corporation

Listed below are subsidiaries under CVS Health Corporation at December 31, 2018 with their jurisdictions of organization shown in parentheses. Subsidiaries excluded from the list below are not insurance companies and would not, in the aggregate, constitute a "significant subsidiary" of CVS Health Corporation, as that term is defined in Rule 1-02(w) of Regulation S-X.

- **CVS Foreign, Inc. (New York)**
    - CVS Caremark Indemnity Ltd. (Bermuda)
    - CVS International, L.L.C. (Delaware)

- **CVS Pharmacy, Inc. (Rhode Island)**
    - Aetna Inc. (Pennsylvania)
        - Aetna Health Holdings, LLC (Delaware)
            - Aetna Health of California Inc. (California)
            - Aetna Health Inc. (Connecticut)
            - Aetna Health Inc. (Florida)
            - Aetna Health Inc. (Georgia)
            - Aetna Health Inc. (Maine)
            - Aetna Health Inc. (Michigan)
            - Aetna Health Inc. (New Jersey)
            - Aetna Health Inc. (New York)
                - Aetna Better Health Inc. (New York)
            - Aetna Health Inc. (Pennsylvania)
            - Aetna Health Inc. (Texas)
            - Aetna Better Health of California Inc. (California)
            - Aetna Better Health of Iowa Inc. (Iowa)
            - Aetna Better Health of Texas Inc. (Texas)
            - Aetna Better Health of Washington, Inc. (Washington)
            - Aetna Better Health Inc. (Georgia)
            - Aetna HealthAssurance Pennsylvania, Inc. (Pennsylvania)
            - Aetna Dental of California Inc. (California)
            - Aetna Dental Inc. (New Jersey)
            - Aetna Dental Inc. (Texas)
            - Aetna Rx Home Delivery, LLC (Delaware)
            - Aetna Health Management, LLC (Delaware)
            - Aetna Ireland Inc. (Delaware)
            - Aetna Specialty Pharmacy, LLC (Delaware)
            - Cofinity, Inc. (Delaware)
            - @Credentials Inc. (Delaware)
            - Aetna Better Health Inc. (Pennsylvania)
            - Aetna Better Health Inc. (Connecticut)
            - Aetna Better Health Inc. (Illinois)
            - Aetna Better Health of Kansas Inc. (Kansas)
            - Aetna Better Health, Inc. (Louisiana)
            - Aetna Florida Inc. (Florida)
            - Aetna Better Health Inc. (Ohio)
            - Aetna Better Health of Oklahoma Inc. (Oklahoma)
            - Aetna Better Health of Nevada Inc. (Nevada)
            - Aetna Better Health Inc. (New Jersey)
            - Aetna Better Health of North Carolina Inc. (North Carolina)
            - Aetna Network Services LLC (Connecticut)

- Aetna Risk Assurance Company of Connecticut Inc. (Connecticut)
- Aetna Student Health Agency Inc. (Massachusetts)
- Delaware Physicians Care, Incorporated (Delaware)
- Schaller Anderson Medical Administrators, Incorporated (Delaware)
- Aetna Medicaid Administrators LLC (Arizona)
- iTriage, LLC (Delaware)
- bswift LLC (Illinois)
- Prodigy Health Group, Inc. (Delaware)
    - Niagara Re, Inc. (New York)
    - Performax, Inc. (Delaware)
    - Scrip World, LLC (Utah)
    - Precision Benefit Services, Inc. (Delaware)
    - American Health Holding, Inc. (Ohio)
    - Meritain Health, Inc. (New York)
        - Administrative Enterprises, Inc. (Arizona)
        - U.S Healthcare Holdings, LLC (Ohio)
        - Prime Net, Inc. (Ohio)
        - Professional Risk Management, Inc. (Ohio)
- ADMINCO, Inc. (Arizona)
- Aetna Pharmacy Management Services, LLC (Delaware)
- Coventry Transplant Network, Inc. (Delaware)
- Aetna Health of Iowa Inc. (Iowa)
- Coventry Health Care of Nebraska, Inc. (Nebraska)
- Aetna Health Inc. (Louisiana)
- HealthAssuance Pennsylvania, Inc. (Pennsylvania)
- Coventry Prescription Management Services Inc. (Nevada)
- Coventry Health and Life Insurance Company (Missouri)
    - Aetna Better Health of Kentucky Insurance Company (Kentucky)
- Coventry Health Care of Virginia, Inc. (Virginia)
- Coventry Health Care of Missouri, Inc. (Missouri)
- Aetna Better Health of Missouri LLC (Missouri)
- Coventry Health Care of Illinois, Inc. (Illinois)
- Coventry Health Care of West Virginia, Inc. (West Virginia)
- Coventry HealthCare Management Corporation (Delaware)
- Coventry Health Care of Kansas, Inc. (Kansas)
- Coventry Health Care National Accounts, Inc. (Delaware)
- Aetna Better Health of Michigan Inc. (Michigan)
- Aetna Health of Utah Inc. (Utah)
- Aetna Better Health Inc. (Tennessee)
- Coventry Health Care National Network, Inc. (Delaware)
- Coventry Consumer Advantage, Inc. (Delaware)
- MHNet Specialty Services, LLC (Maryland)
    - Mental Health Network of New York IPA, Inc. (New York)
    - Mental Health Associates, Inc. (Louisiana)
    - MHNet of Florida, Inc. (Florida)
    - MHNet Life and Health Insurance Company (Texas)
- Group Dental Service, Inc. (Maryland)
    - Group Dental Service of Maryland, Inc. (Maryland)
- Florida Health Plan Administrators, LLC (Florida)
    - Coventry Health Care of Florida, Inc. (Florida)
    - Carefree Insurance Services, Inc. (Florida)
    - Coventry Health Plan of Florida, Inc. (Florida)

- First Health Group Corp. (Delaware)
    - First Health Life & Health Insurance Company (Texas)
    - Claims Administration Corp. (Maryland)
- Coventry Health Care Workers' Compensation, Inc. (Delaware)
    - Coventry Rehabilitation Services, Inc. (Delaware)
    - First Script Network Services, Inc. (Nevada)
    - FOCUS HealthCare Management, Inc. (Tennessee)
    - Medical Examinations of New York, P.C. (New York)
    - MetraComp, Inc. (Connecticut)
- Continental Life Insurance Company of Brentwood, Tennessee (Tennessee)
    - American Continental Insurance Company (Tennessee)
- Aetna Life Insurance Company (Connecticut)
    - AHP Holdings, Inc. (Connecticut)
        - Aetna Insurance Company of Connecticut (Connecticut)
        - AE Fourteen, Incorporated (Connecticut)
        - Aetna Life Assignment Company (Connecticut)
    - Aetna ACO Holdings Inc. (Delaware)
        - Innovation Health Holdings, LLC (Delaware)
            - Innovation Health Insurance Company (Virginia)
                - Innovation Health Plan, Inc. (Virginia)
        - Texas Health + Aetna Health Insurance Holding Company LLC (Texas)
            - Texas Health + Aetna Health Insurance Company (Texas)
                - Texas Health + Aetna Health Plan Inc. (Texas)
    - Banner Health and Aetna Health Insurance Holding Company LLC (Delaware)
- Banner Health and Aetna Health Insurance Company (Arizona)
- Banner Health and Aetna Health Plan Inc. (Arizona)
    - Sutter Health and Aetna Insurance Holding Company LLC (Delaware)
        - Sutter Health and Aetna Administrative Services LLC (Delaware)
        - Sutter Health and Aetna Insurance Company (California)
    - Allina Health and Aetna Insurance Holding Company LLC (Delaware)
        - Allina Health and Aetna Insurance Company (Minnesota)
    - PE Holdings, LLC (Connecticut)
    - Aetna Resources LLC (Delaware)
    - Canal Place, LLC (Delaware)
    - Aetna Ventures, LLC (Delaware)
    - Broadspire National Services, Inc. (Florida)
    - Aetna Multi-Strategy 1099 Fund, LLC (Delaware)
- Phoenix Data Solutions LLC (Delaware)
- Aetna Financial Holdings, LLC (Delaware)
    - Aetna Asset Advisors, LLC (Delaware)
    - U.S. Healthcare Properties, Inc. (Pennsylvania)
    - Aetna Capital Management, LLC (Delaware)
        - Aetna Partners Diversified Fund, LLC (Delaware)
    - Aetna Workers' Comp Access, LLC (Delaware)
    - Aetna Behavioral Health, LLC (Delaware)
    - Managed Care Coordinators, Inc. (Delaware)
    - Horizon Behavioral Services, LLC (Delaware)
        - Employee Assistance Services, LLC (Kentucky)
        - Health and Human Resource Center, Inc. (California)
        - Resources for Living, LLC (Texas)
        - The Vasquez Group Inc. (Illinois)
        - Work and Family Benefits, Inc. (New Jersey)

- Aetna Card Solutions, LLC (Connecticut)
- PayFlex Holdings, Inc. (Delaware)
    - PayFlex Systems USA, Inc. (Nebraska)
- Aetna Health and Life lnsurance Company (Connecticut)
- Aetna Health Insurance Company (Pennsylvania)
- Aetna Health Insurance Company of New York (New York)
- AUSHC Holdings, Inc. (Connecticut)
    - PHPSNE Parent Corporation (Delaware)
- Active Health Management, Inc. (Delaware)
    - Health Data & Management Solutions, Inc. (Delaware)
        - Futrix Limited (New Zealand)
    - Aetna Integrated Informatics, Inc. (Pennsylvania)
- Health Re, Inc. (Vermont)
- ASI Wings, LLC (Delaware)
- Healthagen LLC
- Aetna Corporate Services LLC (Delaware)
- Echo Merger Sub, Inc. (Delaware)
- Aetna International Inc. (Connecticut)
    - Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
    - Aetna Global Holdings Limited (England & Wales)
        - Aetna Insurance (Hong Kong) Limited(Hong Kong)
        - Virtual Home Healthcare LLC (Dubai)
        - Aetna Korea Ltd. (South Korea)
        - Minor Health Entreprise Co, Ltd.
        - Health Care Management Co. Ltd.
            - Aetna Services (Thailand) Limited
        - Aetna Health Insurance (Thailand) Public Company Limited
        - Aetna Holdings (Thailand) Limited
            - Health Care Management Co. Ltd.
            - Minor Health Entreprise Co, Ltd.
                - Aetna Health Insurance (Thailand) Public Company Limited
    - Aetna Global Benefits (Bermuda) Limited (Bermuda)
        - Goodhealth Worldwide (Global) Limited (Bermuda)
        - Aetna Global Benefits (Europe) Limited (England & Wales)
        - Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)
        - Goodhealth Worldwide (Asia) Limited (Hong Kong)
        - Aetna Global Benefits Limited (DIFC, UAE)
        - Aetna Global Benefits (Middle East) LLC (UAE)
        - Pt. Aetna Global Benefits Indonesia (Indonesia)
        - Aetna Global Benefits (Bahamas) Limited (Bahamas)
        - Spinnaker Topco Limited (Bermuda)
            - Spinnaker Bidco Limited (England and Wales)
                - Aetna Holdco (UK) Limited (England and Wales)
                    - Aetna Global Benefits (UK) Limited (England and Wales)
                    - Aetna Insurance Company Limited (England and Wales)
    - Aetna Insurance (Singapore) Pte. Ltd. (Singapore)
    - Aetna Health Insurance Company of Europe DAC (Ireland)
    - Aetna (Shanghai) Enterprise Services Co. Ltd. (China)
        - Aetna (Beijing) Enterprise Management Services Co., Ltd. (China)
    - Aetna Global Benefits (Singapore) PTE. LTD. (Singapore)
        - Indian Health Organisation Private Limited (India)
    - PT Aetna Management Consulting

- Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd (China)

- CVS Pharmacy, Inc. (continued)
  - Alabama CVS Pharmacy, L.L.C. (Alabama)
  - Alaska CVS Pharmacy, L.L.C. (Alaska)
  - American Drug Stores Delaware, L.L.C. (Delaware)
  - Arkansas CVS Pharmacy, L.L.C. (Arkansas)
  - CareCenter Pharmacy, L.L.C. (Delaware)
  - Caremark Rx, L.L.C. (Delaware)
    - CaremarkPCS, L.L.C. (Delaware)
    - Accordant Health Services, L.L.C. (Delaware)
    - AdvancePCS SpecialtyRx, LLC (Delaware)
    - AdvanceRx.com, L.L.C. (Delaware)
    - CaremarkPCS Health, L.L.C. (Delaware)
      - Caremark IPA, L.L.C. (New York)
    - Caremark PhC, L.L.C. (Delaware)
    - Caremark Ulysses Holding Corp. (New York)
      - MemberHealth LLC (Delaware)
      - UAC Holding, Inc. (Delaware)
        - Pennsylvania Life Insurance Company (Pennsylvania)
    - Caremark, L.L.C. (California)
      - Caremark Arizona Mail Pharmacy, LLC (Arizona)
      - Caremark Arizona Specialty Pharmacy, L.L.C. (Arizona)
      - Caremark California Specialty Pharmacy, L.L.C. (California)
      - Caremark Florida Mail Pharmacy, LLC (Florida)
      - Caremark Florida Specialty Pharmacy, LLC (Florida)
      - Caremark Hawaii Mail Pharmacy, L.L.C. (Hawaii)
      - Caremark Hawaii Specialty Pharmacy, LLC (Hawaii)
      - Caremark Illinois Mail Pharmacy, LLC (Illinois)
      - CVS Caremark Advanced Technology Pharmacy, L.L.C. (Illinois)
      - Caremark Illinois Specialty Pharmacy, LLC (Illinois)
      - Caremark Irving Resource Center, LLC (Texas)
      - Caremark Kansas Specialty Pharmacy, LLC (Kansas)
      - Caremark Logistics, LLC (Delaware)
      - Caremark Louisiana Specialty Pharmacy, LLC (Louisiana)
      - Caremark Maryland Specialty Pharmacy, LLC (Maryland)
      - Caremark Massachusetts Specialty Pharmacy, L.L.C. (Massachusetts)
      - Caremark Michigan Specialty Pharmacy, LLC (Michigan)
      - Caremark Minnesota Specialty Pharmacy, LLC (Minnesota)
      - Caremark New Jersey Specialty Pharmacy, LLC (New Jersey)
      - Caremark North Carolina Specialty Pharmacy, LLC (North Carolina)
      - Caremark Ohio Specialty Pharmacy, L.L.C. (Ohio)
      - Caremark Pennsylvania Specialty Pharmacy, LLC (Pennsylvania)
      - Caremark Redlands Pharmacy, L.L.C. (California)
      - Caremark Repack, LLC (Illinois)
      - Caremark Tennessee Specialty Pharmacy, LLC (Tennessee)
      - Caremark Texas Mail Pharmacy, LLC (Texas)
      - Caremark Texas Specialty Pharmacy, LLC (Texas)
      - Caremark Washington Specialty Pharmacy, LLC (Washington)
      - Central Rx Services, LLC (Nevada)
      - Generation Health, L.L.C. (Delaware)

- NovoLogix, LLC (Delaware)
- CaremarkPCS Alabama Mail Pharmacy, LLC (Alabama)
- CaremarkPCS, L.L.C. (Delaware)
- CVS Caremark Part D Services, L.L.C. (Delaware)
- Eckerd Corporation of Florida, Inc. (Florida)
- Express Pharmacy Services of PA, L.L.C. (Delaware)
- Ocean Acquisition Sub, L.L.C. (Delaware)
  - Coram LLC (Delaware)
  - Coram Clinical Trials, Inc. (Delaware)
  - T2 Medical, Inc. (Delaware)
    - Coram Healthcare Corporation of Alabama (Delaware)
    - Coram Healthcare Corporation of Florida (Delaware)
    - Coram Healthcare Corporation of Greater D.C. (Delaware)
    - Coram Healthcare Corporation of Greater New York (New York)
    - Coram Healthcare Corporation of Indiana (Delaware)
    - Coram Healthcare Corporation of Mississippi (Delaware)
    - Coram Healthcare Corporation of Nevada (Delaware)
    - Coram Healthcare Corporation of Northern California (Delaware)
    - Coram Healthcare Corporation of Southern California (Delaware)
    - Coram Healthcare Corporation of Southern Florida (Delaware)
    - Coram Specialty Infusion Services, L.L.C. (Delaware)
      - Coram Rx, LLC (Delaware)
      - Coram Healthcare Corporation of North Texas (Delaware)
      - Coram Healthcare Corporation of Utah (Delaware)
      - Coram Healthcare Corporation of Massachusetts (Delaware)
    - Coram Alternate Site Services, Inc. (Delaware)
      - Geneva Woods Management, LLC (Delaware)
- Part D Holding Company, L.L.C. (Delaware)
  - Accendo Insurance Company (Utah)
  - Silverscript Insurance Company (Tennessee)
- Connecticut CVS Pharmacy, L.L.C. (Connecticut)
- CVS 2948 Henderson, L.L.C. (Nevada)
- CVS AL Distribution, L.L.C. (Alabama)
- CVS Albany, L.L.C. (New York)
- CVS AOC Services, L.L.C. (Delaware)
- CVS Indiana, L.L.C. (Indiana)
- CVS International, L.L.C. (Delaware)
  - CCI Foreign, S'arl (R.C.S. Luxembourg)
    - Beauty Holdings, L.L.C. (Delaware)
      - Drogaria Onofre Ltda. (Brazil)
      - Pamplona Saúde e Beleza LTDA (Brazil)
- CVS Kidney Care, LLC (Delaware)
- CVS Manchester NH, L.L.C. (New Hampshire)
- CVS Michigan, L.L.C. (Michigan)
- CVS Orlando FL Distribution, L.L.C. (Florida)
- CVS PA Distribution, L.L.C. (Pennsylvania)
- CVS PR Center, Inc. (Delaware)
  - Puerto Rico CVS Pharmacy, L.L.C. (Puerto Rico)
  - Caremark Puerto Rico, L.L.C. (Puerto Rico)
  - Caremark Puerto Rico Specialty Pharmacy, L.L.C. (Puerto Rico)
- CVS RS Arizona, L.L.C. (Arizona)
  - Arizona CVS Stores, L.L.C. (Arizona)

    - CVS 3268 Gilbert, L.L.C. (Arizona)
    - CVS 3745 Peoria, L.L.C. (Arizona)
    - CVS Gilbert 3272, L.L.C. (Arizona)
- CVS Rx Services, Inc. (New York)
    - Busse CVS, L.L.C. (Illinois)
    - Goodyear CVS, L.L.C. (Arizona)
    - Sheffield Avenue CVS, L.L.C. (Illinois)
    - South Wabash CVS, L.L.C. (Illinois)
    - Thomas Phoenix CVS, L.L.C. (Arizona)
    - Washington Lamb CVS, L.L.C. (Nevada)
- CVS SC Distribution, L.L.C. (South Carolina)
- CVS State Capital, L.L.C. (Maine)
- CVS TN Distribution, L.L.C. (Tennessee)
- CVS Transportation, L.L.C. (Indiana)
- CVS Vero FL Distribution, L.L.C. (Florida)
- D.A.W., LLC (Massachusetts)
- Delaware CVS Pharmacy, L.L.C. (Delaware)
- Digital eHealth, LLC (Rhode Island)
- District of Columbia CVS Pharmacy, L.L.C. (District of Columbia)
- Enterprise Patient Safety Organization, LLC (Rhode Island)
- E.T.B., INC. (Texas)
- Garfield Beach CVS, L.L.C. (California)
- Georgia CVS Pharmacy, L.L.C. (Georgia)
- German Dobson CVS, L.L.C. (Arizona)
- Grand St. Paul CVS, L.L.C. (Minnesota)
- Highland Park CVS, L.L.C. (Illinois)
- Holiday CVS, L.L.C. (Florida)
- Hook-SupeRx, L.L.C. (Delaware)
- Idaho CVS Pharmacy, L.L.C. (Idaho)
- Iowa CVS Pharmacy, L.L.C. (Iowa)
- Kansas CVS Pharmacy, L.L.C. (Kansas)
- Kentucky CVS Pharmacy, L.L.C. (Kentucky)
- Longs Drug Stores California, L.L.C. (California)
- Louisiana CVS Pharmacy, L.L.C. (Louisiana)
- Maryland CVS Pharmacy, L.L.C. (Maryland)
- Melville Realty Company, Inc. (New York)
- CVS Bellmore Avenue, L.L.C. (New York)
- MinuteClinic, L.L.C. (Delaware)
    - MinuteClinic Diagnostic of Alabama, L.L.C. (Alabama)
    - MinuteClinic Diagnostic of Arizona, LLC (Minnesota)
    - MinuteClinic Diagnostic of Florida, LLC (Minnesota)
    - MinuteClinic Diagnostic of Georgia, LLC (Minnesota)
    - MinuteClinic Diagnostic of Hawaii, L.L.C. (Hawaii)
    - MinuteClinic Diagnostic of Illinois, LLC (Delaware)
    - MinuteClinic Diagnostic of Kentucky, L.L.C. (Kentucky)
    - MinuteClinic Diagnostic of Louisiana, L.L.C. (Louisiana)
    - MinuteClinic Diagnostic of Maine, L.L.C. (Maine)
    - MinuteClinic Diagnostic of Maryland, LLC (Minnesota)
    - MinuteClinic Diagnostic of Massachusetts, LLC (Massachusetts)
    - MinuteClinic Diagnostic of Nebraska, L.L.C. (Nebraska)
    - MinuteClinic Diagnostic of New Hampshire, L.L.C. (New Hampshire)
    - MinuteClinic Diagnostic of New Mexico, L.L.C. (New Mexico)

- MinuteClinic Diagnostic of Ohio, LLC (Ohio)
- MinuteClinic Diagnostic of Oklahoma, LLC (Oklahoma)
- MinuteClinic Diagnostic of Oregon, LLC (Oregon)
- MinuteClinic Diagnostic of Pennsylvania, LLC (Minnesota)
- MinuteClinic Diagnostic of Rhode Island, LLC (Minnesota)
- MinuteClinic Diagnostic of South Carolina, L.L.C. (South Carolina)
- MinuteClinic Diagnostic of Texas, LLC (Minnesota)
- MinuteClinic Diagnostic of Utah, L.L.C. (Utah)
- MinuteClinic Diagnostic of Virginia, LLC (Virginia)
- MinuteClinic Diagnostic of Washington, LLC (Oregon)
- MinuteClinic Diagnostic of Wisconsin, L.L.C. (Wisconsin)
- MinuteClinic Online Diagnostic Services, LLC (Delaware)
- MinuteClinic Telehealth Services, LLC (Delaware)

- Mississippi CVS Pharmacy, L.L.C. (Mississippi)
- Missouri CVS Pharmacy, L.L.C. (Missouri)
- Montana CVS Pharmacy, L.L.C. (Montana)
- Nebraska CVS Pharmacy, L.L.C. (Nebraska)
- New Jersey CVS Pharmacy, L.L.C. (New Jersey)
- North Carolina CVS Pharmacy, L.L.C. (North Carolina)
- Ohio CVS Stores, L.L.C. (Ohio)
- Oklahoma CVS Pharmacy, L.L.C. (Oklahoma)
- Omnicare, Inc. (Delaware)
  - ACS ACQCO CORP. (Delaware)
    - Advanced Care Scripts, Inc. (Florida)
  - Omnicare Holding Company (Delaware)
    - Evergreen Pharmaceutical of California, Inc. (California)
    - JHC Acquisition, LLC (Delaware)
      - Geneva Woods Pharmacy, LLC (Alaska)
        - Geneva Woods Health Services, LLC (Delaware)
          - Geneva Woods Retail Pharmacy LLC (Delaware)
          - Geneva Woods LTC Pharmacy, LLC
            - Geneva Woods Pharmacy Wyoming, LLC (Delaware)
            - Geneva Woods Pharmacy Washington, LLC (Delaware)
            - Geneva Woods Pharmacy Alaska, LLC (Delaware)
    - AMC - Tennessee, LLC (Delaware)
    - CHP Acquisition, LLC (Delaware)
      - Home Pharmacy Services, LLC (Missouri)
    - CP Acquisition, LLC (Oklahoma)
    - Managed Healthcare, LLC (Delaware)
    - Med World Acquisition Corp. (Delaware)
    - Medical Arts Health Care, LLC (Georgia)
    - MHHP Acquisition Company, LLC (Delaware)
    - NCS Healthcare, LLC (Delaware)
      - NCS Healthcare of South Carolina, LLC (Ohio)
      - NCS Healthcare of Tennessee, LLC (Ohio)
      - NCS Healthcare of Kentucky, Inc. (Oh
      - NCS Healthcare of Montana, LLC (Ohio)
      - NCS Healthcare of New Mexico, LLC (Ohio)
      - UNI-Care Health Services of Maine, LLC (New Hampshire)
    - NeighborCare, Inc. (Pennsylvania)
      - Three Forks Apothecary, LLC (Kentucky)
      - NeighborCare Holdings, Inc. (Delaware)

- Badger Acquisition of Kentucky LLC (Delaware)
- NeighborCare Services Corporation (Delaware)
    - D & R Pharmaceutical Services LLC (Kentucky)
    - NeighborCare Pharmacy Services, Inc. (Delaware)
        - APS Acquisition LLC (Delaware)
        - ASCO HealthCare, LLC (Maryland)
        - Badger Acquisition LLC (Delaware)
            - Badger Acquisition of Minnesota LLC (Delaware)
                - Merwin Long Term Care, LLC (Minnesota)
            - Badger Acquisition of Ohio LLC (Delaware)
        - Best Care LTC Acquisition Company, LLC (Delaware)
        - Care Pharmaceutical Services, LP (Delaware)
        - CCRx Holdings, LLC (Delaware)
            - Continuing Care Rx, LLC (Pennsylvania)
            - CCRx of North Carolina LLC (Delaware)
        - Compscript, LLC (Florida)
            - Campo's Medical Pharmacy, LLC (Louisiana)
        - Enloe Drugs, LLC (Delaware)
        - Evergreen Pharmaceutical, LLC (Washington)
        - Home Care Pharmacy, LLC (Delaware)
        - Interlock Pharmacy Systems, LLC (Missouri)
        - Langsam Health Services, LLC (Delaware)
            - LCPS Acquisition, LLC (Delaware)
                - Omnicare Pharmacy of Tennessee LLC (Delaware)
        - Lobos Acquisition, LLC (Delaware)
        - Lo-Med Prescription Services, LLC (Ohio)
            - ZS Acquisition Company, LLC (Delaware)
        - NCS Healthcare of Illinois, LLC (Ohio)
        - NCS Healthcare of Iowa, LLC (Ohio)
            - Martin Health Services, LLC (Delaware)
        - NCS Healthcare of Kansas, LLC (Ohio)
        - NCS Healthcare of Ohio, LLC (Ohio)
        - NCS Healthcare of Wisconsin, LLC (Ohio)
        - North Shore Pharmacy Services LLC (Delaware)
        - Omnicare Indiana Partnership Holding Company LLC (Delaware)
        - Omnicare of New York, LLC (Delaware)
            - NeighborCare of Indiana, LLC (Indiana)
                - Grandview Pharmacy, LLC (Indiana)
            - NeighborCare of Virginia, LLC (Virginia)
        - Omnicare Pharmacies of Pennsylvania West LLC (Pennsylvania)
            - Omnicare Pharmacies of Pennsylvania East LLC (Delaware)
        - Omnicare Pharmacy and Supply Services LLC (South Dakota)
        - Omnicare Pharmacy of the Midwest, LLC (Delaware)
        - Omnicare Property Management, LLC (Delaware)
        - Pharmacy Consultants, LLC (South Carolina)
        - PRN Pharmaceutical Services, LP (Delaware)
        - Roeschen's Healthcare LLC (Wisconsin)
            - PP Acquisition Company LLC (Delaware)
        - Specialized Pharmacy Services, LLC (Michigan)

        - Value Health Care Services LLC (Delaware)
        - VAPS Acquisition Company, LLC (Delaware)
        - Westhaven Services Co, LLC (Ohio)
    - NIV Acquisition, LLC (Delaware)
    - OCR Services, LLC (Delaware)
        - Shore Pharmaceutical Providers, LLC (Delaware)
    - Omnicare of Nevada, LLC (Delaware)
    - Omnicare Pharmacies of the Great Plains Holding, LLC (Delaware)
        - Omnicare of Nebraska LLC (Delaware)
    - Pharmacy Associates of Glenn Falls, LLC (New York)
    - Sterling Healthcare Services, LLC (Delaware)
    - Superior Care Pharmacy, LLC (Delaware)
    - TCPI Acquisition, LLC (Delaware)
    - UC Acquisition, LLC (Delaware)
    - Weber Medical Systems LLC (Delaware)
    - Williamson Drug Company, LLC (Virginia)

- CVS Pharmacy, Inc. (continued)

    - Oregon CVS Pharmacy, L.L.C. (Oregon)
    - Pennsylvania CVS Pharmacy, L.L.C. (Pennsylvania)
    - ProCare Pharmacy Direct, L.L.C. (Ohio)
    - ProCare Pharmacy, L.L.C. (Rhode Island)
    - Red Oak Sourcing, LLC (Delaware)
    - Rhode Island CVS Pharmacy, L.L.C. (Rhode Island)
    - South Carolina CVS Pharmacy, L.L.C. (South Carolina)
    - Tennessee CVS Pharmacy, L.L.C. (Tennessee)
    - Utah CVS Pharmacy, L.L.C. (Utah)
    - Vermont CVS Pharmacy, L.L.C. (Vermont)
    - Virginia CVS Pharmacy, L.L.C. (Virginia)
    - Warm Springs Road CVS, L.L.C. (Nevada)
    - Washington CVS Pharmacy, L.L.C. (Washington)
    - Wellpartner, LLC (Delaware)
    - West Virginia CVS Pharmacy, L.L.C. (West Virginia)
    - Wisconsin CVS Pharmacy, L.L.C. (Wisconsin)
    - Woodward Detroit CVS, L.L.C. (Michigan)

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3ASR No. 333-217596) of CVS Health Corporation, and
(2) Registration Statements (Form S-8 Nos. 333-228622, 333-167746, 333-217853, 333-208805, 333-141481, 333-139470, 333-63664, 333-91253, 333-49407, 333-34927, and 333-28043) of CVS Health Corporation;

of our reports dated February 28, 2019, with respect to the consolidated financial statements of CVS Health Corporation and the effectiveness of internal control over financial reporting of CVS Health Corporation incorporated by reference in this Annual Report (Form 10-K) of CVS Health Corporation for the year ended December 31, 2018.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 28, 2019

Exhibit 31.1

Certification

I, Larry J. Merlo, President and Chief Executive Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;

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

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

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

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

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

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

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

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

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

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

Date: February 28, 2019

By: /s/ LARRY J. MERLO

Larry J. Merlo

President and Chief Executive Officer

Exhibit 31.2

Certification

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;

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

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

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

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

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

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

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

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

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

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

Date: February 28, 2019

By: / s / EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2018 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Larry J. Merlo, President and Chief Executive Officer of the Company, certify that, to the best of my knowledge:

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

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 28, 2019

/ s / LARRY J. MERLO

Larry J. Merlo

President and Chief Executive Officer

Exhibit 32.2

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2018 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of the Company, certify that, to the best of my knowledge:

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

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 28, 2019

/ s / EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

DentaQuest Financials

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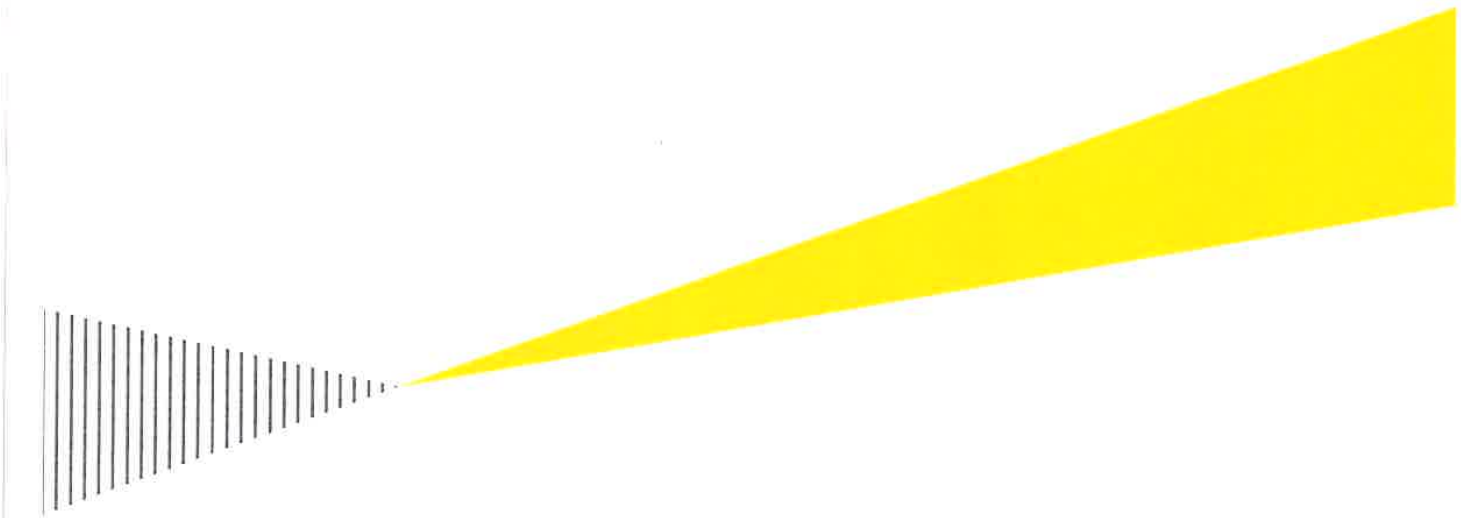
STATUTORY-BASIS FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

DentaQuest USA Insurance Company, Inc.
Years Ended December 31, 2016 and 2015
With Report of Independent Auditors

Ernst & Young LLP



Building a better working world

DentaQuest USA Insurance Company, Inc.

Statutory-Basis Financial Statements
and Supplementary Information

Years Ended December 31, 2016 and 2015

Contents

1611-2119458

Ernst & Young LLP
200 Clarendon Street
Boston, MA 02116

Tel: +1 617 266 2000
Fax: +1 617 266 5843
ey.com

Building a better working world

Report of Independent Auditors

The Board of Directors
DentaQuest USA Insurance Company, Inc.

We have audited the accompanying statutory-basis financial statements of DentaQuest USA Insurance Company, Inc., which comprise the statutory-basis statements of admitted assets, liabilities and capital and surplus as of December 31, 2016 and 2015, and the related statutory-basis statements of income and changes in capital and surplus, and cash flow for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with accounting practices prescribed or permitted by the State of Texas Department of Insurance. Management also is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Building a better working world

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, to meet the requirements of the State of Texas the financial statements have been prepared in conformity with accounting practices prescribed or permitted by the State of Texas Department of Insurance, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are described in Note 2. The effects on the accompanying financial statements of these variances are not reasonably determinable but are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the effects of the matter described in the preceding paragraph, the statutory-basis financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of DentaQuest USA Insurance Company, Inc. at December 31, 2016 and 2015, or the results of its operations and its cash flows for the years then ended.

Opinion on Statutory-Basis of Accounting

However, in our opinion, the statutory-basis financial statements referred to above present fairly, in all material respects, the financial position of DentaQuest USA Insurance Company, Inc. at December 31, 2016 and 2015, and the results of its operations and its cash flow for the years then ended in conformity with accounting practices prescribed or permitted by the State of Texas Department of Insurance.

Ernst & Young LLP

May 30, 2017

DentaQuest USA Insurance Company, Inc.

Statutory-Basis Statements of Admitted Assets, Liabilities, and Capital and Surplus

(in thousands, except for share data)	December 31 2016	2015
Admitted assets		
Bonds	**$ 59,925**	$ 63,987
Unrestricted cash, cash equivalents, and short-term investments	**72,017**	86,261
Restricted cash and short-term investments	**12,637**	7,451
Receivable for open trades	**112**	130
Investment in affiliate	**7,000**	7,437
Cash and invested assets	**151,691**	165,266
Premiums receivable	**11,349**	10,434
Management service revenue receivable	**7,809**	7,792
Affordable care act recoverable	**20,118**	19,991
Electronic data processing equipment and software	**100**	135
Investment income – due and accrued	**415**	403
Net deferred tax asset	**1,506**	1,278
Total admitted assets	**$ 192,988**	$ 205,299
Liabilities		
Unpaid service provider costs	**$ 43,234**	$ 38,333
Unpaid claims adjustment expenses	**697**	778
Premiums received in advance	**2,411**	658
Risk share accrual	**11,306**	25,900
Accounts payable and accrued liabilities	**1,381**	2,252
Federal income taxes payable	**3,601**	782
Payables for open trades	**113**	647
Due to Parent	**4,841**	14,483
Total liabilities	**67,584**	83,833
Capital and surplus		
Common stock $2.86 par value; 700,000 shares authorized; 700,000 shares issued and outstanding	**2,002**	2,002
Gross paid-in and contributed surplus	**24,516**	24,516
Surplus note	**–**	4,000
ACA fee special surplus adjustment	**–**	12,924
Unassigned surplus	**98,886**	78,024
Total capital and surplus	**125,404**	121,466
Total liabilities and capital and surplus	**$ 192,988**	$ 205,299

The accompanying notes are an integral part of these statutory-basis financial statements.

DentaQuest USA Insurance Company, Inc.

Statutory-Basis Statements of Income and Changes in Capital and Surplus

(in thousands)	Year Ended December 31 2016	2015
Revenues		
Direct premiums	**$ 801,956**	$ 761,571
Risk revenue	**110,868**	95,839
Assumed reinsurance premiums	**–**	11,042
Total revenues	**912,824**	868,452
Expenses		
Service provider costs	**805,877**	774,905
Assumed reinsurance claims incurred	**–**	7,213
General and administrative expenses	**59,849**	52,860
Total underwriting deductions	**865,726**	834,978
Net underwriting gain	**47,098**	33,474
Net realized investments gains	**323**	28
Net investment income	**498**	1,171
Net income before federal income taxes	**47,919**	34,673
Federal income tax expense	**21,561**	16,775
Net income	**$ 26,358**	$ 17,898
Changes in capital and surplus		
Capital and unassigned surplus at beginning of year	**$ 121,466**	$ 103,345
Net income	**26,358**	17,898
Change in unrealized gains	**(416)**	(608)
Change in non-admitted assets	**(32)**	1,048
Change in surplus note	**(4,000)**	–
Dividends to parent	**(18,200)**	–
Changes in net deferred income tax	**228**	(217)
Special surplus funds – ACA Section 9010 fee	**–**	(12,924)
Capital and unassigned surplus at end of year	**125,404**	108,542
Special surplus funds at beginning of year	**12,924**	12,895
Special surplus funds – prior year ACA Section 9010 fee	**(12,924)**	(12,895)
Special surplus funds – ACA Section 9010 fee	**–**	12,924
Special surplus funds at end of year	**–**	12,924
Capital and surplus at end of year	**$ 125,404**	$ 121,466

The accompanying notes are an integral part of these statutory-basis financial statements.

DentaQuest USA Insurance Company, Inc.

Statutory-Basis Statements of Cash Flow

(in thousands)	Year Ended December 31 2016	2015
Operating activities		
Premiums collected	**$ 787,852**	$ 768,816
Net investment income collected (paid)	**1,146**	1,562
Risk revenue collected	**110,868**	95,839
Payments to service providers	**(800,976)**	(769,744)
General administrative expenses paid	**(60,880)**	(53,199)
Federal income taxes paid	**(18,742)**	(19,584)
Net cash provided by operations	**19,268**	23,690
Investing activities		
Proceeds from sale and maturities of bonds	**32,416**	22,561
Miscellaneous applications	**(488)**	49
Purchases of bonds	**(28,698)**	(32,949)
Net cash provided by (used in) investing activities	**3,230**	(10,339)
Financing and miscellaneous sources		
Surplus note	**(4,000)**	–
Other cash used	**(9,356)**	(12,462)
Dividends paid to parent	**(18,200)**	–
Net cash used in financing and miscellaneous sources	**(31,556)**	(12,462)
Net change in cash and short-term investments	**(9,058)**	889
Cash, restricted cash on deposit, cash equivalents and short-term investments, beginning of year	**93,712**	92,823
Cash, restricted cash on deposit, cash equivalents and short-term investments, end of year	**$ 84,654**	$ 93,712

The accompanying notes are an integral part of these statutory-basis financial statements.

DentaQuest USA Insurance Company, Inc.

Notes to Statutory-Basis Financial Statements

December 31, 2016

1. Nature of Operations

DentaQuest USA Insurance Company, Inc. (the Company) is a Texas Corporation that was organized on August 31, 2005, for general business purposes, including providing dental insurance services in the State of Texas. The Company holds licenses and meets minimum requirements to provide these services. The Company owns 100% interest of DSM USA Insurance Company, Inc. (DSM USA). DSM USA is a licensed life, accident and health insurer in thirty eight states and the District of Columbia.

The Company is a wholly owned subsidiary of DentaQuest, LLC (DQ LLC or the Parent), a Delaware limited liability company. The ultimate parent of DQ LLC is DentaQuest Group, Inc. (DentaQuest), incorporated under the laws of the state of Delaware, which has its principal place of business in Boston, Massachusetts. DentaQuest is an indirect, wholly owned subsidiary of Dental Service of Massachusetts, Inc. (DSM), a not-for-profit corporation incorporated under Chapter 176E of the Massachusetts General Laws.

On August 18, 2011, DSM entered into a Corporate Guarantee (the Guarantee) of the Managed Care Contract between the Company and the Texas Health and Human Services Commission (the HHSC Contract). Pursuant to the HHSC Contract, which became operational on March 1, 2012, with an initial term through August 31, 2015, and was subsequently extended through February 28, 2019, the Company provides dental benefits on a capitated basis to approximately one-half of the participants in the Texas Medicaid program and Children's Health Insurance Program (CHIP). Pursuant to the Guarantee, DSM unconditionally guarantees the Company's performance of all of its obligations under the HHSC Contract.

The Company has foreign licenses to operate as a health insurer in nine other states. Aside from the HHSC contract, the Company has several other contracts that provide dental benefits and administrative services only (ASO) in the states of Texas, Colorado, Georgia, Tennessee and Utah. During 2016, the Company also offered dental benefits to individuals through state marketplaces both directly, in the state of Texas, and through health plans, in the states of Texas Georgia, Louisiana, Massachusetts, and New Hampshire.

In addition, the Company had two assumed reinsurance contracts to provide dental services in the states of Tennessee and Utah. The Tennessee State Children's Health Insurance Plan (SCHIP) reinsurance agreement and the Utah CHIP reinsurance agreement ended on June 30, 2015 and September 30, 2015, respectively. Effective July 1, 2015 and October 1, 2015, respectively, the Company began covering enrollees of these programs on a direct basis.

On September 18, 2013, the Company purchased Significa Insurance Group, Inc., renamed DSM USA Insurance Company, Inc. (DSM USA) for $9,483,000. DSM USA is a licensed life, accident and health insurer in thirty eight states and the District of Columbia.

2. Significant Accounting Policies

The following is a summary of the significant accounting policies followed by the Company.

Basis of Presentation

The accompanying statutory basis financial statements have been prepared in conformity with the accounting practices prescribed or permitted by the State of Texas Department of Insurance. The State of Texas has adopted the National Association of Insurance Commissioners (NAIC) statutory accounting practices (NAIC SAP) as the basis of its statutory accounting practice. NAIC SAP is a comprehensive basis of accounting other than the accounting principles generally accepted in the United State of America (GAAP). Prescribed statutory accounting practices include a variety of publications of the NAIC, as well as state laws, regulations and general administrative rules. Permitted statutory accounting practices encompass all accounting practices not so prescribed. The Company has no permitted accounting practices which vary from prescribed accounting practices.

The more significant variances from GAAP are as follows:

Investments in bonds are generally carried at amortized cost, while under GAAP, they are carried at either amortized cost or fair value based on their classification according to the Company's ability and intent to hold or trade the securities.

Certain assets designated as "non-admitted," including deferred federal income taxes in excess of certain statutory limits, furniture, fixtures and equipment, leasehold improvements, prepaid expenses, premium receivable balances aged over 90 days, pledged assets, intangibles on investments in subsidiaries, and other assets not specifically identified as an admitted asset within the Statements of Statutory Accounting Principles (SSAP) are excluded from the accompanying Statutory-Basis Statements of Admitted Assets, Liabilities and Capital and Surplus and are charged directly to surplus. Under GAAP, such assets are included in the balance sheets.

Under SSAP 41, *Surplus Notes*, interest shall not be recorded as a liability nor an expense until approval for payment of such interest has been granted by the commissioner of the state of domicile. All interest, including interest in arrears, shall be expensed in the Statements of

Income and Changes in Capital and Surplus when approved for payment. Unapproved interest shall not be reported through operations, shall not be represented as an addition to the principal or notional amount of the instrument, and shall not accrue further interest (i.e., interest on interest). Under GAAP, interest is expensed when incurred. Also, under GAAP, the surplus note is classified as a liability on the balance sheet, while under SSAP 41, the note is treated as a component of surplus.

The accounts and operations of the Company's subsidiary is not consolidated with the accounts and operations of the Company, as would be required under GAAP.

Admitted assets and the statements of cash flow under statutory accounting practices present cash and short-term investments, including investments with maturities of one year or less from the date of acquisition. Under GAAP, cash equivalents include securities maturing in three months or less from acquisition date.

Under statutory accounting, a statement of comprehensive income is not provided.

Under SSAP 101, *Income Taxes*, gross deferred tax assets are admitted in an amount equal to the sum of: (a) federal income taxes paid in prior years that can be recovered through loss carry-backs for existing temporary differences not to exceed three years from the balance sheet date; (b) the lesser of: (i.) the remaining gross deferred tax assets expected to be realized in a timeframe consistent with NAIC standards; or (ii.) a percentage of surplus consistent with NAIC standards, excluding any net deferred tax assets, electronic data processing (EDP) equipment and operating software; and (c) the amount of remaining gross deferred tax assets that can be offset against existing gross deferred tax liabilities. The remaining deferred tax assets are non-admitted.

The application of SSAP 101 also requires a company to evaluate the recoverability of deferred tax assets and to establish a statutory valuation allowance if necessary to reduce the deferred tax asset to an amount which is more likely than not to be realized. Under GAAP, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets not realizable.

The Company's estimated annual fee under Section 9010 of the Federal Affordable Care Act (ACA) for the subsequent year is segregated in special surplus under NAIC SAP as of December 31. Under GAAP, the fee is accrued ratably throughout the fee year.

The effects of the foregoing variances from GAAP on the accompanying statutory-basis financial statements have not been determined, but are presumed to be material.

Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, as well as the reported amounts of revenues and expenses during the reporting periods. Actual results could differ from those estimates.

Business Concentrations

The Company's operations are subject to regulatory, legal, environmental and other changes that may impact the state of Texas or the geographical region. Additionally, for the years ended December 31, 2016 and 2015, the Company generated 98% and 99% of its revenues from five contracts, respectively. For the year ended December 31, 2016, the largest contract represented 86% of total revenues, and the second largest represented 7%. For the year ended December 31, 2015, the largest contract represented 87% of total revenues, and the second largest represented 7%.

Investments

Invested assets are valued in accordance with the statutory basis of valuation prescribed by the NAIC. Bonds are generally stated at amortized cost. Bonds not backed by other loans are valued under the scientific (constant yield) method. Bonds with an NAIC rating of "3" or higher are carried at the lower of amortized cost or fair value.

Securities that experience declines in fair value are regularly evaluated for other-than-temporary impairments. The decision on whether to record other-than-temporary impairments is determined in part by management's assessment of the financial condition and prospects of a particular issuer, recoverability of the particular security as well as management's assertion of its intention to sell the security, and if it is more likely than not that the securities will be sold before recovery. For such securities, realized losses are recorded in the Statutory-Basis Statements Income and Changes in Capital and Surplus in net realized investment gains.

Investment income is recorded on an accrual basis. Realized capital gains or losses are recorded using the specific identification of investments sold.

Direct Premium Revenue Recognition

The Company earns revenue from short duration contracts for which the Company bears the underwriting risk. Premiums are billed in advance of the coverage month and recognized as revenue over the coverage month. Costs of acquiring and renewing business are charged to expense as incurred.

Assumed Reinsurance Premiums

The Company earns assumed reinsurance premium revenue from short duration contracts for which the Company assumes the underwriting risk. Costs of acquiring and renewing business are charged to expense as incurred.

For uncollected premium, after the calculation of non-admitted amounts, an evaluation is made of the remaining admitted assets in accordance with SSAP 5R, *Liabilities, Contingencies, and Impairment of Assets Revised*, to determine if there is a collectability issue. If it is probable that the balance is uncollectible, any uncollectible amount is written off and charged to income in the period the determination is made.

Management Service Revenue Recognition

Management service revenues are derived from arrangements to provide claims adjudication services and other administrative and management services for dental plans. Revenue for services is earned as services are rendered. The net management service revenue is included in general and administrative expenses on the Statutory Statements of Income and Changes in Capital and Surplus.

The Company does not incur underwriting risk associated with the management services business, which is billed monthly, on either a level monthly fee or paid claims basis, using a one-month lag.

Premium Deficiency Reserve

When the expected claim payments and administrative expenses exceed the premiums to be collected for the remainder of the contract period, a premium deficiency reserve is recorded for the difference, with a corresponding charge to operations. The Company does not consider anticipated investment income in its analysis. For purposes of determining whether a premium deficiency exists, contracts are grouped in a manner consistent with the Company's method of

acquiring, servicing, and measuring the profitability of such contracts. No premium deficiency reserve was required to be recorded in either 2016 or 2015.

Premiums and Management Service Revenue Receivables

All receivables outstanding are less than 90 days past due. Items greater than 90 days past due are considered non-admitted assets.

Risk Revenue

Risk revenue represents amounts paid to the Company on a capitated basis from other insurers in exchange for the provision of services for covered members of the counterparty. Risk revenue is recognized as revenue in the month for which the Company has agreed to provide services.

Service Provider Costs

The Company utilizes an established network of dentists to provide comprehensive services to its members. The Company compensates these providers on a fee-for-service basis based upon discounted fee schedules.

The cost of dental health services provided is accrued in the period in which it is provided to a member based in part on estimates, including an accrual for dental services incurred but not reported (IBNR).

The Company estimates the IBNR using standard actuarial methodologies, including historical experience and current utilization estimates, and incorporates the information included in a report from its consulting actuary. The estimates of unpaid claims can be lesser or greater than the amounts ultimately paid. Differences between estimated IBNR and actual amounts incurred are recorded as an increase/decrease to service provider costs in the Statutory-Basis Statements of Revenue and Expenses and Changes in Capital and Surplus in the period that they become known.

Risk Share Accrual

The Company records accruals for contracts that have risk sharing arrangements with clients. These accruals limit the maximum profitability of the Company in any one contract and are repaid to the client periodically based on the contract terms.

Income Taxes

The Company is included in the federal consolidated income tax return filed by DentaQuest. The method of allocation of tax among the members of the consolidated income tax return is determined by a tax-sharing agreement and is based on separate return calculations with current credit for net losses incurred by any one of the companies to the extent those losses are used in the consolidated return. Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting basis of assets and liabilities based on enacted tax rates and laws. However, the admissibility of any resulting deferred tax asset is subject to certain criteria in accordance with SSAP 101.

Statutory valuation allowances are provided if, based upon the weight of the available evidence, it is more likely than not that some or all of the deferred tax assets will not be realized.

Cash, Cash Equivalents, and Short-Term Investments

Cash and cash equivalents include all highly liquid investments with an original maturity date of three months or less. Short-term investments consist of liquid investments and include money market funds and U.S. Treasury securities with maturity dates of one year or less at the date of acquisition. Short-term investments are carried at amortized cost.

Restricted Cash and Securities on Deposit

The Company maintains certain restricted cash and securities to meet the requirement of the Texas Department of Insurance. These securities are accordingly classified as restricted and are carried at amortized cost. See Note 10.

Furniture, Fixtures, and Equipment

The Company owns certain furniture, fixtures, and equipment and depreciates these assets using the straight-line method. Depreciation expense recorded for 2016 and 2015 amounted to $415,000 and $691,000, respectively.

Advanced Premiums

Advanced premiums represent the unearned portion of premiums received in advance for dental service to be provided to members in the future.

Affordable Care Act Recoverable

The Company has received a signed agreement from its Medicaid state customer that commits them to reimburse the Company for their portion of the annual fee under Section 9010 of the Affordable Care Act (ACA fee), including the related gross-up for the effect of federal and state income taxes. The ACA fee recoverable is reflected on the Statutory-Basis Statements of Admitted Assets, Liabilities, and Capital and Surplus as an asset, and on the Statutory-Basis Statements of Income and Changes in Capital and Surplus reducing general and administrative expenses.

3. Non-admitted Assets

Certain assets, designated as non-admitted by the NAIC SAP, have been charged against capital and surplus and are summarized as follows:

(in thousands)	**2016**	**2015**
Premiums receivable	**$ 3,313**	$ 2,901
Furniture and equipment	**357**	611
Electronic data processing equipment	**356**	482
Investment in DSM USA- licenses intangible	**3,009**	3,009
Securities on deposit	**111**	111
Total non-admitted assets	**$ 7,146**	$ 7,114

4. Furniture, Fixtures, and Equipment

The estimated useful lives, cost and accumulated depreciation of furniture, fixtures and equipment at December 31, 2016, are as follows:

(in thousands)	Lives	2016	2015
Electronic data processing equipment	3–7 years	$ 1,997	$ 1,997
Computer hardware	3–7 years	173	173
Office furniture and equipment	5–10 years	559	559
Leasehold improvements	7–15 years	695	695
		3,424	3,424
Less: Accumulated depreciation		(2,611)	(2,196)
Less: Nonadmitted assets		(713)	(1,093)
		$ 100	$ 135

5. Unpaid Service Provider Costs

Activity is summarized as follows:

(in thousands)	2016	2015
Balance at beginning of year	$ 38,333	$ 25,959
Incurred related to:		
Current year	806,857	776,438
Prior year	(980)	5,680
	805,877	782,118
Paid related to:		
Current year	763,998	738,391
Prior year	36,978	31,353
	800,976	769,744
Balance at end of year	$ 43,234	$ 38,333

The Company recognizes changes in accounting estimates for claims incurred but unpaid as more experience is acquired or as additional information is obtained. Negative amounts reported above are due to incurred claims related to prior years being settled for amounts less than was originally estimated. Positive amounts reported above are for incurred claims related to prior year's results being settled for amounts higher than was originally estimated.

The above table excludes claims adjustment expenses and changes in accrued claims adjustment expenses, which are included in general and administrative expenses.

6. Investments

At December 31, 2016 the cost, fair values and gross unrealized gains and losses of investments are as follows:

(in thousands)	2016			
	Amortized Cost/Cost	**Gross Unrealized Gains**	**Gross Unrealized Losses**	**Fair Value**
U.S. Treasury, and obligations of U.S. government and agencies	**$ 16,346**	**$ 29**	**$ (374)**	**$ 16,001**
Residential mortgage securities	**17,909**	**89**	**(185)**	**17,813**
Commercial mortgage and ABS securities	**9,433**	**29**	**(62)**	**9,400**
Industrial and miscellaneous	**16,237**	**130**	**(163)**	**16,204**
Total bonds	**$ 59,925**	**$ 277**	**$ (784)**	**$ 59,418**

At December 31, 2015 the cost, fair values and gross unrealized gains and losses of investments are as follows:

(in thousands)	2015			
	Amortized Cost/Cost	**Gross Unrealized Gains**	**Gross Unrealized Losses**	**Fair Value**
U.S. Treasury, and obligations of U.S. government and agencies	$ 21,319	$ 49	$ (79)	$ 21,289
Residential mortgage securities	14,266	102	(59)	14,309
Commercial mortgage and ABS securities	12,265	19	(164)	12,120
Industrial and miscellaneous	16,137	17	(362)	15,792
Total bonds	$ 63,987	$ 187	$ (664)	$ 63,510

The amortized cost and fair value of bonds at December 31, 2016, by contractual maturity, are shown below. Actual maturities will differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
Due in one year or less	$ 1,258	$ 1,260
Due after one year through five years	15,363	15,387
Due after five years through ten years	11,534	11,455
Due after ten years	27,167	26,760
Due after one year for mortgage-backed securities	4,603	4,556
	$ 59,925	$ 59,418

Unrealized Holding Losses

Management believes that the gross unrealized losses reflected on the Company's bond portfolio as of December 31, 2016 were primarily the result of increases in market interest rates from the time of acquisition to the current period. These decreases in value are viewed as being temporary as the Company does not intend to sell the bonds and it is not more likely than not that the Company will be required to sell the investments before recovery of their recorded values, which may be maturity.

The following table shows the Company's unrealized losses and fair value by security type. Securities in a continuous loss position for more than 12 months are immaterial as of December 31, 2016 and 2015.

(in thousands)	2016		2015	
	Under 12 Months		Under 12 Months	
	Unrealized Losses	Fair Value of Investments With Unrealized Losses	Unrealized Losses	Fair Value of Investments With Unrealized Losses
U.S. Treasury and obligations of U.S. government, and agencies	**$ (374)**	**$ 11,506**	$ (79)	$ 14,891
Residential mortgage Securities	**(185)**	**10,212**	(59)	7,025
Commercial mortgage and ABS securities	**(62)**	**1,676**	(164)	9,712
Industrial and miscellaneous	**(163)**	**2,757**	(362)	13,407
	$ (784)	**$ 26,151**	$ (664)	$ 45,035

There were 142 and 262 securities in an unrealized loss position as of December 31, 2016 and 2015, respectively.

Gross gains of $462,000 and $146,000 and gross losses of $139,000 and $118,000 were realized on sales of bonds during 2016 and 2015, respectively.

Net investment income for December 31, 2016 consisted of the following:

(in thousands)	Year Ended December 31 2016	2015
Bond income	**$ 1,427**	$ 1,346
Investment expenses	**(929)**	(175)
	$ 498	$ 1,171

Fair Value

Assets and liabilities carried at fair value are to be classified and disclosed in one of the following three categories:

Level 1: Quoted market prices in active markets for identical assets or liabilities that the Company has the ability to access.

Level 2: Observable market based inputs or unobservable inputs that are corroborated by market data such as quoted prices, interest rates, and yield curves.

Level 3: Inputs are unobservable data points that are not corroborated by market data.

The Company used the following methods and assumptions in estimating the fair value of financial instruments as well as the general classification of such financial instruments pursuant to the above fair value hierarchy:

Bonds

At each valuation date, the Company uses various valuation techniques to estimate the fair value of its bond portfolio. The primary method for valuing the Company's securities is through independent third-party valuation service providers. The evaluation and prioritization of these valuation sources is systematic and predetermined resulting in a single price for each financial instrument. The following describes the techniques generally used to determine the fair value of the Company's bonds by asset class:

U.S. Treasury and Obligations of U.S. Government and Agencies

U.S. Treasury and obligations of U.S. government and agencies securities consist primarily of bonds issued by the U.S. Treasury and mortgage pass-through agencies such as the Federal Home Loan Bank, the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation. As the fair values of the Company's U.S. Treasury securities are based on unadjusted market prices, they are classified within Level 1. The fair value of U.S. government agency securities is generally determined using observable market inputs that include quoted prices for identical or similar assets in markets that are not active, benchmark yields, reported trades, bids, offers and credit spreads. Accordingly, the fair value of U.S. government agency securities is classified within Level 2.

Residential Mortgage-Backed Securities

The Company's portfolio of residential Mortgage-Backed Securities (MBS) are originated by both agencies and non-agencies, whose cash flows come from residential debt such as mortgages, home-equity loans and sub-prime mortgages. The fair value of MBS is generally determined using observable market inputs that include quoted prices for identical or similar assets in markets that are not active, benchmark yields, contractual cash flows, prepayment speeds, collateral performance and credit spreads. Accordingly, the fair value of MBS is primarily classified within Level 2.

Commercial Mortgage-Backed Securities

The Company's portfolio of commercial MBS are originated by both agencies and non-agencies, whose cash flows come from loans on commercial properties. The fair value of MBS is generally determined using observable market inputs that include quoted prices for identical or similar assets in markets that are not active, benchmark yields, contractual cash flows, prepayment speeds, collateral performance and credit spreads. Accordingly, the fair value of MBS is primarily classified within Level 2.

Asset-Backed Securities (ABS)

ABS include mostly investment-grade bonds backed by pools of loans, primarily automobile loan receivables, originated by a variety of financial institutions. The fair value of ABS is generally determined using observable market inputs that include quoted prices for identical or similar assets in markets that are not active, benchmark yields, contractual cash flows, prepayment speeds, collateral performance and credit spreads. Accordingly, the fair value of ABS is primarily classified within Level 2.

Industrial and Miscellaneous

Industrial and miscellaneous securities consist primarily of investment-grade debt of a wide variety of corporate issuers and industries. The fair value of corporate and other securities is generally determined using observable market inputs that include quoted prices for identical or similar assets in markets that are not active, benchmark yields, new issuances, issuer ratings, reported trades of identical or comparable securities, bids, offers and credit spreads. Accordingly, the fair value of corporate and other securities is primarily classified within Level 2.

Fair Value Classification

(in thousands)	Fair Value December 31, 2016	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Bonds	$ 59,418	$ 16,001	$ 43,417	$ –
Cash equivalents	2,831	2,831	–	–
Total assets	$ 62,249	$ 18,832	$ 43,417	$ –

(in thousands)	Fair Value December 31, 2015	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Bonds	$ 63,510	$ 21,289	$ 42,221	$ –
Cash equivalents	2,935	2,935	–	–
Total assets	$ 66,445	$ 24,224	$ 42,221	$ –

At December 31, 2016 and 2015, cash equivalents measured at fair value of $2,831,000 and $2,935,000, respectively, are included in unrestricted cash, cash equivalents and short-term investments of $72,017,000 and $86,261,000, respectively, on the Statutory-Basis Statements of Admitted Assets, Liabilities, and Capital and Surplus. The cash equivalents consist of short-term money market holdings.

No transfers between levels of the fair value hierarchy occurred in 2016 and 2015. The Company recognizes transfers between levels of the fair value hierarchy on an annual basis at the end of the year.

7. Income Taxes

Components of deferred tax assets (DTAs) and deferred tax liabilities (DTLs) are as follows:

(in thousands)	2016	2015	Changes
Gross deferred tax assets	**$ 1,506**	$ 1,533	$ (27)
Statutory valuation allowance adjustment	–	–	–
Adjusted gross deferred tax assets	**1,506**	1,533	(27)
Deferred tax assets non-admitted	–	–	–
Subtotal net admitted deferred tax asset	**1,506**	1,533	(27)
Deferred tax liabilities	–	255	(255)
Net deferred tax assets	**$ 1,506**	$ 1,278	$ 228

All the Company's deferred tax assets for the years ended December 31, 2016 and 2015, are ordinary in nature.

The admission calculation components are as follows:

(in thousands)	2016	2015	Changes
a. Federal income taxes paid in prior years recoverable through loss carrybacks	**$ 1,506**	$ 1,278	$ 228
b. Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from (a) above) after application of the threshold limitation	–	–	–
i. Adjusted Gross Deferred Tax Assets Expected to be Realized Following the Balance Sheet Date	–	–	–
ii. Adjusted Gross Tax Assets Allowed per Limitation Threshold	**18,585**	18,028	557
c. Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from (a) and (b) above) offset by gross deferred tax liabilities	–	255	(255)
d. Deferred tax assets admitted as the result of application of SSAP 101.	–	–	–
Total (a) + (b) + (c)	**$ 1,506**	$ 1,533	$ (27)

Other admissibility criteria are as follows:

(in thousands, except percentages)	2016	2015
Ratio percentage used to determine recovery period and threshold limitation amount	**402%**	403%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b) above	**$ 123,899**	$ 120,188

The Company does not currently employ tax planning strategies to recognize the admission of deferred tax assets.

Current income taxes incurred consist of the following components:

(in thousands)	2016	2015
Current income tax expense	**$ 21,561**	$ 16,775
Federal income taxes incurred	**$ 21,561**	$ 16,775

There are no temporary differences for which a deferred tax liability has not been established.

The tax effects that give rise to significant portions of deferred tax assets are as follows:

(in thousands)	2016	2015	Changes
Deferred tax assets resulting from book/ tax differences in:			
Reserves	**$ 108**	$ 92	$ 16
Unearned premium	**–**	46	(46)
Fixed asset basis	**105**	144	(39)
Premiums receivable	**1,159**	1,015	144
Reserve for Provider Receivable	**94**	197	(103)
Other deferred assets	**40**	39	1
Total net deferred tax assets	**$ 1,506**	$ 1,533	$ (27)
Non-admitted deferred tax assets	**$ –**	$ –	$ –

The tax effects that give rise to significant portions of deferred tax liabilities are as follows:

(in thousands)	2016	2015	Change
Deferred tax liabilities resulting from book/tax differences in:			
Surplus note	**$ –**	$ 255	$ (255)
Total net deferred tax liabilities	**$ –**	$ 255	$ (255)

The change in net deferred income taxes is comprised of the following:

(in thousands)	December 31 2016	2015	Change
Total gross deferred tax assets	**$ 1,506**	$ 1,533	$ (27)
Total gross deferred tax liabilities	**–**	255	(255)
Net deferred tax assets	**$ 1,506**	$ 1,278	$ 228
Tax effect of unrealized capital gains			–
Change in net deferred income taxes			$ 228

The Company's provision for federal income taxes differs from the federal statutory tax rate of 35% applied to net income before federal taxes as follows:

(in thousands)	2016
Provision computed at statutory rate	$ 16,772
Change in non-admitted assets	(11)
Affordable Care Act assessment	4,556
Amortization	16
Total	$ 21,333
Federal income taxes incurred	$ 21,561
Change in deferred income taxes	(228)
Total statutory income taxes	$ 21,333

The Company does not have any protective tax deposits under section 6603 of the Internal Revenue Code.

The Company is included in a federal consolidated tax return and files a separate Georgia tax return. The Company does not have net operating loss carryforwards as of December 31, 2016. The members of the DentaQuest federal consolidated income tax return consisted of: DentaQuest Group, Inc., DentaQuest Management, Inc., DQ Massachusetts Business Trust, Pacific Dental Network, Inc., California Dental Network, Inc., DentaQuest of Florida, Inc., DSM USA Insurance Company, Inc. and the Company.

Below is a table of the earliest tax years that remain subject to examination by major jurisdictions:

Jurisdiction	Earliest Tax Year Subject to Examination
U.S. Federal	2013
Georgia	2013

All years including and subsequent to the above years remain open to examination by the taxing authorities. The amount of federal income taxes incurred and available for recoupment in the event of future net losses is $21,561,000 and $16,775,000 at December 31, 2016 and 2015, respectively.

8. Assumed Reinsurance

Effective March 20, 2008, the Company entered into an assumed reinsurance agreement with National Guardian Life Insurance Company (NGL). NGL provides dental coverage for eligible individuals enrolled in Coverkids, Tennessee's State Children's Health Insurance Plan (SCHIP). The Company assumes 100% of the risk and also pays NGL (via the Parent) a carrier fee, and reimburses premium taxes paid by NGL to the State of Tennessee. DentaQuest of Tennessee, LLC, an affiliated company, was contracted by NGL as the third party administrator for the arrangement and performs the services related to the contract for a 5% administration fee. For the year ended December 31, 2016 and 2015, the Company recorded carrier fees including amounts for premium taxes of zero and $593,000 respectively, in connection with the Coverkids contract. For the years ended December 31, 2016 and 2015, the Company recorded administrative fee expenses of zero and $623,000 respectively, in connection with the Coverkids contract.

The NGL reinsurance agreement for Tennessee's SCHIP program ended on June 30, 2015. Effective July 1, 2015 the Company began covering enrollees of these programs on a direct basis.

Effective July 1, 2010, the Company entered into an assumed reinsurance agreement with NGL to reinsure NGL for the Children's Health Insurance Program (CHIP) in the State of Utah, Department of Health. The Company assumes 100% of the risk and also pays NGL (via the Parent) a carrier fee, and agrees to reimburse premium taxes as determined by state regulation to NGL pursuant to the contract. DQ LLC, the Parent company, was contracted by NGL as the third party administrator of the agreement, and performs the services related to the contract for a 5% administration fee. For the year ended December 31, 2015, the Company recorded carrier fees of

$15,000, in connection with the Utah CHIP contract. For the years ended December 31, 2015, the Company recorded administrative fee expenses of $25,000, in connection with the Utah CHIP contract.

The NGL reinsurance agreement for Utah's CHIP program ended on September 30, 2015. Effective October 1, 2015, the Company began covering enrollees of these programs on a direct basis.

9. Related-Party Transactions

During 2016 and 2015, the allocated costs from DQ LLC amounted to $71,333,000 and $62,212,000, respectively. These costs were for information technology, facilities and equipment, human resources services, executive and managerial support, legal services, regulatory filing and compliance services, accounting services, cash management services, actuarial and underwriting services, sales and marketing services, enrollment services, claims processing services, billing and collection services, customer services, provider relations and credentialing services, and other additional services provided by DQ LLC to the Company. As of December 31, 2016 and 2015, the Company had an amount due to DQ LLC of $4,841,000 and $14,483,000, respectively.

As a result of the significant related party transactions, the Company's financial condition and results from operations may not necessarily be indicative of the financial condition or results from operations that would have occurred if the Company had been operating on a standalone basis.

10. Restricted Cash and Securities on Deposit

On February 2, 2007, DQ LLC (formerly co-borrower with DQV and DentaQuest, as Parent Guarantor) entered into a Credit Agreement with a group of lenders for a $200,000,000 revolving line of credit to meet the capital needs of the DentaQuest companies. DQ LLC, together with all of the subsidiaries of DentaQuest, including the Company, also entered into a Guarantee and Collateral Agreement (together with the Credit Agreement, the Credit Facility).

On June 24, 2014, DQ, LLC entered into an amendment to the Credit Agreement that extended the maturity date to the earlier of June 24, 2019, or the date DQ LLC terminates the Credit Agreement with appropriate notice and repayment.

Under the laws of the State of Texas, the Company is required to maintain a minimum surplus of $1,400,000. On May 14, 2010, the State of Texas Commissioner of Insurance issued a consent

order requiring the Company to make an initial additional deposit of approximately $7,100,000 into a restricted account with the Comptroller of Public Accounts for the State of Texas to satisfy certain of its statutory obligations. As of December 31, 2011, additional deposits had been made to this restricted account and the carrying value of these restricted securities was $14,500,000 at December 31, 2011. On April 13, 2012, another consent order was issued releasing the Company from most of the requirements of the previous order. The Company was given permission to withdraw approximately $7,250,000 of the deposit. On November 20, 2014 the Company made an additional deposit in the amount of $5,183,000 to replace securities on deposit which had matured during 2016, and now. As of December 31, 2016, the Company maintained a restricted account balance of $12,637,000 with the Texas Comptroller.

The Company also has two other restricted deposits. One deposit is with the State of Georgia Office of Commissioner of Insurance in the approximate amount of $100,000 in relation to the Company's extended license in the State of Georgia. The other deposit is maintained by the Commonwealth of Massachusetts, Department of State Treasurer in the approximate amount of $101,000 in relation to the Company's extended license in the Commonwealth of Massachusetts.

11. Capital and Surplus

The Company is required to file financial statements with the Texas Department of Insurance (TDI). Under the laws of the State of Texas, the Company is required to maintain a minimum surplus of $1,400,000. The Company met the required minimum capital and surplus requirements. Regulatory limits restrict dividends without approval of state insurance regulators.

In connection with discussions with the TDI regarding the pledging of the Company's stock in relation to an affiliated credit facility, on May 18, 2010, the Company issued a 3.25% $4,000,000 surplus debenture note to Dental Service of Massachusetts, Inc. This note was approved by the Commissioner of Insurance of Texas pursuant to Sections 427.053 and 823.102 of the Texas Insurance Code. The note was amended in 2015, to change the maturity date. The amended note matured on December 31, 2016. Interest accruing on this note must be approved by TDI prior to being released. As of December 31, 2016 and 2015, there was zero and $731,000 of unapproved interest on the note, respectively. The Company paid the principal and interest on November 18, 2016 in the amount of $4,847,000. On March 8, 2016, the Company paid $18,200,000 of dividends to its sole stockholder, DentaQuest, LLC.

12. Legal Proceedings

In the normal course of business, the Company is subject to various contingencies such as market conduct examinations, guaranty fund assessments and legal matters. Management does not anticipate any significant unaccrued claims or costs to result from any known or existing contingencies as of December 31, 2016 and 2015.

The Company's subsidiary, DQ USA is the subject of a suit in United States District Court of Tennessee. This matter arises out of DQ USA's decision not to include the plaintiff in the provider network established for the TennCare Medicaid program for the State of Tennessee. The plaintiff claims that DQ USA was a state actor and violated their right to free speech, due process and equal protection by not including them in the network. The plaintiff seeks compensatory damages, punitive damages and attorneys' fees. The matter went to trial on the issue of the plaintiff's right to free speech; the other claims were dismissed. A jury found for plaintiff, including compensatory and punitive damages. The Company disputes this claim. DQ USA's post-trial motions to set the jury verdict aside are currently pending. The Company has a liability policy which provides some insurance coverage. The Company's exposure ranges from $0 to approximately $15 million. In accordance with ASC 405, the Company has accrued $4 million.

13. Subsequent Events

The Company's management evaluated subsequent events through May 30, 2017, which is the date statutory-basis financial statements were available to be issued.

In 2017, the Company will again write premiums that will be subject to an annual fee under Section 9010 of the Federal ACA. The annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2016, the Company has written health insurance subject to the ACA assessment, and expects to conduct health insurance business in 2017. However, the federal government has suspended the ACA

assessment for 2017, so the Company estimates its portion of the annual health insurance industry fee to be zero, and will not be payable on September 30, 2017.

(in thousands)	**2016**	**2015**
ACA fee assessment payable for upcoming year	**$ –**	$ 12,924
ACA fee assessment paid	**13,019**	12,784
Premium written subject to ACA 9010 assessment	**801,956**	755,705
Total Adjusted Capital before surplus adjustment	**125,404**	121,466
Authorized Control Level before surplus adjustment	**30,824**	29,843
Total Adjusted Capital after surplus adjustment	**125,404**	108,542
Authorized Control Level after surplus adjustment	**30,824**	29,843
Would reporting the ACA assessment as of December 31, 2016, have triggered an RBC action level?	**No**	No

Supplementary Information

1611-2119458

Ernst & Young LLP
200 Clarendon Street
Boston, MA 02116

Tel: +1 617 266 2000
Fax: +1 617 266 5843
ey.com

Building a better working world

Report of Independent Auditors on Supplementary Information

The Board of Directors of DentaQuest USA Insurance Company, Inc.

Our audits were conducted for the purpose of forming an opinion on the statutory-basis financial statements as a whole. The accompanying supplemental investment disclosures are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

This report is intended solely for the information and use of the Company and state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

May 30, 2017

DentaQuest USA Insurance Company, Inc.

Supplementary Schedule of Investment Risk Interrogatories

December 31, 2016

1. The Company's total admitted assets as reported on Page 2 of its Annual Statement is $192,988,000.

2. Following are the ten largest exposures to a single issuer/borrower/investment, excluding: (i) U.S. government, U.S. government agency securities and those U.S. government money market funds listed in the Appendix to the *SVO Practices and Procedures Manual* as exempt, (ii) property occupied by the Company and (iii) policy loans:

Issuer	Description of Exposure	Amount	Percentage of Total Admitted Assets
Porsche Innov LSE TR 2014-1	Bond	$ 624,980	0.324%
GS MTG SECS TR 2012-GCJ7	Bond	464,844	0.241%
COMM MTG TR 2012-CCRE2	Bond	441,692	0.229%
Ford Credit FLRPLN TR A 2106-5	Bond	430,917	0.223%
Comcast Corp	Bond	410,295	0.213%
GS MTG COML 2010-C1	Bond	385,746	0.200%
Blackstone Holdings FIN 144A	Bond	378,377	0.196%
Invitation Homes TR 2013-SFR1	Bond	367,358	0.190%
Nextgear FLRPLN OWN TR 2016-1	Bond	314,942	0.163%
Boston Properties	Bond	310,672	0.161%

DentaQuest USA Insurance Company, Inc.

Supplementary Schedule of Investment Risk Interrogatories (continued)

3. The Company's total admitted assets held in bonds and preferred stock by NAIC rating are:

Bonds and Short-Term Investments

NAIC Rating	Amount	Percentage of Total Admitted Assets
NAIC-1	$ 53,586,430	27.767%
NAIC-2	6,165,800	3.195%
NAIC-3	98,577	0.051%
NAIC-4	74,155	0.038%
NAIC-5	-	0.000%
NAIC-6	-	0.000%
	$ 59,924,962	

4. The Company has no assets held in foreign investments greater than 2.5% of the reporting entity's total admitted assets.

5. The Company has no aggregate foreign investment exposure categories by NAIC sovereign rating greater than 2.5% of reporting entity's total admitted assets.

6. The Company has no foreign investment exposures in a single country, categories by the country's NAIC sovereign rating greater than 2.5% of reporting entity's total admitted assets.

7. The Company has no unhedged foreign currency exposure.

8. The Company has no aggregate unhedged foreign currency exposure.

9. The Company has no unhedged foreign currency exposures to a single country.

10. The Company has no non-sovereign (i.e., non-governmental) foreign issues greater than 2.5% of total admitted assets.

11. The Company has no assets held in Canadian investments that are greater than 2.5% of the reporting entity's total admitted assets.

12. The Company has no admitted assets held in investments with contractual sales restrictions.

13. The Company has no investments in equity interests.

14. The Company has no assets held in nonaffiliated, privately placed equities that are greater than 2.5% of the reporting entity's total admitted assets.

15. The Company has no assets held in general partnership interests that are greater than 2.5% of the reporting entity's total admitted assets.

16. The Company has no mortgage loans greater than 2.5% of the reporting entity's total admitted assets.

17. The Company has no aggregate mortgage loans that are greater than 2.5% of the reporting entity's total admitted assets.

18. The Company has no assets held in real estate reported that are greater than 2.5% of the reporting entity's total admitted assets, excluding home office properties.

19. The Company has no assets held in investments held in mezzanine real estate loans greater than 2.5% of the reporting entity's total admitted assets.

20. The Company had no assets subject to security lending agreements, repurchase agreements, reverse repurchase agreements, dollar repurchase agreements, or dollar reverse repurchase agreements during 2016.

21. The Company had no warrants not attached to other financial instruments, options, caps, and floors during 2016.

22. The Company had no potential exposure for collars, swaps, and forwards during 2016.

23. The Company had no potential exposure for future contracts during 2016.

DentaQuest USA Insurance Company, Inc.

Summary Investment Schedule

December 31, 2016

Investment Categories	Gross Investment Holdings* Amount	Gross Investment Holdings* Percentage of Total Invested Assets	Admitted Invested Assets as Reported in the Annual Statement Amount	Admitted Invested Assets as Reported in the Annual Statement Percentage of Total Invested Assets
Bonds:				
U.S. Treasury securities	$ 11,752,297	7.597%	$ 11,752,297	7.747%
U.S. government agency obligations (excluding mortgage-backed securities):				
Issued by U.S. government agencies	337,891	0.218	337,891	0.223
Issued by U.S. government sponsored agencies	141,718	0.092	141,718	0.093
Securities issued by states, territories, and possessions and political subdivisions in the U.S.:				
Political subdivisions of states, territories and possessions and political subdivisions general obligations	127,517	0.082	127,517	0.084
Revenue and assessment obligations	1,197,546	0.774	1,197,546	0.789
Mortgage-backed securities(includes residential and commercial MBS):				
Pass- through securities:				
Issued or guaranteed by GNMA	524,040	0.339	524,040	0.345
Issued or guaranteed by FNMA and FHLMC	8,239,182	5.326	8,239,182	5.432
CMO's and REMIC's:				
Issued or guaranteed by GNMA, FNMA, FHLMC or VA	8,859,287	5.727	8,859,287	5.840
Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies	924,357	0.598	924,357	0.609
All other	3,678,773	2.378	3,678,773	2.425

DentaQuest USA Insurance Company, Inc.

Supplementary Schedule of Investment Risk Interrogatories (continued)

Investment Categories	Gross Investment Holdings* Amount	Gross Investment Holdings* Percentage of Total Invested Assets	Admitted Invested Assets as Reported in the Annual Statement Amount	Admitted Invested Assets as Reported in the Annual Statement Percentage of Total Invested Assets
Other debt and other fixed income securities (excluding short-term):				
Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	$ 24,071,355	15.560%	$ 24,071,355	15.869%
Unaffiliated Non-U.S. securities (including Canada)	71,000	0.046	71,000	0.047
Affiliated securities	-		-	
Other equity securities:				
Affiliated	10,009,041	6.470	6,999,781	4.614
Unaffiliated	-		-	
Contract loans	-		-	
Receivables for securities	112,416	0.073	112,416	0.074
Cash, cash equivalents, and short-term investments	84,654,572	54.721	84,654,572	55.807
Total invested assets	$ 154,700,991	100.000%	$ 151,691,731	100.000%

*Gross investment holdings as valued in compliance with the NAIC's *Accounting Practices and Procedures Manual.*

DentaQuest USA Insurance Company, Inc.

Note to Supplementary Information

December 31, 2016

The accompanying supplemental schedules present selected statutory-basis financial data as of December 31, 2016, and for the year then ended for purposes of complying with the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and agrees to or is included in the amounts reported in the Company's Statutory Annual Statement as filed with the State of Texas Department of Insurance.

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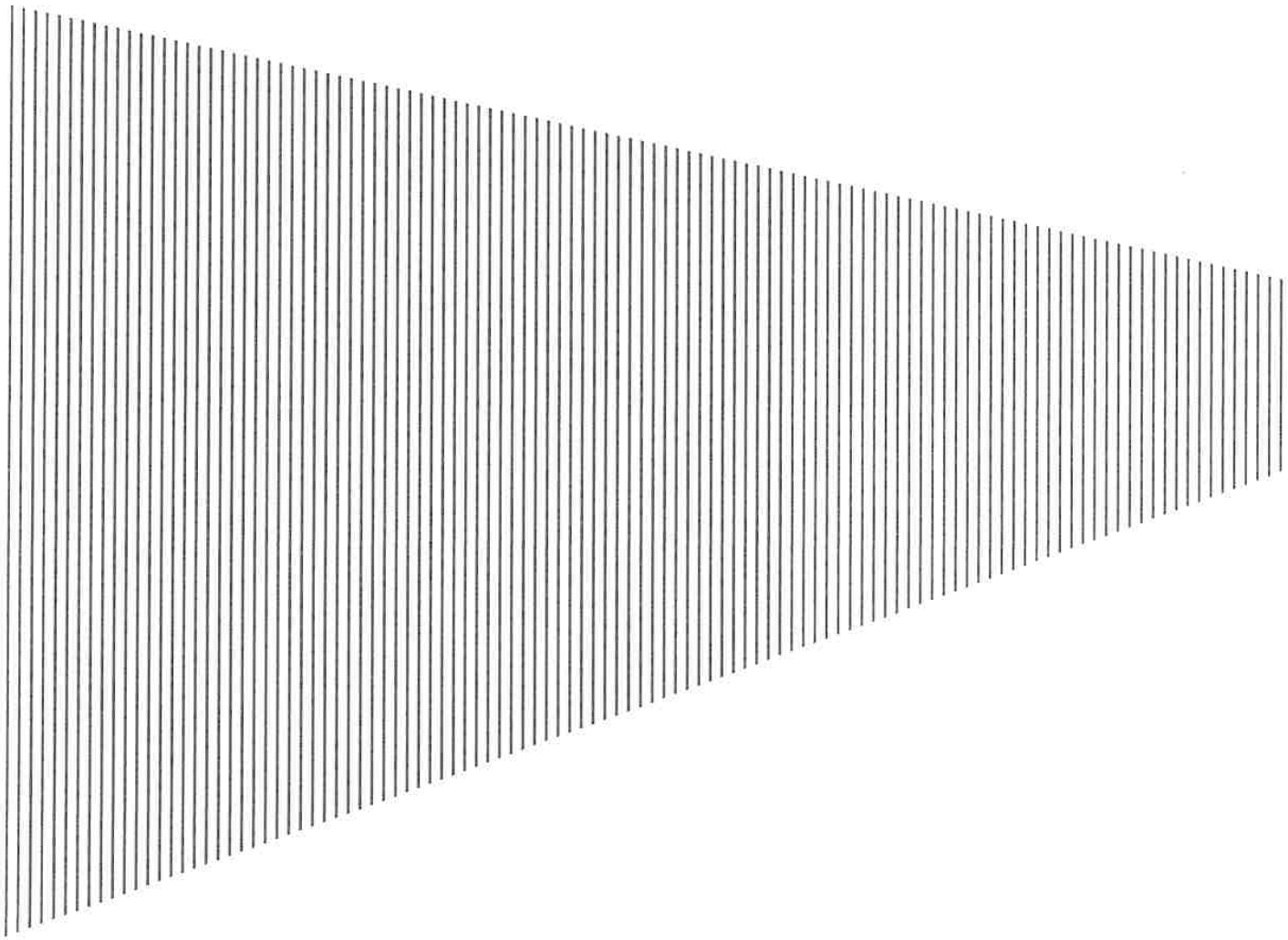
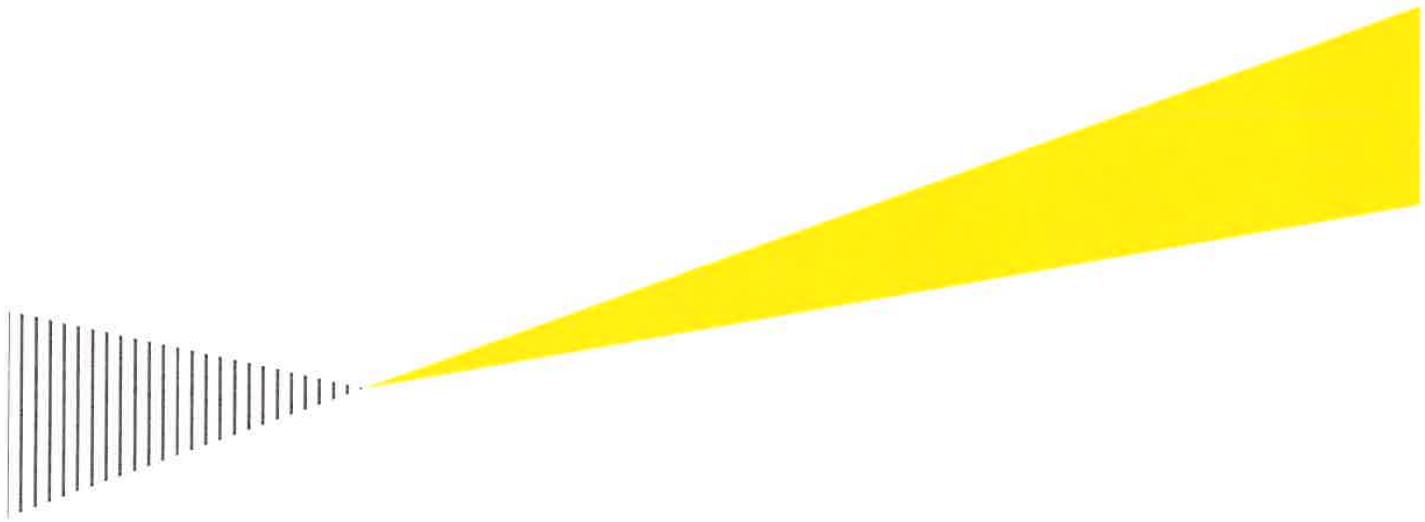


STATUTORY-BASIS FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

DentaQuest USA Insurance Company, Inc.
Years Ended December 31, 2017 and 2016
With Report of Independent Auditors

Ernst & Young LLP



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DentaQuest USA Insurance Company, Inc.

Statutory-Basis Financial Statements
and Supplementary Information

Years Ended December 31, 2017 and 2016

Contents

Ernst & Young LLP
200 Clarendon Street
Boston, MA 02116

Tel: +1 617 266 2000
Fax: +1 617 266 5843
ey.com

Building a better working world

Report of Independent Auditors

The Board of Directors
DentaQuest USA Insurance Company, Inc.

We have audited the accompanying statutory-basis financial statements of DentaQuest USA Insurance Company, Inc., which comprise the statutory-basis statements of admitted assets, liabilities and capital and surplus as of December 31, 2017 and 2016, and the related statements of income and changes in capital and surplus, and cash flow for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with accounting practices prescribed or permitted by the State of Texas Department of Insurance. Management also is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Building a better working world

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2, to meet the requirements of the State of Texas the financial statements have been prepared in conformity with accounting practices prescribed or permitted by the State of Texas Department of Insurance, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are described in Note 2. The effects on the accompanying financial statements of these variances are not reasonably determinable but are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the effects of the matter described in the preceding paragraph, the statutory-basis financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of DentaQuest USA Insurance Company, Inc. at December 31, 2017 and 2016, or the results of its operations and its cash flows for the years then ended.

Opinion on Statutory-Basis of Accounting

However, in our opinion, the statutory-basis financial statements referred to above present fairly, in all material respects, the financial position of DentaQuest USA Insurance Company, Inc. at December 31, 2017 and 2016, and the results of its operations and its cash flows for the years then ended in conformity with accounting practices prescribed or permitted by the State of Texas Department of Insurance.

Ernst & Young LLP

May 31, 2018

DentaQuest USA Insurance Company, Inc.

Statutory-Basis Statements of Admitted Assets, Liabilities, and Capital and Surplus

(in thousands, except for share data)	December 31 2017	2016
Admitted assets		
Bonds	$ **63,749**	$ 59,925
Unrestricted cash, cash equivalents, and short-term investments	**63,411**	72,017
Restricted cash and short-term investments	**12,634**	12,637
Receivable for open trades	**–**	112
Investment in affiliate	**6,768**	7,000
Cash and invested assets	**146,562**	151,691
Premiums receivable	**9,724**	11,349
Management service revenue receivable	**10,076**	7,809
Prepaid premium taxes	**3,130**	–
Affordable care act recoverable	**–**	20,118
Electronic data processing equipment and software	**65**	100
Investment income – due and accrued	**402**	415
Net deferred tax asset	**1,159**	1,506
Total admitted assets	$ **171,118**	$ 192,988
Liabilities		
Unpaid service provider costs	$ **40,088**	$ 43,234
Unpaid claims adjustment expenses	**684**	697
Premiums received in advance	**291**	2,411
Risk share accrual	**3,665**	11,306
Accounts payable and accrued liabilities	**255**	1,381
Federal income taxes payable	**1,747**	3,601
Payables for open trades	**869**	113
Due to Parent	**6,013**	4,841
Total liabilities	**53,612**	67,584
Capital and surplus		
Common stock $2.86 par value; 700,000 shares authorized; 700,000 shares issued and outstanding	**2,002**	2,002
Gross paid-in and contributed surplus	**24,516**	24,516
ACA fee special surplus adjustment	**14,666**	–
Unassigned surplus	**76,322**	98,886
Total capital and surplus	**117,506**	125,404
Total liabilities and capital and surplus	$ **171,118**	$ 192,988

The accompanying notes are an integral part of these statutory-basis financial statements.

DentaQuest USA Insurance Company, Inc.

Statutory-Basis Statements of Income and Changes in Capital and Surplus

(in thousands)	Year Ended December 31 2017	2016
Revenues		
Direct premiums	**$ 803,067**	$ 801,956
Risk revenue	**49,464**	110,868
Total revenues	**852,531**	912,824
Expenses		
Service provider costs	**762,196**	805,877
General and administrative expenses	**61,521**	59,849
Total underwriting deductions	**823,717**	865,726
Net underwriting gain	**28,814**	47,098
Net realized investments gains	**22**	323
Net investment income	**1,388**	498
Net income before federal income taxes	**30,224**	47,919
Federal income tax expense	**10,700**	21,561
Net income	**$ 19,524**	$ 26,358
Changes in capital and surplus		
Capital and unassigned surplus at beginning of year	**$ 125,404**	$ 121,466
Net income	**19,524**	26,358
Change in unrealized gains	**(162)**	(416)
Change in non-admitted assets	**(913)**	(32)
Change in surplus note	**–**	(4,000)
Dividends to parent	**(26,000)**	(18,200)
Changes in net deferred income tax	**(347)**	228
Special surplus funds – ACA Section 9010 fee	**(14,666)**	–
Capital and unassigned surplus at end of year	**102,840**	125,404
Special surplus funds at beginning of year	**–**	12,924
Special surplus funds – prior year ACA Section 9010 fee	**–**	(12,924)
Special surplus funds – ACA Section 9010 fee	**14,666**	–
Special surplus funds at end of year	**14,666**	–
Capital and surplus at end of year	**$ 117,506**	$ 125,404

The accompanying notes are an integral part of these statutory-basis financial statements.

DentaQuest USA Insurance Company, Inc.

Statutory-Basis Statements of Cash Flow

(in thousands)	Year Ended December 31 2017	2016
Operating activities		
Premiums collected	**$ 793,856**	$ 787,852
Net investment income collected	**1,838**	1,146
Risk revenue collected	**49,465**	110,868
Payments to service providers	**(765,343)**	(800,976)
General administrative expenses paid	**(65,093)**	(60,880)
Federal income taxes paid	**(12,553)**	(18,742)
Net cash provided by operations	**2,170**	19,268
Investing activities		
Proceeds from sale and maturities of bonds	**24,363**	32,416
Miscellaneous proceeds (applications)	**929**	(488)
Purchases of bonds	**(28,593)**	(28,698)
Net cash (used in) provided by investing activities	**(3,301)**	3,230
Financing and miscellaneous sources		
Repayment of surplus note	**–**	(4,000)
Other cash provided (used)	**18,522**	(9,356)
Dividends paid to parent	**(26,000)**	(18,200)
Net cash used in financing and miscellaneous sources	**(7,478)**	(31,556)
Net change in cash and short-term investments	**(8,609)**	(9,058)
Cash, restricted cash on deposit, cash equivalents and short-term investments, beginning of year	**84,654**	93,712
Cash, restricted cash on deposit, cash equivalents and short-term investments, end of year	**$ 76,045**	$ 84,654

The accompanying notes are an integral part of these statutory-basis financial statements.

DentaQuest USA Insurance Company, Inc.

Notes to Statutory-Basis Financial Statements

December 31, 2017

1. Nature of Operations

DentaQuest USA Insurance Company, Inc. (the Company) is a Texas Corporation that was organized on August 31, 2005, for general business purposes, including providing dental insurance services in the State of Texas. The Company holds licenses and meets minimum requirements to provide these services.

The Company is a wholly owned subsidiary of DentaQuest, LLC (DQ LLC or the Parent), a Delaware limited liability company. The ultimate parent of DQ LLC is DentaQuest Group, Inc. (DentaQuest), incorporated under the laws of the state of Delaware, which has its principal place of business in Boston, Massachusetts. DentaQuest is an indirect, wholly owned subsidiary of Dental Service of Massachusetts, Inc. (DSM), a not-for-profit corporation incorporated under Chapter 176E of the Massachusetts General Laws.

On August 18, 2011, DSM entered into a Corporate Guarantee (the Guarantee) of the Managed Care Contract between the Company and the Texas Health and Human Services Commission (the HHSC Contract). Pursuant to the HHSC Contract, which became operational on March 1, 2012, with an initial term through August 31, 2015, and was subsequently extended through February 28, 2019, the Company provides dental benefits on a capitated basis to approximately one-half of the participants in the Texas Medicaid program and Children's Health Insurance Program (CHIP). Pursuant to the Guarantee, DSM unconditionally guarantees the Company's performance of all of its obligations under the HHSC Contract.

The Company has foreign licenses to operate as a health insurer in nine other states. Aside from the HHSC contract, the Company has several other contracts that provide dental benefits and administrative services only (ASO) in the states of Texas, Colorado, Georgia, Tennessee and Utah. During 2017, the Company also offered dental benefits to individuals through state marketplaces both directly, in the state of Texas, and through health plans, in the states of Texas Georgia, Louisiana, Massachusetts, and New Hampshire.

On September 18, 2013, the Company purchased Significa Insurance Group, Inc., renamed DSM USA Insurance Company, Inc. (DSM USA) for $9,483,000. DSM USA is a licensed life, accident and health insurer in thirty eight states and the District of Columbia. The Company owns 100% of DSM USA Insurance Company, Inc. (DSM USA). DSM USA is a licensed life, accident and health insurer in thirty eight states and the District of Columbia.

2. Significant Accounting Policies

The following is a summary of the significant accounting policies followed by the Company.

Basis of Presentation

The accompanying statutory basis financial statements have been prepared in conformity with the accounting practices prescribed or permitted by the State of Texas Department of Insurance. The State of Texas has adopted the National Association of Insurance Commissioners (NAIC) statutory accounting practices (NAIC SAP) as the basis of its statutory accounting practice. NAIC SAP is a comprehensive basis of accounting other than the accounting principles generally accepted in the United State of America (GAAP). Prescribed statutory accounting practices include a variety of publications of the NAIC, as well as state laws, regulations and general administrative rules. Permitted statutory accounting practices encompass all accounting practices not so prescribed. The Company has no permitted accounting practices which vary from prescribed accounting practices.

The more significant variances from GAAP are as follows:

Investments in bonds are generally carried at amortized cost, while under GAAP, they are carried at either amortized cost or fair value based on their classification according to the Company's ability and intent to hold or trade the securities.

Certain assets designated as "non-admitted," including deferred federal income taxes in excess of certain statutory limits, furniture, fixtures and equipment, leasehold improvements, prepaid expenses, premium receivable balances aged over 90 days, pledged assets, intangibles on investments in subsidiaries, and other assets not specifically identified as an admitted asset within the Statements of Statutory Accounting Principles (SSAP) are excluded from the accompanying Statutory-Basis Statements of Admitted Assets, Liabilities and Capital and Surplus and are charged directly to surplus. Under GAAP, such assets are included in the balance sheets.

Under SSAP 41, *Surplus Notes*, interest shall not be recorded as a liability nor an expense until approval for payment of such interest has been granted by the commissioner of the state of domicile. All interest, including interest in arrears, shall be expensed in the Statements of Income and Changes in Capital and Surplus when approved for payment. Unapproved interest shall not be reported through operations, shall not be represented as an addition to the principal or notional amount of the instrument, and shall not accrue further interest (i.e., interest on interest). Under GAAP, interest is expensed when incurred. Also, under GAAP, the surplus

note is classified as a liability on the balance sheet, while under SSAP 41, the note is treated as a component of surplus. The surplus note was repaid on November 22, 2016.

The accounts and operations of the Company's subsidiary is not consolidated with the accounts and operations of the Company, as would be required under GAAP.

Admitted assets and the statements of cash flow under statutory accounting practices present cash and short-term investments, including investments with maturities of one year or less from the date of acquisition. Under GAAP, cash equivalents include securities maturing in three months or less from acquisition date.

Under statutory accounting, a statement of comprehensive income is not provided.

Under SSAP 101, *Income Taxes*, gross deferred tax assets are admitted in an amount equal to the sum of: (a) federal income taxes paid in prior years that can be recovered through loss carry-backs for existing temporary differences not to exceed three years from the balance sheet date; (b) the lesser of: (i.) the remaining gross deferred tax assets expected to be realized in a timeframe consistent with NAIC standards; or (ii.) a percentage of surplus consistent with NAIC standards, excluding any net deferred tax assets, electronic data processing (EDP) equipment and operating software; and (c) the amount of remaining gross deferred tax assets that can be offset against existing gross deferred tax liabilities. The remaining deferred tax assets are non-admitted.

The application of SSAP 101 also requires a company to evaluate the recoverability of deferred tax assets and to establish a statutory valuation allowance if necessary to reduce the deferred tax asset to an amount which is more likely than not to be realized. Under GAAP, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets not realizable.

The Company's estimated annual fee under Section 9010 of the Federal Affordable Care Act (ACA) for the subsequent year is segregated in special surplus under NAIC SAP as of December 31. Under GAAP, the fee is accrued ratably throughout the fee year.

The effects of the foregoing variances from GAAP on the accompanying statutory-basis financial statements have not been determined, but are presumed to be material.

Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, as well as the reported amounts of revenues and expenses during the reporting periods. Actual results could differ from those estimates.

Business Concentrations

The Company's operations are subject to regulatory, legal, environmental and other changes that may impact the state of Texas or the geographical region. Additionally, for the years ended December 31, 2017 and 2016, the Company generated 99% and 98% of its revenues from five contracts, respectively. For the year ended December 31, 2017, the largest contract represented 92% of total revenues, and the second largest represented 2%. For the year ended December 31, 2016, the largest contract represented 86% of total revenues, and the second largest represented 7%.

Investments

Invested assets are valued in accordance with the statutory basis of valuation prescribed by the NAIC. Bonds are generally stated at amortized cost. Bonds not backed by other loans are valued under the scientific (constant yield) method. Bonds with an NAIC rating of "3" or higher are carried at the lower of amortized cost or fair value.

Securities that experience declines in fair value are regularly evaluated for other-than-temporary impairments. The decision on whether to record other-than-temporary impairments is determined in part by management's assessment of the financial condition and prospects of a particular issuer, recoverability of the particular security as well as management's assertion of its intention to sell the security, and if it is more likely than not that the securities will be sold before recovery. For such securities, realized losses are recorded in the Statutory-Basis Statements Income and Changes in Capital and Surplus in net realized investment gains.

Investment income is recorded on an accrual basis. Realized capital gains or losses are recorded using the specific identification of investments sold.

Direct Premium Revenue Recognition

The Company earns revenue from short duration contracts for which the Company bears the underwriting risk. Premiums are billed in advance of the coverage month and recognized as revenue over the coverage month. Costs of acquiring and renewing business are charged to expense as incurred.

Management Service Revenue Recognition

Management service revenues are derived from arrangements to provide claims adjudication services and other administrative and management services for dental plans. Revenue for services is earned as services are rendered. The net management service revenue is included in general and administrative expenses on the Statutory Statements of Income and Changes in Capital and Surplus.

The Company does not incur underwriting risk associated with the management services business, which is billed monthly, on either a level monthly fee or paid claims basis, using a one-month lag.

Premium Deficiency Reserve

When the expected claim payments and administrative expenses exceed the premiums to be collected for the remainder of the contract period, a premium deficiency reserve is recorded for the difference, with a corresponding charge to operations. The Company does not consider anticipated investment income in its analysis. For purposes of determining whether a premium deficiency exists, contracts are grouped in a manner consistent with the Company's method of acquiring, servicing, and measuring the profitability of such contracts. No premium deficiency reserve was required to be recorded in either 2017 or 2016.

Premiums and Management Service Revenue Receivables

All receivables outstanding are less than 90 days past due. Items greater than 90 days past due are considered non-admitted assets.

Prepaid Premium Tax

Prepaid Premium Tax represents the amount estimated and paid to the states, in which the Company recognizes insurance premium revenue. This estimate is calculated based on the premiums reported to the NAIC.

Risk Revenue

Risk revenue represents amounts paid to the Company on a capitated basis from other insurers in exchange for the provision of services for covered members of the counterparty. Risk revenue is recognized as revenue in the month for which the Company has agreed to provide services.

Service Provider Costs

The Company utilizes an established network of dentists to provide comprehensive services to its members. The Company compensates these providers on a fee-for-service basis based upon discounted fee schedules.

The cost of dental health services provided is accrued in the period in which it is provided to a member based in part on estimates, including an accrual for dental services incurred but not reported (IBNR).

The Company estimates the IBNR using standard actuarial methodologies, including historical experience and current utilization estimates, and incorporates the information included in a report from its consulting actuary. The estimates of unpaid claims can be lesser or greater than the amounts ultimately paid. Differences between estimated IBNR and actual amounts incurred are recorded as an increase/decrease to service provider costs in the Statutory-Basis Statements of Revenue and Expenses and Changes in Capital and Surplus in the period that they become known.

Risk Share Accrual

The Company records accruals for contracts that have risk sharing arrangements with clients. These accruals limit the maximum profitability of the Company in any one contract and are repaid to the client periodically based on the contract terms.

Income Taxes

The Company is included in the federal consolidated income tax return filed by DentaQuest. The method of allocation of tax among the members of the consolidated income tax return is determined by a tax-sharing agreement and is based on separate return calculations with current credit for net losses incurred by any one of the companies to the extent those losses are used in the consolidated return. Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting basis of assets and liabilities based on enacted tax rates and laws. However, the admissibility of any resulting deferred tax asset is subject to certain criteria in accordance with SSAP 101.

Statutory valuation allowances are provided if, based upon the weight of the available evidence, it is more likely than not that some or all of the deferred tax assets will not be realized.

Cash, Cash Equivalents, and Short-Term Investments

Cash and cash equivalents include all highly liquid investments with an original maturity date of three months or less. Short-term investments consist of liquid investments and include money market funds and U.S. Treasury securities with maturity dates of one year or less at the date of acquisition. Short-term investments are carried at amortized cost.

Restricted Cash and Securities on Deposit

The Company maintains certain restricted cash and securities to meet the requirement of the Texas Department of Insurance. These securities are accordingly classified as restricted and are carried at amortized cost. See Note 10.

Furniture, Fixtures, and Equipment

The Company owns certain furniture, fixtures, and equipment and depreciates these assets using the straight-line method. Depreciation expense recorded for 2017 and 2016 amounted to $362,000 and $415,000, respectively.

Advanced Premiums

Advanced premiums represent the unearned portion of premiums received in advance for dental service to be provided to members in the future.

Affordable Care Act Recoverable

The Company has received a signed agreement from its Medicaid state customer that commits them to reimburse the Company for their portion of the annual fee under Section 9010 of the Affordable Care Act (ACA fee), including the related gross-up for the effect of federal and state income taxes. The ACA fee recoverable is reflected on the Statutory-Basis Statements of Admitted Assets, Liabilities, and Capital and Surplus as an asset, and on the Statutory-Basis Statements of Income and Changes in Capital and Surplus reducing general and administrative expenses.

3. Non-admitted Assets

Certain assets, designated as non-admitted by the NAIC SAP, have been charged against capital and surplus and are summarized as follows:

(in thousands)	2017	2016
Premiums receivable	**$ 4,553**	$ 3,313
Furniture and equipment	**156**	357
Electronic data processing equipment	**230**	356
Investment in DSM USA- licenses intangible	**3,009**	3,009
Securities on deposit	**111**	111
Total non-admitted assets	**$ 8,059**	$ 7,146

4. Furniture, Fixtures, and Equipment

The estimated useful lives, cost and accumulated depreciation of furniture, fixtures and equipment at December 31, 2017, are as follows:

(in thousands)	Lives	2017	2016
Electronic data processing equipment	3–7 years	**$ 1,997**	$ 1,997
Computer hardware	3–7 years	**173**	173
Office furniture and equipment	5–10 years	**559**	559
Leasehold improvements	7–15 years	**695**	695
		3,424	3,424
Less: Accumulated depreciation		**(2,973)**	(2,611)
Less: Nonadmitted assets		**(386)**	(713)
		$ 65	$ 100

The accumulated depreciation relating to Electronic data processing equipment was $1,703,000 and $1,542,000 for 2017 and 2016, respectively.

5. Unpaid Service Provider Costs

Activity is summarized as follows:

(in thousands)	**2017**	**2016**
Balance at beginning of year	**$ 43,234**	$ 38,333
Incurred related to:		
Current year	**762,803**	806,857
Prior year	**(607)**	(980)
	762,196	805,877
Paid related to:		
Current year	**724,294**	763,998
Prior year	**41,048**	36,978
	765,342	800,976
Balance at end of year	**$ 40,088**	$ 43,234

The Company recognizes changes in accounting estimates for claims incurred but unpaid as more experience is acquired or as additional information is obtained. Negative amounts reported above are due to incurred claims related to prior years being settled for amounts less than was originally estimated. Positive amounts reported above are for incurred claims related to prior year's results being settled for amounts higher than was originally estimated.

The above table excludes claims adjustment expenses and changes in accrued claims adjustment expenses, which are included in general and administrative expenses.

6. Investments

At December 31, 2017 the cost, fair values and gross unrealized gains and losses of investments are as follows:

(in thousands)	2017			
	Amortized Cost/Cost	**Gross Unrealized Gains**	**Gross Unrealized Losses**	**Fair Value**
U.S. Treasury, and obligations of U.S. government and agencies	**$ 17,789**	**$ 102**	**$ (181)**	**$ 17,710**
Residential mortgage securities	**19,517**	**77**	**(189)**	**19,405**
Commercial mortgage and ABS securities	**7,375**	**27**	**(64)**	**7,338**
Industrial and miscellaneous	**19,068**	**419**	**(50)**	**19,437**
Total bonds	**$ 63,749**	**$ 625**	**$ (484)**	**$ 63,890**

At December 31, 2016 the cost, fair values and gross unrealized gains and losses of investments are as follows:

(in thousands)	2016			
	Amortized Cost/Cost	**Gross Unrealized Gains**	**Gross Unrealized Losses**	**Fair Value**
U.S. Treasury, and obligations of U.S. government and agencies	$ 16,346	$ 29	$ (374)	$ 16,001
Residential mortgage securities	17,909	89	(185)	17,813
Commercial mortgage and ABS securities	9,433	29	(62)	9,400
Industrial and miscellaneous	16,237	130	(163)	16,204
Total bonds	$ 59,925	$ 277	$ (784)	$ 59,418

The amortized cost and fair value of bonds at December 31, 2017, by contractual maturity, are shown below. Actual maturities will differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

(in thousands)	Amortized Cost	Fair Value
Due in one year or less	$ 1,192	$ 1,191
Due after one year through five years	14,792	14,831
Due after five years through ten years	7,927	7,932
Due after ten years	12,946	13,193
Due after one year for mortgage-backed securities	26,892	26,743
	$ 63,749	$ 63,890

Unrealized Holding Losses

Management believes that the gross unrealized losses reflected on the Company's bond portfolio as of December 31, 2017 were primarily the result of increases in market interest rates from the time of acquisition to the current period. These decreases in value are viewed as being temporary as the Company does not intend to sell the bonds and it is not more likely than not that the Company will be required to sell the investments before recovery of their recorded values, which may be maturity.

The following table shows the Company's unrealized losses and fair value by security type. Securities in a continuous loss position for more than 12 months are immaterial as of December 31, 2017 and 2016.

(in thousands)	2017		2016	
	Unrealized Losses	Fair Value of Investments With Unrealized Losses	Unrealized Losses	Fair Value of Investments With Unrealized Losses
U.S. Treasury and obligations of U.S. government, and agencies	**$ (181)**	**$ 13,934**	$ (374)	$ 11,506
Residential mortgage Securities	**(189)**	**12,484**	(185)	10,212
Commercial mortgage and ABS securities	**(64)**	**4,595**	(62)	1,676
Industrial and miscellaneous	**(50)**	**6,482**	(163)	2,757
	$ (484)	**$ 37,495**	$ (784)	$ 26,151

There were 217 and 142 securities in an unrealized loss position as of December 31, 2017 and 2016, respectively.

Gross gains of $135,000 and $462,000 and gross losses of $113,000 and $139,000 were realized on sales of bonds during 2017 and 2016, respectively.

Net investment income for December 31, 2017 consisted of the following:

(in thousands)	Year Ended December 31 2017	2016
Bond income	**$ 1,629**	$ 1,427
Investment expenses	**(241)**	(929)
	$ 1,388	$ 498

Fair Value

Assets and liabilities carried at fair value are to be classified and disclosed in one of the following three categories:

Level 1: Quoted market prices in active markets for identical assets or liabilities that the Company has the ability to access.

Level 2: Observable market based inputs or unobservable inputs that are corroborated by market data such as quoted prices, interest rates, and yield curves.

Level 3: Inputs are unobservable data points that are not corroborated by market data.

The Company used the following methods and assumptions in estimating the fair value of financial instruments as well as the general classification of such financial instruments pursuant to the above fair value hierarchy:

Bonds

At each valuation date, the Company uses various valuation techniques to estimate the fair value of its bond portfolio. The primary method for valuing the Company's securities is through independent third-party valuation service providers. The evaluation and prioritization of these valuation sources is systematic and predetermined resulting in a single price for each financial

instrument. The following describes the techniques generally used to determine the fair value of the Company's bonds by asset class:

U.S. Treasury and Obligations of U.S. Government and Agencies

U.S. Treasury and obligations of U.S. government and agencies securities consist primarily of bonds issued by the U.S. Treasury and mortgage pass-through agencies such as the Federal Home Loan Bank, the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation. As the fair values of the Company's U.S. Treasury securities are based on unadjusted market prices, they are classified within Level 1. The fair value of U.S. government agency securities is generally determined using observable market inputs that include quoted prices for identical or similar assets in markets that are not active, benchmark yields, reported trades, bids, offers and credit spreads. Accordingly, the fair value of U.S. government agency securities is classified within Level 2.

Residential Mortgage-Backed Securities

The Company's portfolio of residential Mortgage-Backed Securities (MBS) are originated by both agencies and non-agencies, whose cash flows come from residential debt such as mortgages, home-equity loans and sub-prime mortgages. The fair value of MBS is generally determined using observable market inputs that include quoted prices for identical or similar assets in markets that are not active, benchmark yields, contractual cash flows, prepayment speeds, collateral performance and credit spreads. Accordingly, the fair value of MBS is primarily classified within Level 2.

Commercial Mortgage-Backed Securities

The Company's portfolio of commercial MBS are originated by both agencies and non-agencies, whose cash flows come from loans on commercial properties. The fair value of MBS is generally determined using observable market inputs that include quoted prices for identical or similar assets in markets that are not active, benchmark yields, contractual cash flows, prepayment speeds, collateral performance and credit spreads. Accordingly, the fair value of MBS is primarily classified within Level 2.

Asset-Backed Securities (ABS)

ABS include mostly investment-grade bonds backed by pools of loans, primarily automobile loan receivables, originated by a variety of financial institutions. The fair value of ABS is generally determined using observable market inputs that include quoted prices for identical or similar assets

in markets that are not active, benchmark yields, contractual cash flows, prepayment speeds, collateral performance and credit spreads. Accordingly, the fair value of ABS is primarily classified within Level 2.

Industrial and Miscellaneous

Industrial and miscellaneous securities consist primarily of investment-grade debt of a wide variety of corporate issuers and industries. The fair value of corporate and other securities is generally determined using observable market inputs that include quoted prices for identical or similar assets in markets that are not active, benchmark yields, new issuances, issuer ratings, reported trades of identical or comparable securities, bids, offers and credit spreads. Accordingly, the fair value of corporate and other securities is primarily classified within Level 2.

Fair Value Classification

(in thousands)	**Fair Value December 31, 2017**	**Quoted Prices in Active Markets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Assets				
Bonds	**$ 63,890**	**$ 17,710**	**$ 46,180**	**$ –**
Cash equivalents	**1,339**	**1,339**	**–**	**–**
Total assets	**$ 65,229**	**$ 19,049**	**$ 46,180**	**$ –**

(in thousands)	**Fair Value December 31, 2016**	**Quoted Prices in Active Markets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Assets				
Bonds	$ 59,418	$ 16,001	$ 43,417	$ –
Cash equivalents	2,831	2,831	–	–
Total assets	$ 62,249	$ 18,832	$ 43,417	$ –

At December 31, 2017 and 2016, cash equivalents measured at fair value of $1,339,000 and $2,831,000, respectively, are included in unrestricted cash, cash equivalents and short-term investments of $63,411,000 and $72,017,000, respectively, on the Statutory-Basis Statements of Admitted Assets, Liabilities, and Capital and Surplus. The cash equivalents consist of short-term money market holdings.

No transfers between levels of the fair value hierarchy occurred in 2017 and 2016. The Company recognizes transfers between levels of the fair value hierarchy on an annual basis at the end of the year.

7. Income Taxes

Components of deferred tax assets (DTAs) and deferred tax liabilities (DTLs) are as follows:

(in thousands)	2017	2016	Changes
Gross deferred tax assets	**$ 1,159**	$ 1,506	$ (347)
Statutory valuation allowance adjustment	–	–	–
Adjusted gross deferred tax assets	**1,159**	1,506	(347)
Deferred tax assets non-admitted	–	–	–
Subtotal net admitted deferred tax asset	**1,159**	1,506	(347)
Deferred tax liabilities	–	–	–
Net deferred tax assets	**$ 1,159**	$ 1,506	$ (347)

All the Company's deferred tax assets for the years ended December 31, 2017 and 2016, are ordinary in nature.

The admission calculation components are as follows:

(in thousands)	2017	2016	Changes
a. Federal income taxes paid in prior years recoverable through loss carrybacks	**$ 1,159**	$ 1,506	$ (347)
b. Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from (a) above) after application of the threshold limitation	–	–	–
i. Adjusted Gross Deferred Tax Assets Expected to be Realized Following the Balance Sheet Date	–	–	–
ii. Adjusted Gross Tax Assets Allowed per Limitation Threshold	**17,452**	18,585	(1,133)
c. Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from (a) and (b) above) offset by gross deferred tax liabilities	–	–	–
d. Deferred tax assets admitted as the result of application of SSAP 101.	–	–	–
Total (a) + (b) + (c)	**$ 1,159**	$ 1,506	$ (347)

Other admissibility criteria are as follows:

(in thousands, except percentages)	2017	2016
Ratio percentage used to determine recovery period and threshold limitation amount	**399%**	402%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b) above	**$ 116,347**	$ 123,899

The Company does not currently employ tax planning strategies to recognize the admission of deferred tax assets.

Current income taxes incurred consist of the following components:

(in thousands)	2017	2016
Current income tax expense	**$ 10,700**	$ 21,561
Federal income taxes incurred	**$ 10,700**	$ 21,561

There are no temporary differences for which a deferred tax liability has not been established.

The tax effects that give rise to significant portions of deferred tax assets are as follows:

(in thousands)	2017	2016	Changes
Deferred tax assets resulting from book/ tax differences in:			
Reserves	**$ 73**	$ 108	$ (35)
Unearned premium	**12**	–	12
Fixed asset basis	**46**	105	(59)
Premiums receivable	**957**	1,159	(202)
Reserve for Provider Receivable	**48**	94	(46)
Other deferred assets	**23**	40	(17)
Total net deferred tax assets	**$ 1,159**	$ 1,506	$ (347)
Non-admitted deferred tax assets	**$ –**	$ –	$ –

The tax effects that give rise to significant portions of deferred tax liabilities are as follows:

(in thousands)	2017	2016	Change
Deferred tax liabilities resulting from book/tax differences in:			
Surplus note	**$ –**	$ –	$ –
Total net deferred tax liabilities	**$ –**	$ –	$ –

The change in net deferred income taxes is comprised of the following:

(in thousands)	December 31 2017	2016	Change
Total gross deferred tax assets	**$ 1,159**	$ 1,506	$ (347)
Total gross deferred tax liabilities	–	–	–
Net deferred tax assets	**$ 1,159**	$ 1,506	$ (347)
Tax effect of unrealized capital gains			–
Change in net deferred income taxes			$ (347)

The Company's provision for federal income taxes differs from the federal statutory tax rate of 35% applied to net income before federal taxes as follows:

(in thousands)	
Provision computed at statutory rate	$ 10,578
Change in non-admitted assets	(320)
Change in effective tax rate effect	773
Amortization	16
Total	$ 11,047
Federal income taxes incurred	$ 10,700
Change in deferred income taxes	347
Total statutory income taxes	$ 11,047

The Company does not have any protective tax deposits under section 6603 of the Internal Revenue Code.

With the enactment of the Tax Cuts and Jobs Act (the "Act") on December 22, 2017, the Company has used the best available information in the recording of its tax provisions reflected in the 2017 financial statements. In 2018, the Company will adjust its provisional amounts as further regulatory and IRS guidance emerges. The revaluation of deferred tax assets and liabilities from 35% to 21% resulted in the following impacts: Change in Net Unrealized Capital Gains (Losses) less Capital Gains Tax, $0, Change in Net Deferred Income Tax, $773,000, and Change in nonadmitted, ($320,000).

The Company is included in a federal consolidated tax return and files a separate Georgia tax return. The Company does not have net operating loss carryforwards as of December 31, 2017. The members of the DentaQuest federal consolidated income tax return consisted of: DentaQuest Group, Inc., DentaQuest Management, Inc., DQ Massachusetts Business Trust, Pacific Dental Network, Inc., California Dental Network, Inc., DentaQuest of Florida, Inc., DSM USA Insurance Company, Inc. and the Company.

Below is a table of the earliest tax years that remain subject to examination by major jurisdictions:

Jurisdiction	Earliest Tax Year Subject to Examination
U.S. Federal	2014
Georgia	2014

All years including and subsequent to the above years remain open to examination by the taxing authorities. The amount of federal income taxes incurred and available for recoupment in the event of future net losses is $10,700,000 and $21,561,000 at December 31, 2017 and 2016, respectively.

8. Uninsured Plans

The gain from Administrative Services Only (ASO) uninsured plans was as follows:

(in thousands)	Year Ended December 31 2017	2016
Net reimbursement for administrative expenses (including in excess of actual expenses)	**$ 21,751**	$ 19,462
Total net other expenses (including interest paid or received from plans)	**(23,584)**	(21,065)
Net (loss) gain from operations	**(1,833)**	(1,603)
Total claim payment volume	**$ 504,107**	$ 506,646

9. Related-Party Transactions

During 2017 and 2016, the allocated costs from DQ LLC amounted to $68,131,000 and $71,333,000, respectively. These costs were for information technology, facilities and equipment, human resources services, executive and managerial support, legal services, regulatory filing and compliance services, accounting services, cash management services, actuarial and underwriting services, sales and marketing services, enrollment services, claims processing services, billing and collection services, customer services, provider relations and credentialing services, and other additional services provided by DQ LLC to the Company. As of December 31, 2017 and 2016, the Company had an amount due to DQ LLC of $6,013,000 and $4,841,000, respectively.

As a result of the significant related party transactions, the Company's financial condition and results from operations may not necessarily be indicative of the financial condition or results from operations that would have occurred if the Company had been operating on a standalone basis.

10. Restricted Cash and Securities on Deposit

On February 2, 2007, DQ LLC (formerly co-borrower with DQV and DentaQuest, as Parent Guarantor) entered into a Credit Agreement with a group of lenders for a $200,000,000 revolving line of credit to meet the capital needs of the DentaQuest companies. DQ LLC, together with all of the subsidiaries of DentaQuest, including the Company, also entered into a Guarantee and Collateral Agreement (together with the Credit Agreement, the Credit Facility).

On June 24, 2014, DQ, LLC entered into an amendment to the Credit Agreement that extended the maturity date to the earlier of June 24, 2019, or the date DQ LLC terminates the Credit Agreement with appropriate notice and repayment.

Under the laws of the State of Texas, the Company is required to maintain a minimum surplus of $1,400,000. As of December 31, 2017, the Company maintained a restricted account balance of $12,433,000 with the Texas Comptroller.

The Company also has two other restricted deposits. One deposit is with the State of Georgia Office of Commissioner of Insurance in the approximate amount of $100,000 in relation to the Company's extended license in the State of Georgia. The other deposit is maintained by the Commonwealth of Massachusetts, Department of State Treasurer in the approximate amount of $101,000 in relation to the Company's extended license in the Commonwealth of Massachusetts.

11. Capital and Surplus

The Company is required to file financial statements with the Texas Department of Insurance (TDI). Under the laws of the State of Texas, the Company is required to maintain a minimum surplus of $1,400,000. The Company met the required minimum capital and surplus requirements. Regulatory limits restrict dividends without approval of state insurance regulators.

In connection with discussions with the TDI regarding the pledging of the Company's stock in relation to an affiliated credit facility, on May 18, 2010, the Company issued a 3.25% $4,000,000 surplus debenture note to Dental Service of Massachusetts, Inc. This note was approved by the Commissioner of Insurance of Texas pursuant to Sections 427.053 and 823.102 of the Texas Insurance Code. The note was amended in 2015, to change the maturity date. The amended note matured on December 31, 2016. Interest accruing on this note must be approved by TDI prior to being released. The Company paid the principal and interest on November 18, 2016 in the amount of $4,847,000. On March 8, 2016, the Company paid $18,200,000 of dividends to its sole stockholder, DentaQuest, LLC and on March 10, 2017, the Company paid $26,000,000 to DentaQuest, LLC.

12. Legal Proceedings

In the normal course of business, the Company is subject to various contingencies such as market conduct examinations, guaranty fund assessments and legal matters. Management does not anticipate any significant unaccrued claims or costs to result from any known or existing contingencies as of December 31, 2017 and 2016.

13. Subsequent Events

The Company's management evaluated subsequent events through May 31, 2018, which is the date statutory-basis financial statements were available to be issued.

On January 1, 2018, the Company will be subject to an annual fee under Section 9010 of the Federal Affordable Care Act (ACA). This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2017, the Company has written health insurance subject to the ACA assessment and expects to conduct health insurance business in 2018. As of December 31, 2017, the Company has written health insurance subject to the ACA

assessment, expects to conduct health insurance business in 2018, and estimates its portion of the annual health insurance industry fee to be payable on September 30, 2018 to be $14,666,000. This amount is reflected in special surplus. The impact on risk based capital (RBC) to be 50%. Reporting the ACA assessment as of December 31, 2017, would not have triggered an RBC action level.

(in thousands)	**2017**	**2016**
ACA fee assessment payable for upcoming year	**$ 14,666**	$ –
ACA fee assessment paid	**–**	13,019
Premium written subject to ACA 9010 assessment	**803,067**	801,956
Total Adjusted Capital before surplus adjustment	**117,506**	125,404
Authorized Control Level before surplus adjustment	**29,174**	30,824
Total Adjusted Capital after surplus adjustment	**102,840**	125,404
Authorized Control Level after surplus adjustment	**29,174**	30,824
Would reporting the ACA assessment as of December 31, 2017, have triggered an RBC action level?	**No**	No

Supplementary Information

1802-2586125

Ernst & Young LLP
200 Clarendon Street
Boston, MA 02116

Tel: +1 617 266 2000
Fax: +1 617 266 5843
ey.com

Building a better working world

Report of Independent Auditors on Supplementary Information

The Board of Directors of DentaQuest USA Insurance Company, Inc.

Our audits were conducted for the purpose of forming an opinion on the statutory-basis financial statements as a whole. The accompanying supplemental investment disclosures are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

This report is intended solely for the information and use of the Company and state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

May 31, 2018

DentaQuest USA Insurance Company, Inc.

Supplementary Schedule of Investment Risk Interrogatories

December 31, 2017

1. The Company's total admitted assets as reported on Page 2 of its Annual Statement is $171,118,000.

2. Following are the ten largest exposures to a single issuer/borrower/investment, excluding: (i) U.S. government, U.S. government agency securities and those U.S. government money market funds listed in the Appendix to the *SVO Practices and Procedures Manual* as exempt, (ii) property occupied by the Company and (iii) policy loans:

Issuer	Description of Exposure	Amount	Percentage of Total Admitted Assets
UBS COML MTG TR 2012-C1	Bond	$ 466,183	0.272%
COMM MTG TR 2012-CCRE2	Bond	440,698	0.258%
GS MTG SECS TR 2012-GCJ7	Bond	439,615	0.257%
FORD CREDIT FLRPLN TR A 2016-5	Bond	430,952	0.252%
FHLMC PC GOLD PC 30YR 3.500 20471	Bond	408,395	0.239%
GS MTG COML 2010-C1	Bond	380,606	0.222%
CITIBANK NA N Y	Bond	374,813	0.219%
INVITATION HOMES TR 2015-SFR3	Bond	363,536	0.212%
FNMA PASS-THRU LNG 30 YEAR	Bond	347,927	0.203%
COMCAST CORP NEW 4.049%52	Bond	334,098	0.195%

3. The Company's total admitted assets held in bonds and preferred stock by NAIC rating are:

Bonds and Short-Term Investments

NAIC Rating	Amount	Percentage of Total Admitted Assets
NAIC-1	$ 57,152,220	33.39%
NAIC-2	6,495,146	3.79%
NAIC-3	102,087	0.06%
NAIC-4	–	0.00%
NAIC-5	–	0.00%
NAIC-6	–	0.00%
	$ 63,749,453	

4. The Company has no assets held in foreign investments greater than 2.5% of the reporting entity's total admitted assets.

5. The Company has no aggregate foreign investment exposure categories by NAIC sovereign rating greater than 2.5% of reporting entity's total admitted assets.

6. The Company has no foreign investment exposures in a single country, categories by the country's NAIC sovereign rating greater than 2.5% of reporting entity's total admitted assets.

7. The Company has no unhedged foreign currency exposure.

8. The Company has no aggregate unhedged foreign currency exposure.

9. The Company has no unhedged foreign currency exposures to a single country.

10. The Company has no non-sovereign (i.e., non-governmental) foreign issues greater than 2.5% of total admitted assets.

11. The Company has no assets held in Canadian investments that are greater than 2.5% of the reporting entity's total admitted assets.

12. The Company has no admitted assets held in investments with contractual sales restrictions.

13. The Company has no investments in equity interests.

14. The Company has no assets held in nonaffiliated, privately placed equities that are greater than 2.5% of the reporting entity's total admitted assets.

15. The Company has no assets held in general partnership interests that are greater than 2.5% of the reporting entity's total admitted assets.

16. The Company has no mortgage loans greater than 2.5% of the reporting entity's total admitted assets.

17. The Company has no aggregate mortgage loans that are greater than 2.5% of the reporting entity's total admitted assets.

18. The Company has no assets held in real estate reported that are greater than 2.5% of the reporting entity's total admitted assets, excluding home office properties.

19. The Company has no assets held in investments held in mezzanine real estate loans greater than 2.5% of the reporting entity's total admitted assets.

20. The Company had no assets subject to security lending agreements, repurchase agreements, reverse repurchase agreements, dollar repurchase agreements, or dollar reverse repurchase agreements during 2017.

21. The Company had no warrants not attached to other financial instruments, options, caps, and floors during 2017.

22. The Company had no potential exposure for collars, swaps, and forwards during 2017.

23. The Company had no potential exposure for future contracts during 2017.

DentaQuest USA Insurance Company, Inc.

Summary Investment Schedule

December 31, 2017

Investment Categories	Gross Investment Holdings* Amount	Gross Investment Holdings* Percentage of Total Invested Assets	Admitted Invested Assets as Reported in the Annual Statement Amount	Admitted Invested Assets as Reported in the Annual Statement Percentage of Total Invested Assets
Bonds:				
U.S. Treasury securities	$ 13,113,543	8.77%	$ 13,113,543	8.95%
U.S. government agency obligations (excluding mortgage-backed securities):				
Issued by U.S. government agencies	144,651	0.10	144,651	0.10
Issued by U.S. government sponsored agencies	–	0.00	–	0.00
Securities issued by states, territories, and possessions and political subdivisions in the U.S.:				
States, territories and possessions general obligations	165,162	0.11	165,162	0.11
Political subdivisions of states, territories and possessions and political subdivisions general obligations	179,725	0.12	179,725	0.12
Revenue and assessment obligations	4,185,691	2.80	4,185,691	2.86
Mortgage-backed securities(includes residential and commercial MBS):				
Pass- through securities:				
Issued or guaranteed by GNMA	772,267	0.52	772,267	0.53
Issued or guaranteed by FNMA and FHLMC	9,396,437	6.28	9,396,437	6.41
CMOs and REMICs:				
Issued or guaranteed by GNMA, FNMA, FHLMC or VA	8,682,325	5.80	8,682,325	5.92
Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies	666,347	0.45	666,347	0.45
All other	7,375,313	4.93	7,375,313	5.03

DentaQuest USA Insurance Company, Inc.

Supplementary Schedule of Investment Risk Interrogatories (continued)

Investment Categories	Gross Investment Holdings* Amount	Gross Investment Holdings* Percentage of Total Invested Assets	Admitted Invested Assets as Reported in the Annual Statement Amount	Admitted Invested Assets as Reported in the Annual Statement Percentage of Total Invested Assets
Other debt and other fixed income securities (excluding short-term):				
Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	$ 18,899,967	12.64%	$ 18,899,967	12.90%
Unaffiliated Non-U.S. securities (including Canada)	167,993	0.11	167,993	0.11
Affiliated securities	–	0.00	–	0.00
Other equity securities:				
Affiliated	9,777,312	6.54	6,768,052	4.62
Unaffiliated	–	0.00	–	0.00
Contract loans	–	0.00	–	0.00
Receivables for securities	–	0.00	–	0.00
Cash, cash equivalents, and short-term investments	76,044,537	50.83	76,044,537	51.89
Total invested assets	$ 149,571,270	100.00%	$ 146,562,070	100.00%

*Gross investment holdings as valued in compliance with the NAIC's *Accounting Practices and Procedures Manual.*

DentaQuest USA Insurance Company, Inc.

Note to Supplementary Information

December 31, 2017

The accompanying supplemental schedules present selected statutory-basis financial data as of December 31, 2017, and for the year then ended for purposes of complying with the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and agrees to or is included in the amounts reported in the Company's Statutory Annual Statement as filed with the State of Texas Department of Insurance.

EY | Assurance | Tax | Transactions | Advisory

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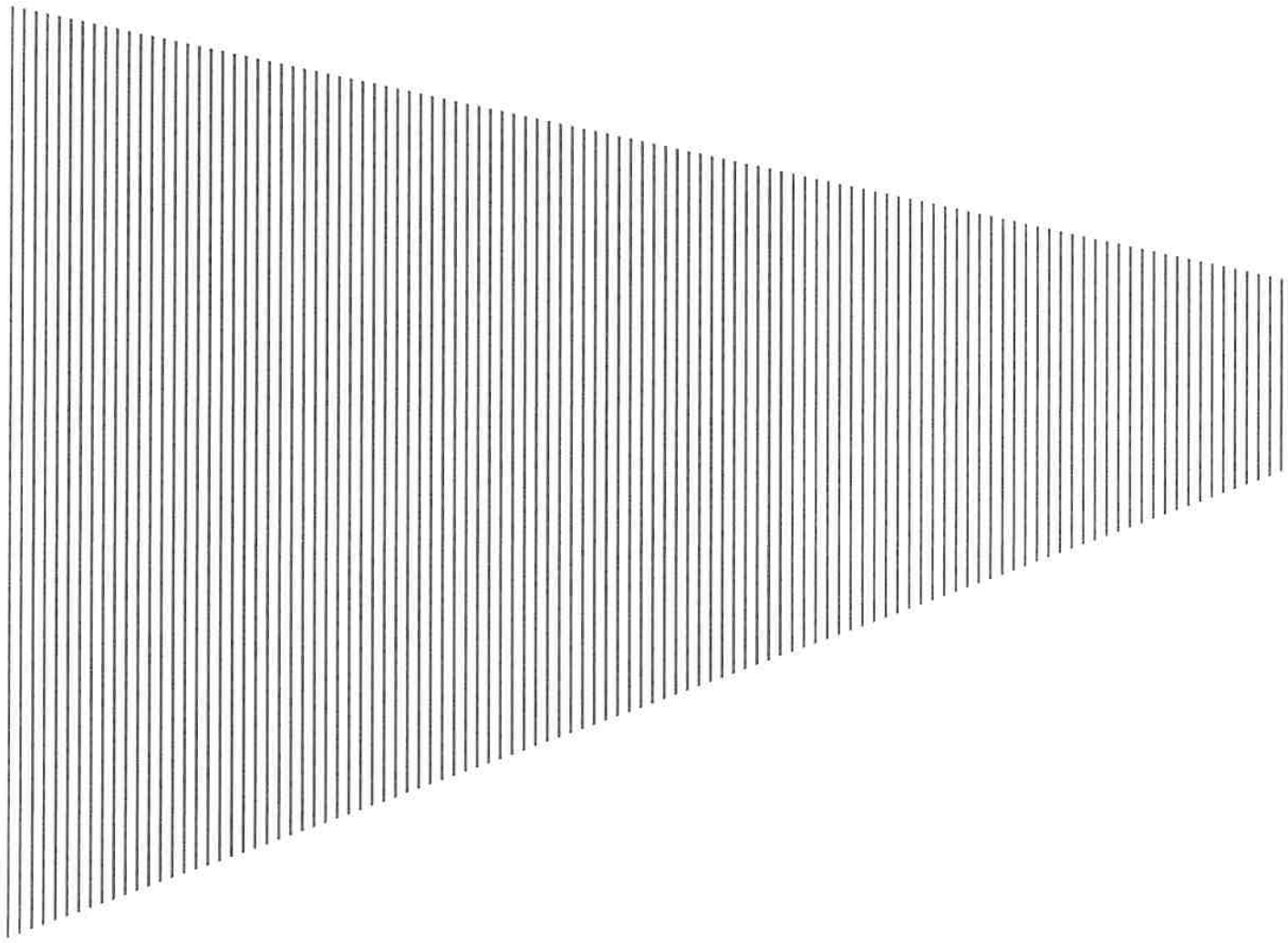


ANNUAL STATEMENT

OF THE

DentaQuest USA Insurance Company, Inc.

of

Austin

in the state of

Texas

2018

TO THE

Insurance Department

OF THE STATE OF

Texas

For the Year Ending
DECEMBER 31, 2018

HEALTH

2018

12307201820100100 2018 Document Code: 201

ANNUAL STATEMENT

For the Year Ending DECEMBER 31, 2018

OF THE CONDITION AND AFFAIRS OF THE

DentaQuest USA Insurance Company, Inc.

NAIC Group Code 4512 (Current Period), 4512 (Prior Period) NAIC Company Code 12307 Employer's ID Number 20-2970185

Organized under the Laws of Texas, State of Domicile or Port of Entry TX

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health[X] Property/Casualty[ ] Hospital, Medical & Dental Service or Indemnity[ ]
Dental Service Corporation[ ] Vision Service Corporation[ ] Health Maintenance Organization[ ]
Other[ ] Is HMO Federally Qualified? Yes[ ] No[ ] N/A[X]

Incorporated/Organized 08/26/2005 Commenced Business 03/20/2008

Statutory Home Office 11044 Research Boulevard, Building D, Suite D-400 (Street and Number), Austin, TX, US 78759 (City or Town, State, Country and Zip Code)

Main Administrative Office 465 Medford Street (Street and Number)
Boston, MA, US 02129 (City or Town, State, Country and Zip Code) (617)886-1818 (Area Code) (Telephone Number)

Mail Address 465 Medford Street (Street and Number or P.O. Box), Boston, MA, US 02129 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 465 Medford Street (Street and Number)
Boston, MA, US 02129 (City or Town, State, Country and Zip Code) (617)886-1818 (Area Code) (Telephone Number)

Internet Website Address www.dentaquestgov.com

Statutory Statement Contact Michael Kelly (Name) (617)886-1332 (Area Code)(Telephone Number)(Extension)
michael.kelly@dentaquest.com (E-Mail Address) (617)886-1771 (Fax Number)

OFFICERS

Name	Title
Steven J. Pollock	President
James P. Hawkins	Secretary
Jeffrey C. Brown	Treasurer
Gregory P. Winn	Assistant Treasurer

OTHERS

DIRECTORS OR TRUSTEES

Steven J. Pollock
Brett A. Bostrack
David Abelman
Alan L. Madison
James P. Hawkins

State of Massachusetts
County of Suffolk ss

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of the said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

(Signature)	(Signature)	(Signature)
Steven J. Pollock	James P. Hawkins	Jeffrey C. Brown
(Printed Name)	(Printed Name)	(Printed Name)
1.	2.	3.
President	Secretary	Treasurer
(Title)	(Title)	(Title)

Subscribed and sworn to before me this 20th day of February, 2019

(Notary Public Signature)

a. Is this an original filing? Yes[X] No[ ]
b. If no, 1. State the amendment number
2. Date filed
3. Number of pages attached

ANNE D. BOROCOV
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
January 30, 2026

ASSETS

		Current Year			Prior Year
		1	2	3	4
		Assets	Nonadmitted Assets	Net Admitted Assets (Cols.1-2)	Net Admitted Assets
1.	Bonds (Schedule D)	54,056,501		54,056,501	63,749,421
2.	Stocks (Schedule D):				
	2.1 Preferred stocks				
	2.2 Common Stocks				
3.	Mortgage loans on real estate (Schedule B):				
	3.1 First liens				
	3.2 Other than first liens				
4.	Real estate (Schedule A):				
	4.1 Properties occupied by the company (less $.....0 encumbrances)				
	4.2 Properties held for the production of income (less $.....0 encumbrances)				
	4.3 Properties held for sale (less $.....0 encumbrances)				
5.	Cash ($.....60,061,010, Schedule E Part 1), cash equivalents ($.....1,557,937, Schedule E Part 2) and short-term investments ($.....110,356, Schedule DA)	61,729,303		61,729,303	76,044,537
6.	Contract loans (including $.....0 premium notes)				
7.	Derivatives (Schedule DB)				
8.	Other invested assets (Schedule BA)				
9.	Receivables for securities				
10.	Securities Lending Reinvested Collateral Assets (Schedule DL)				
11.	Aggregate write-ins for invested assets	12,172,661	3,009,260	9,163,401	6,768,052
12.	Subtotals, cash and invested assets (Lines 1 to 11)	127,958,465	3,009,260	124,949,205	146,562,010
13.	Title plants less $.....0 charged off (for Title insurers only)				
14.	Investment income due and accrued	366,685		366,685	402,769
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection	6,260,172	3,076,864	3,183,308	9,723,678
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (Including $.....0 earned but unbilled premiums)				
	15.3 Accrued retrospective premiums ($.....0) and contracts subject to redetermination ($.....0)				
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers				
	16.2 Funds held by or deposited with reinsured companies				
	16.3 Other amounts receivable under reinsurance contracts				
17.	Amounts receivable relating to uninsured plans	5,491,865	281,412	5,210,453	10,076,639
18.1	Current federal and foreign income tax recoverable and interest thereon	1,049,912		1,049,912	63,639
18.2	Net deferred tax asset	907,359		907,359	1,158,778
19.	Guaranty funds receivable or on deposit				
20.	Electronic data processing equipment and software	134,046	134,046		64,538
21.	Furniture and equipment, including health care delivery assets ($.....0)	111,625	111,625		
22.	Net adjustment in assets and liabilities due to foreign exchange rates				
23.	Receivables from parent, subsidiaries and affiliates				
24.	Health care ($.....0) and other amounts receivable				
25.	Aggregate write-ins for other than invested assets	23,516,972	111,071	23,405,901	3,129,837
26.	TOTAL assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	165,797,101	6,724,278	159,072,823	171,181,888
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28.	TOTAL (Lines 26 and 27)	165,797,101	6,724,278	159,072,823	171,181,888
DETAILS OF WRITE-INS					
1101.	Investment in DSM USA Insurance Co- Licenses Intangible	3,009,260	3,009,260		
1102.	Investment in DSM USA Insurance Company, Inc.	8,950,076		8,950,076	6,509,816
1103.	Investment in DSM USA Insurance Co - Goodwill	213,325		213,325	258,236
1198.	Summary of remaining write-ins for Line 11 from overflow page				
1199.	TOTALS (Lines 1101 through 1103 plus 1198) (Line 11 above)	12,172,661	3,009,260	9,163,401	6,768,052
2501.	PREPAID SECURITY DEPOSIT		111,071	(111,071)	0
2502.	Health Care Reform Assessment Recoverable	19,600,266		19,600,266	
2503.	Prepaid Premium Tax	3,805,635		3,805,635	3,129,837
2598.	Summary of remaining write-ins for Line 25 from overflow page	111,071		111,071	
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)	23,516,972	111,071	23,405,901	3,129,837

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $.....0 reinsurance ceded)	25,313,198		25,313,198	35,878,958
2.	Accrued medical incentive pool and bonus amounts	1,085,591		1,085,591	4,208,522
3.	Unpaid claims adjustment expenses	759,000		759,000	683,999
4.	Aggregate health policy reserves, including the liability of $.....7,791,313 for medical loss ratio rebate per the Public Health Service Act	7,791,313		7,791,313	3,664,645
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	4,764,426		4,764,426	290,822
9.	General expenses due or accrued	35,459		35,459	255,226
10.1	Current federal and foreign income tax payable and interest thereon (including $.....0 on realized capital gains (losses))				
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others				
13.	Remittances and items not allocated				
14.	Borrowed money (including $.....0 current) and interest thereon $.....0 (including $.....0 current)				
15.	Amounts due to parent, subsidiaries and affiliates	9,141,149		9,141,149	7,824,054
16.	Derivatives				
17.	Payable for securities				869,440
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $.....0 authorized reinsurers, $.....0 unauthorized reinsurers and $.....0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified ($.....0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans				
23.	Aggregate write-ins for other liabilities (including $.....0 current)				
24.	TOTAL Liabilities (Lines 1 to 23)	48,890,136		48,890,136	53,675,666
25.	Aggregate write-ins for special surplus funds	XXX	XXX		14,666,000
26.	Common capital stock	XXX	XXX	2,002,000	2,002,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	24,516,291	24,516,291
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	83,664,396	76,321,931
32.	Less treasury stock, at cost:				
	32.1 .....0 shares common (value included in Line 26 $.....0)	XXX	XXX		
	32.2 .....0 shares preferred (value included in Line 27 $.....0)	XXX	XXX		
33.	TOTAL Capital and Surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	110,182,687	117,506,222
34.	TOTAL Liabilities, Capital and Surplus (Lines 24 and 33)	XXX	XXX	159,072,823	171,181,888
DETAILS OF WRITE-INS					
2301.					
2302.					
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	TOTALS (Lines 2301 through 2303 plus 2398) (Line 23 above)				
2501.	2018 Health Care Reform Assessment	XXX	XXX		14,666,000
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		14,666,000
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	TOTALS (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

STATEMENT OF REVENUE AND EXPENSES

		Current Year		Prior Year
		1 Uncovered	2 Total	3 Total
1.	Member Months	XXX	23,625,408	24,050,937
2.	Net premium income (including $.....0 non-health premium income)	XXX	768,963,667	803,066,544
3.	Change in unearned premium reserves and reserve for rate credits	XXX		
4.	Fee-for-service (net of $.....0 medical expenses)	XXX		
5.	Risk revenue	XXX	52,492,721	49,464,201
6.	Aggregate write-ins for other health care related revenues	XXX		
7.	Aggregate write-ins for other non-health revenues	XXX		
8.	TOTAL Revenues (Lines 2 to 7)	XXX	821,456,388	852,530,745
Hospital and Medical:				
9.	Hospital/medical benefits			
10.	Other professional services		741,969,381	755,792,141
11.	Outside referrals			
12.	Emergency room and out-of-area			
13.	Prescription drugs			
14.	Aggregate write-ins for other hospital and medical			
15.	Incentive pool, withhold adjustments and bonus amounts		791,757	6,404,002
16.	Subtotal (Lines 9 to 15)		742,761,138	762,196,143
Less:				
17.	Net reinsurance recoveries			
18.	TOTAL Hospital and Medical (Lines 16 minus 17)		742,761,138	762,196,143
19.	Non-health claims (net)			
20.	Claims adjustment expenses, including $.....642,317 cost containment expenses		11,561,692	11,073,839
21.	General administrative expenses		52,669,929	50,447,488
22.	Increase in reserves for life and accident and health contracts (including $.....0 increase in reserves for life only)			
23.	TOTAL Underwriting Deductions (Lines 18 through 22)		806,992,759	823,717,470
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	14,463,629	28,813,275
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		1,596,710	1,388,242
26.	Net realized capital gains (losses) less capital gains tax of $.....0		(909,476)	21,634
27.	Net investment gains (losses) (Lines 25 plus 26)		687,234	1,409,876
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $.....0) (amount charged off $.....0)]			
29.	Aggregate write-ins for other income or expenses			
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	15,150,863	30,223,151
31.	Federal and foreign income taxes incurred	XXX	6,493,266	10,700,059
32.	Net income (loss) (Lines 30 minus 31)	XXX	8,657,597	19,523,092
DETAILS OF WRITE-INS				
0601.		XXX		
0602.		XXX		
0603.		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX		
0699.	TOTALS (Lines 0601 through 0603 plus 0698) (Line 6 above)	XXX		
0701.		XXX		
0702.		XXX		
0703.		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX		
0799.	TOTALS (Line 0701 through 0703 plus 0798) (Line 7 above)	XXX		
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page			
1499.	TOTALS (Lines 1401 through 1403 plus 1498) (Line 14 above)			
2901.				
2902.				
2903.				
2998.	Summary of remaining write-ins for Line 29 from overflow page			
2999.	TOTALS (Line 2901 through 2903 plus 2998) (Line 29 above)			

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL & SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	117,506,222	125,403,986
34.	Net income or (loss) from Line 32	8,657,597	19,523,092
35.	Change in valuation basis of aggregate policy and claim reserves		
36.	Change in net unrealized capital gains (losses) less capital gains tax of $.....0	2,443,221	(160,679)
37.	Change in net unrealized foreign exchange capital gain or (loss)		
38.	Change in net deferred income tax	(251,419)	(346,519)
39.	Change in nonadmitted assets	1,335,159	(913,658)
40.	Change in unauthorized and certified reinsurance		
41.	Change in treasury stock		
42.	Change in surplus notes		
43.	Cumulative effect of changes in accounting principles		
44.	Capital Changes:		
	44.1 Paid in		
	44.2 Transferred from surplus (Stock Dividend)		
	44.3 Transferred to surplus		
45.	Surplus adjustments:		
	45.1 Paid in		0
	45.2 Transferred to capital (Stock Dividend)		
	45.3 Transferred from capital		
46.	Dividends to stockholders	(19,500,000)	(26,000,000)
47.	Aggregate write-ins for gains or (losses) in surplus		
48.	Net change in capital and surplus (Lines 34 to 47)	(7,315,442)	(7,897,764)
49.	Capital and surplus end of reporting year (Line 33 plus 48)	110,190,780	117,506,222
DETAILS OF WRITE-INS			
4701.			
4702.			
4703.			
4798.	Summary of remaining write-ins for Line 47 from overflow page		
4799.	TOTALS (Lines 4701 through 4703 plus 4798) (Line 47 above)		

CASH FLOW

		1 Current Year	2 Prior Year
	Cash from Operations		
1.	Premiums collected net of reinsurance	785,126,639	793,855,757
2.	Net investment income	1,962,040	1,838,402
3.	Miscellaneous income	52,492,721	49,464,201
4.	TOTAL (Lines 1 through 3)	839,581,400	845,158,359
5.	Benefit and loss related payments	756,449,829	765,343,041
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7.	Commissions, expenses paid and aggregate write-ins for deductions	59,338,310	65,093,288
8.	Dividends paid to policyholders		
9.	Federal and foreign income taxes paid (recovered) net of $.....0 tax on capital gains (losses)	7,479,539	14,364,584
10.	TOTAL (Lines 5 through 9)	823,267,678	844,800,913
11.	Net cash from operations (Line 4 minus Line 10)	16,313,722	357,446
	Cash from Investments		
12.	Proceeds from investments sold, matured or repaid:		
	12.1 Bonds	25,478,447	24,363,154
	12.2 Stocks		
	12.3 Mortgage loans		
	12.4 Real estate		
	12.5 Other invested assets		
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments		
	12.7 Miscellaneous proceeds	465,490	424,801
	12.8 TOTAL Investment proceeds (Lines 12.1 to 12.7)	25,943,937	24,787,955
13.	Cost of investments acquired (long-term only):		
	13.1 Bonds	17,019,323	28,592,856
	13.2 Stocks		
	13.3 Mortgage loans		
	13.4 Real estate		
	13.5 Other invested assets		
	13.6 Miscellaneous applications	1,300,076	(504,526)
	13.7 TOTAL Investments acquired (Lines 13.1 to 13.6)	18,319,399	28,088,331
14.	Net increase (decrease) in contract loans and premium notes		
15.	Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	7,624,537	(3,300,375)
	Cash from Financing and Miscellaneous Sources		
16.	Cash provided (applied):		
	16.1 Surplus notes, capital notes		
	16.2 Capital and paid in surplus, less treasury stock		0
	16.3 Borrowed funds		
	16.4 Net deposits on deposit-type contracts and other insurance liabilities		
	16.5 Dividends to stockholders	19,500,000	26,000,000
	16.6 Other cash provided (applied)	(18,753,493)	20,332,894
17.	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(38,253,493)	(5,667,105)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	(14,315,234)	(8,610,035)
19.	Cash, cash equivalents and short-term investments:		
	19.1 Beginning of year	76,044,537	84,654,572
	19.2 End of year (Line 18 plus Line 19.1)	61,729,303	76,044,537

Note: Supplemental Disclosures of Cash Flow Information for Non-Cash Transactions:

20.0001			

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

		1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1.	Net premium income	768,963,667			768,963,667						
2.	Change in unearned premium reserves and reserve for rate credit										
3.	Fee-for-service (net of $.....0 medical expenses)										XXX
4.	Risk revenue	52,492,721			52,492,721						XXX
5.	Aggregate write-ins for other health care related revenues										XXX
6.	Aggregate write-ins for other non-health care related revenues		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
7.	TOTAL Revenues (Lines 1 to 6)	821,456,388			821,456,388						
8.	Hospital/medical benefits										XXX
9.	Other professional services	741,969,381			741,969,381						XXX
10.	Outside referrals										XXX
11.	Emergency room and out-of-area										XXX
12.	Prescription drugs										XXX
13.	Aggregate write-ins for other hospital and medical										XXX
14.	Incentive pool, withhold adjustments and bonus amounts	791,757			791,757						XXX
15.	Subtotal (Lines 8 to 14)	742,761,138			742,761,138						XXX
16.	Net reinsurance recoveries										XXX
17.	TOTAL Hospital and Medical (Lines 15 minus 16)	742,761,138			742,761,138						XXX
18.	Non-health claims (net)		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19.	Claims adjustment expenses including $.....642,317 cost containment expenses	11,561,692			11,561,692						
20.	General administrative expenses	52,669,929			52,669,929						
21.	Increase in reserves for accident and health contracts										XXX
22.	Increase in reserves for life contracts		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23.	TOTAL Underwriting Deductions (Lines 17 to 22)	806,992,759			806,992,759						
24.	Net underwriting gain or (loss) (Line 7 minus Line 23)	14,463,629			14,463,629						
DETAILS OF WRITE-INS											
0501.											XXX
0502.											XXX
0503.											XXX
0598.	Summary of remaining write-ins for Line 5 from overflow page										XXX
0599.	TOTALS (Lines 0501 through 0503 plus 0598) (Line 5 above)										XXX
0601.			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698.	Summary of remaining write-ins for Line 6 from overflow page		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0699.	TOTALS (Lines 0601 through 0603 plus 0698) (Line 6 above)		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
1301.											XXX
1302.											XXX
1303.											XXX
1398.	Summary of remaining write-ins for Line 13 from overflow page										XXX
1399.	TOTALS (Lines 1301 through 1303 plus 1398) (Line 13 above)										XXX

UNDERWRITING AND INVESTMENT EXHIBIT

PART 1 - PREMIUMS

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Columns 1 + 2 - 3)
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only	768,963,667			768,963,667
4. Vision only				
5. Federal Employees Health Benefits Plan				
6. Title XVIII - Medicare				
7. Title XIX - Medicaid				
8. Other health				
9. Health subtotal (Lines 1 through 8)	768,963,667			768,963,667
10. Life				
11. Property/casualty				
12. TOTALS (Lines 9 to 11)	768,963,667			768,963,667

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 - CLAIMS INCURRED DURING THE YEAR

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Payments during the year:										
1.1 Direct	750,331,587			747,400,136	2,931,451					
1.2 Reinsurance assumed										
1.3 Reinsurance ceded										
1.4 Net	750,331,587			747,400,136	2,931,451					
2. Paid medical incentive pools and bonuses	3,914,688			3,914,688						
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	25,313,198			25,164,198	149,000					
3.2 Reinsurance assumed										
3.3 Reinsurance ceded										
3.4 Net	25,313,198			25,164,198	149,000					
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct										
4.2 Reinsurance assumed										
4.3 Reinsurance ceded										
4.4 Net										
5. Accrued medical incentive pools and bonuses, current year	1,085,591			1,085,591						
6. Net healthcare receivables (a)										
7. Amounts recoverable from reinsurers December 31, current year										
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	35,878,958			35,878,958						
8.2 Reinsurance assumed										
8.3 Reinsurance ceded										
8.4 Net	35,878,958			35,878,958						
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct										
9.2 Reinsurance assumed										
9.3 Reinsurance ceded										
9.4 Net										
10. Accrued medical incentive pools and bonuses, prior year	4,208,522			4,208,522						
11. Amounts recoverable from reinsurers December 31, prior year										
12. Incurred benefits:										
12.1 Direct	739,765,827			736,685,376	3,080,451					
12.2 Reinsurance assumed										
12.3 Reinsurance ceded										
12.4 Net	739,765,827			736,685,376	3,080,451					
13. Incurred medical incentive pools and bonuses	791,757			791,757						

(a) Excludes $.....0 loans or advances to providers not yet expensed.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A - CLAIMS LIABILITY END OF CURRENT YEAR

	1 Total	2 Compre-hensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Reported in Process of Adjustment:										
1.1 Direct	4,208,522			4,208,522						
1.2 Reinsurance assumed										
1.3 Reinsurance ceded										
1.4 Net	4,208,522			4,208,522						
2. Incurred but Unreported:										
2.1 Direct										
2.2 Reinsurance assumed										
2.3 Reinsurance ceded										
2.4 Net										
3. Amounts Withheld from Paid Claims and Capitations:										
3.1 Direct	21,104,676			20,955,676	149,000					
3.2 Reinsurance assumed										
3.3 Reinsurance ceded										
3.4 Net	21,104,676			20,955,676	149,000					
4. TOTALS										
4.1 Direct	25,313,198			25,164,198	149,000					
4.2 Reinsurance assumed										
4.3 Reinsurance ceded										
4.4 Net	25,313,198			25,164,198	149,000					

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2B - ANALYSIS OF CLAIMS UNPAID-PRIOR YEAR-NET OF REINSURANCE

Line of Business		Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5	6
		1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1.	Comprehensive (hospital and medical)						
2.	Medicare Supplement						
3.	Dental only	31,476,712	715,923,424	3,822	25,160,376	31,480,534	35,878,958
4.	Vision only		2,931,451		149,000		
5.	Federal Employees Health Benefits Plan						
6.	Title XVIII - Medicare						
7.	Title XIX - Medicaid						
8.	Other health						
9.	Health subtotal (Lines 1 to 8)	31,476,712	718,854,875	3,822	25,309,376	31,480,534	35,878,958
10.	Healthcare receivables (a)						
11.	Other non-health						
12.	Medical incentive pool and bonus amounts	2,199,066	1,715,622		1,085,591	2,199,066	
13.	TOTALS (Lines 9 - 10 + 11 + 12)	33,675,778	720,570,497	3,822	26,394,967	33,679,600	35,878,958

(a) Excludes $.....0 loans or advances to providers not yet expensed.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS ($000 Omitted)

Grand Total

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	631,169	631,169	631,169	631,169	631,169
2. 2014	695,484	724,641	724,641	724,641	724,641
3. 2015	XXX	761,161	795,938	795,938	795,938
4. 2016	XXX	XXX	761,797	800,646	800,646
5. 2017	XXX	XXX	XXX	722,094	753,569
6. 2018	XXX	XXX	XXX	XXX	718,855

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	631,169	631,169	631,169	631,169	631,169
2. 2014	721,443	724,641	724,641	724,641	724,641
3. 2015	XXX	799,494	795,938	795,938	795,938
4. 2016	XXX	XXX	805,035	800,646	800,646
5. 2017	XXX	XXX	XXX	762,181	753,569
6. 2018	XXX	XXX	XXX	XXX	745,253

12 Grand Total

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. 2014	686,748	724,641	6,816	0.941	731,457	106.510			731,457	106.510
2. 2015	761,571	795,938	90	0.011	796,028	104.524			796,028	104.524
3. 2016	801,956	800,646	687	0.086	801,332	99.922			801,332	99.922
4. 2017	803,067	753,569	759	0.101	754,328	93.931			754,328	93.931
5. 2018	768,864	718,855			718,855	93.496	26,398	759	746,012	97.028

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Hospital and Medical . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Hospital and Medical . . . NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Hospital and Medical . . . NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Medicare Supplement . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Medicare Supplement . . . NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Medicare Supplement . . . NONE

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS ($000 Omitted)

Dental Only

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	631,169	631,169	631,169	631,169	631,169
2. 2014	695,484	724,641	724,641	724,641	724,641
3. 2015	XXX	761,161	795,938	795,938	795,938
4. 2016	XXX	XXX	761,797	800,646	800,646
5. 2017	XXX	XXX	XXX	722,094	753,569
6. 2018	XXX	XXX	XXX	XXX	718,855

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	631,169	631,169	631,169	631,169	631,169
2. 2014	721,443	724,641	724,641	724,641	724,641
3. 2015	XXX	799,494	795,938	795,938	795,938
4. 2016	XXX	XXX	805,035	800,646	800,646
5. 2017	XXX	XXX	XXX	762,181	753,569
6. 2018	XXX	XXX	XXX	XXX	745,253

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. 2014	686,748	724,641	6,816	0.941	731,457	106.510			731,457	106.510
2. 2015	761,571	795,938	90	0.011	796,028	104.524			796,028	104.524
3. 2016	801,956	800,646	687	0.086	801,332	99.922			801,332	99.922
4. 2017	803,067	753,569	759	0.101	754,328	93.931			754,328	93.931
5. 2018	768,864	718,855			718,855	93.496	26,398	759	746,012	97.028

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Vision Only . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Vision Only . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Vision Only . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Fed Emp HBPP . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Fed Emp HBPP . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Fed Emp HBPP . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Title XVIII-Medicare . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Title XVIII-Medicare . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Title XVIII-Medicare . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Title XIX-Medicaid . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Title XIX-Medicaid . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Title XIX-Medicaid . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Other . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur Claims - Other . . . . . NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Other . . . . . NONE

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

		1 Total	2 Compre-hensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other
1.	Unearned premium reserves	7,791,313			7,791,313					
2.	Additional policy reserves (a)									
3.	Reserve for future contingent benefits									
4.	Reserve for rate credits or experience rating refunds (including $.....0 for investment income)									
5.	Aggregate write-ins for other policy reserves									
6.	TOTALS (Gross)	7,791,313			7,791,313					
7.	Reinsurance ceded									
8.	TOTALS (Net) (Page 3, Line 4)	7,791,313			7,791,313					
9.	Present value of amounts not yet due on claims									
10.	Reserve for future contingent benefits									
11.	Aggregate write-ins for other claim reserves									
12.	TOTALS (Gross)									
13.	Reinsurance ceded									
14.	TOTALS (Net) (Page 3, Line 7)									
DETAILS OF WRITE-INS										
0501.										
0502.										
0503.										
0598.	Summary of remaining write-ins for Line 5 from overflow page									
0599.	TOTALS (Lines 0501 through 0503 plus 0598) (Line 5 above)									
1101.										
1102.										
1103.										
1198.	Summary of remaining write-ins for Line 11 from overflow page									
1199.	TOTALS (Lines 1101 through 1103 plus 1198) (Line 11 above)									

(a) Includes $.....0 premium deficiency reserve.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

		Claim Adjustment Expenses		3	4	5
		1 Cost Containment Expenses	2 Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
1.	Rent ($.....0 for occupancy of own building)	14,017	238,282	1,149,362		1,401,661
2.	Salaries, wages and other benefits	408,650	6,947,047	33,509,287		40,864,984
3.	Commissions (less $.....0 ceded plus $.....0 assumed)	688	11,701	56,438		68,827
4.	Legal fees and expenses	3,938	66,948	322,924		393,810
5.	Certifications and accreditation fees					
6.	Auditing, actuarial and other consulting services	41,568	706,659	3,408,589		4,156,816
7.	Traveling expenses	8,966	152,416	735,185		896,567
8.	Marketing and advertising	20,590	350,033	1,688,394		2,059,017
9.	Postage, express and telephone	33,827	575,051	2,773,775		3,382,653
10.	Printing and office supplies	26,569	451,665	2,178,619		2,656,853
11.	Occupancy, depreciation and amortization	7,780	132,252	637,923		777,955
12.	Equipment	20,328	345,581	1,666,922		2,032,831
13.	Cost or depreciation of EDP equipment and software					
14.	Outsourced services including EDP, claims, and other services	18,082	307,394	1,482,724		1,808,200
15.	Boards, bureaus and association fees	14	234	1,131		1,379
16.	Insurance, except on real estate	6,689	113,713	548,497		668,899
17.	Collection and bank service charges	2,778	47,227	227,802		277,807
18.	Group service and administration fees					
19.	Reimbursements by uninsured plans					
20.	Reimbursements from fiscal intermediaries					
21.	Real estate expenses					
22.	Real estate taxes	313	5,320	25,659		31,292
23.	Taxes, licenses and fees:					
	23.1 State and local insurance taxes					
	23.2 State premium taxes					
	23.3 Regulatory authority licenses and fees	901	15,320	73,898		90,119
	23.4 Payroll taxes	25,892	440,170	2,123,174		2,589,236
	23.5 Other (excluding federal income and real estate taxes)	727	12,362	59,626		72,715
24.	Investment expenses not included elsewhere				206,756	206,756
25.	Aggregate write-ins for expenses					
26.	TOTAL Expenses Incurred (Lines 1 to 25)	642,317	10,919,375	52,669,929	206,756	(a) 64,438,377
27.	Less expenses unpaid December 31, current year			35,459		35,459
28.	Add expenses unpaid December 31, prior year	38,000	645,999	255,226		939,225
29.	Amounts receivable relating to uninsured plans, prior year					
30.	Amounts receivable relating to uninsured plans, current year					
31.	TOTAL Expenses Paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	680,317	11,565,374	52,889,696	206,756	65,342,143
DETAILS OF WRITE-INS						
2501.						
2502.						
2503.						
2598.	Summary of remaining write-ins for Line 25 from overflow page					
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)					

(a) Includes management fees of $.....0 to affiliates and $.....0 to non-affiliates.

EXHIBIT OF NET INVESTMENT INCOME

		1 Collected During Year	2 Earned During Year
1.	U.S. Government bonds	(a) 436,514	405,545
1.1	Bonds exempt from U.S. tax	(a)	
1.2	Other bonds (unaffiliated)	(a) 1,385,319	1,380,999
1.3	Bonds of affiliates	(a)	
2.1	Preferred stocks (unaffiliated)	(b)	
2.11	Preferred stocks of affiliates	(b)	
2.2	Common stocks (unaffiliated)		
2.21	Common stocks of affiliates		
3.	Mortgage loans	(c)	
4.	Real estate	(d)	
5.	Contract loans		
6.	Cash, cash equivalents and short-term investments	(e) 16,922	16,922
7.	Derivative instruments	(f)	
8.	Other invested assets		
9.	Aggregate write-ins for investment income		
10.	TOTAL gross investment income	1,838,755	1,803,466
11.	Investment expenses		(g) 206,756
12.	Investment taxes, licenses and fees, excluding federal income taxes		(g)
13.	Interest expense		(h)
14.	Depreciation on real estate and other invested assets		(i)
15.	Aggregate write-ins for deductions from investment income		
16.	TOTAL Deductions (Lines 11 through 15)		206,756
17.	Net Investment income (Line 10 minus Line 16)		1,596,710
DETAILS OF WRITE-INS			
0901.			
0902.			
0903.			
0998.	Summary of remaining write-ins for Line 9 from overflow page		
0999.	TOTALS (Lines 0901 through 0903 plus 0998) (Line 9 above)		
1501.			
1502.			
1503.			
1598.	Summary of remaining write-ins for Line 15 from overflow page		
1599.	TOTALS (Lines 1501 through 1503 plus 1598) (Line 15 above)		

(a) Includes $.....0 accrual of discount less $.....0 amortization of premium and less $.....0 paid for accrued interest on purchases.
(b) Includes $.....0 accrual of discount less $.....0 amortization of premium and less $.....0 paid for accrued dividends on purchases.
(c) Includes $.....0 accrual of discount less $.....0 amortization of premium and less $.....0 paid for accrued interest on purchases.
(d) Includes $.....0 for company's occupancy of its own buildings; and excludes $.....0 interest on encumbrances.
(e) Includes $.....0 accrual of discount less $.....0 amortization of premium and less $.....0 paid for accrued interest on purchases.
(f) Includes $.....0 accrual of discount less $.....0 amortization of premium.
(g) Includes $.....0 investment expenses and $.....0 investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
(h) Includes $.....0 interest on surplus notes and $.....0 interest on capital notes.
(i) Includes $.....0 depreciation on real estate and $.....0 depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

		1 Realized Gain (Loss) on Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1.	U.S. Government bonds	(710,090)		(710,090)		
1.1	Bonds exempt from U.S. tax					
1.2	Other bonds (unaffiliated)	(199,369)		(199,369)		
1.3	Bonds of affiliates					
2.1	Preferred stocks (unaffiliated)					
2.11	Preferred stocks of affiliates					
2.2	Common stocks (unaffiliated)					
2.21	Common stocks of affiliates					
3.	Mortgage loans					
4.	Real estate					
5.	Contract loans					
6.	Cash, cash equivalents and short-term investments	(17)		(17)	3,432	
7.	Derivative instruments					
8.	Other invested assets					
9.	Aggregate write-ins for capital gains (losses)				2,440,260	
10.	TOTAL Capital gains (losses)	(909,476)		(909,476)	2,443,692	
DETAILS OF WRITE-INS						
0901.	Investment in DSM USA Insurance Company, Inc.				2,440,260	
0902.						
0903.						
0998.	Summary of remaining write-ins for Line 9 from overflow page					
0999.	TOTALS (Lines 0901 through 0903 plus 0998) (Line 9 above)				2,440,260	

EXHIBIT OF NONADMITTED ASSETS

		1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1.	Bonds (Schedule D)			
2.	Stocks (Schedule D):			
	2.1 Preferred stocks			
	2.2 Common stocks			
3.	Mortgage loans on real estate (Schedule B):			
	3.1 First liens			
	3.2 Other than first liens			
4.	Real estate (Schedule A):			
	4.1 Properties occupied by the company			
	4.2 Properties held for the production of income			
	4.3 Properties held for sale			
5.	Cash (Schedule E-Part 1), cash equivalents (Schedule E-Part 2) and short-term investments (Schedule DA)			
6.	Contract loans			
7.	Derivatives (Schedule DB)			
8.	Other invested assets (Schedule BA)			
9.	Receivables for securities			
10.	Securities lending reinvested collateral assets (Schedule DL)			
11.	Aggregate write-ins for invested assets	3,009,260	3,009,260	
12.	Subtotals, cash and invested assets (Lines 1 to 11)	3,009,260	3,009,260	
13.	Title plants (for Title insurers only)			
14.	Invested income due and accrued			
15.	Premium and considerations:			
	15.1 Uncollected premiums and agents' balances in the course of collection	3,076,864	4,099,194	1,022,330
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due			
	15.3 Accrued retrospective premiums and contracts subject to redetermination			
16.	Reinsurance:			
	16.1 Amounts recoverable from reinsurers			
	16.2 Funds held by or deposited with reinsured companies			
	16.3 Other amounts receivable under reinsurance contracts			
17.	Amounts receivable relating to uninsured plans	281,412	453,303	171,891
18.1	Current federal and foreign income tax recoverable and interest thereon			
18.2	Net deferred tax asset			
19.	Guaranty funds receivable or on deposit			
20.	Electronic data processing equipment and software	134,046	230,363	96,317
21.	Furniture and equipment, including health care delivery assets	111,625	156,246	44,621
22.	Net adjustment in assets and liabilities due to foreign exchange rates			
23.	Receivables from parent, subsidiaries and affiliates			
24.	Health care and other amounts receivable			
25.	Aggregate write-ins for other than invested assets	111,071	111,071	0
26.	TOTAL Assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	6,724,278	8,059,437	1,335,159
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts			
28.	TOTAL (Lines 26 and 27)	6,724,278	8,059,437	1,335,159
DETAILS OF WRITE-INS				
1101.	Investment in DSM USA Insurance Co - Licenses Intangible	3,009,260	3,009,260	
1102.				
1103.				
1198.	Summary of remaining write-ins for Line 11 from overflow page			
1199.	TOTALS (Lines 1101 through 1103 plus 1198) (Line 11 above)	3,009,260	3,009,260	
2501.	Texas Lease Security Deposit	111,071	111,071	0
2502.				
2503.				
2598.	Summary of remaining write-ins for Line 25 from overflow page			
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)	111,071	111,071	0

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	Current Year Member Months
1. Health Maintenance Organizations						
2. Provider Service Organizations	2,047,245	2,011,780	1,974,854	1,929,977	1,934,970	23,625,408
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business						
7. TOTAL	2,047,245	2,011,780	1,974,854	1,929,977	1,934,970	23,625,408
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page						
0699. TOTALS (Lines 0601 through 0603 plus 0698) (Line 6 above)						

EXHIBIT 2 - ACCIDENT AND HEALTH PREMIUMS DUE AND UNPAID

1 Name of Debtor	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	7 Admitted
0199999 TOTAL Individuals						
0299998 Premiums due and unpaid not individually listed						
0299999 TOTAL Group						
0399999 Premiums due and unpaid from Medicare entities						
0499999 Premiums due and unpaid from Medicaid entities						
0599999 Accident and health premiums due and unpaid (Page 2, Line 15)						

EXHIBIT 4 - CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Individually Listed Claims Unpaid						
TX Marketplace	86,000					86,000
TN Marketplace	11,000					11,000
TX Amerigroup	139,000					139,000
Anthem Colorado Medicare	15,000					15,000
TX Superior	525,000					525,000
TX CHIP	2,297,000					2,297,000
TX Medicaid	21,170,000					21,170,000
TN Coverkids	210,000					210,000
TN Amerigroup	23,000					23,000
TX Cigna Healthspring	628,000					628,000
NC Cigna Healthspring	11,372					11,372
TN Cigna Healthspring	156,741					156,741
GA Cigna Healthspring	38,085					38,085
SC Cigna Healthspring	2,000					2,000
TX Blue Cross Blue Shield	1,000					1,000
0199999 Total - Individually Listed Claims Unpaid	25,313,198					25,313,198
0299999 Aggregate Accounts Not Individually Listed - Uncovered						
0399999 Aggregate Accounts Not Individually Listed - Covered						
0499999 Subtotals	25,313,198					25,313,198
0599999 Unreported claims and other claim reserves						
0699999 TOTAL Amounts Withheld						
0799999 TOTAL Claims Unpaid						25,313,198
0899999 Accrued Medical Incentive Pool and Bonus Amounts						1,085,591

EXHIBIT 5 - AMOUNTS DUE FROM PARENT, SUBSIDIARIES AND AFFILIATES

1	2	3	4	5	6	Admitted	
						7	8
Name of Affiliate	1 - 30 Days	31 - 60 Days	61 - 90 Days	Over 90 Days	Nonadmitted	Current	Non-Current
	NONE						
0399999 TOTAL Gross Amounts Receivable							

EXHIBIT 6 - AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

1 Affiliate	2 Description	3 Amount	4 Current	5 Non-Current
Individually Listed Payables				
DentaQuest LLC		9,141,149	9,141,149	
0199999 Total - Individually Listed Payables	X X X	9,141,149	9,141,149	
0299999 Payables not Individually Listed	X X X			
0399999 TOTAL Gross Payables	X X X	9,141,149	9,141,149	

EXHIBIT 7 - PART 1 - SUMMARY OF TRANSACTIONS WITH PROVIDERS

Payment Method	1 Direct Medical Expense Payment	2 Column 1 as a % of Total Payments	3 Total Members Covered	4 Column 3 as a % of Total Members	5 Column 1 Expenses Paid to Affiliated Providers	6 Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups						
2. Intermediaries						
3. All other providers						
4. TOTAL Capitation Payments						
Other Payments:						
5. Fee-for-service	750,331,586	100.000	X X X	X X X		750,331,586
6. Contractual fee payments			X X X	X X X		
7. Bonus/withhold arrangements - fee-for-service			X X X	X X X		
8. Bonus/withhold arrangements - contractual fee payments			X X X	X X X		
9. Non-contingent salaries			X X X	X X X		
10. Aggregate cost arrangements			X X X	X X X		
11. All other payments			X X X	X X X		
12. TOTAL Other Payments	750,331,586	100.000	X X X	X X X		750,331,586
13. TOTAL (Line 4 plus Line 12)	750,331,586	100.000	X X X	X X X		750,331,586

EXHIBIT 7 - PART 2 - SUMMARY OF TRANSACTIONS WITH INTERMEDIARIES

1 NAIC Code	2 Name of Intermediary	3 Capitation Paid	4 Average Monthly Capitation	5 Intermediary's Total Adjusted Capital	6 Intermediary's Authorized Control Level RBC
	NONE				
9999999 TOTALS			X X X	X X X	X X X

EXHIBIT 8 - FURNITURE, EQUIPMENT AND SUPPLIES OWNED

	Description	1 Cost	2 Improvements	3 Accumulated Depreciation	4 Book Value Less Encumbrances	5 Assets Not Admitted	6 Net Admitted Assets
1.	Administrative furniture and equipment	1,425,847		1,314,222	111,625	111,625	
2.	Medical furniture, equipment and fixtures						
3.	Pharmaceuticals and surgical supplies						
4.	Durable medical equipment						
5.	Other property and equipment						
6.	TOTAL	1,425,847		1,314,222	111,625	111,625	

Notes to Financial Statements

1. Summary of Significant Accounting Policies

A) Accounting Practices

DentaQuest USA Insurance Company, Inc. ("DQ USA" or the "Company") prepares its financial statements in conformity with the accounting practices prescribed or permitted by the State of Texas Department of Insurance. The State of Texas has adopted the National Association of Insurance Commissioners' statutory accounting practices ("NAIC SAP") as the basis of its statutory accounting practice. NAIC SAP is a comprehensive basis of accounting other than the accounting principles generally accepted in the United States of America ("GAAP"). Prescribed statutory accounting practices include a variety of publications of the NAIC, as well as state laws, regulations and general administrative rules. Permitted statutory accounting practices encompass all accounting practices not so subscribed. The Company has no permitted accounting practices which vary from prescribed accounting practices.

A reconciliation of the Company's net income and capital and surplus between NAIC SAP and practices prescribed and permitted by the State of Texas is shown below:

	NET INCOME	SSAP #	F/S Page	F/S Line #	2018	2017
(1)	DQ USA Insurance Company, Inc. state basis (Page 4, Line 32, Column 2 & 3)	72	4	32	$ 8,657,597	$ 19,523,092
(2)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
	e.g. Depreciation of fixed assets				-	-
(3)	State Permitted Practices that increase/(decrease) NAIC SAP:					
	e.g. Depreciation, home office property				-	-
(4)	NAIC SAP (1-2-3=4)	72	4	32	$ 8,657,597	$ 19,523,092
	SURPLUS					
(5)	DQ USA Insurance Company, Inc. state basis (Page 3, Line 33, Column 3 & 4)	72	3	33	$ 110,182,687	$ 117,506,222
(6)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
	e.g. Goodwill, net					
	e.g. Fixed assets, net				-	-
(7)	State Permitted Practices that increase/(decrease) NAIC SAP:					
	e.g. Home office property				-	-
(8)	NAIC SAP (5-6-7=8)	72	3	33	$ 110,182,687	$ 117,506,222

B) Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting periods. Actual results could differ from those estimates.

C) Accounting Policies

1) Short-term investments consist of liquid investments, with maturity dates of one year or less at the date of acquisition and are stated at amortized cost.

2) Values of bonds have been determined in accordance with methods and values adopted by the NAIC. Bonds are stated at amortized cost, including inflationary adjustments for inflation projected securities.

3) The Company does not currently hold common stock.

4) The Company does not currently hold preferred stock.

5) The Company does not issue mortgage loans on real estate.

6) The Company owns mortgage-backed securities (MBS) and collateralized mortgage obligations. The value of such securities has been determined in accordance with methods and values adopted by the NAIC.

7) Investments in the Company's sole subsidiary, DSM USA Insurance Company, Inc. ("DSM USA"), are carried using the statutory equity method as required by SSAP No. 97.

8) The Company does not have any investments in joint ventures, partnerships or limited liability companies.

9) The Company has no investments in derivatives.

10) The Company does not have a premium deficiency reserve.

11) Reserves for unpaid claims include incurred but not reported amounts, which are estimated using the Company's historical paid claim and accumulated statistical data, adjusted for current experience.

12) The Company did not change its capitalization policy in 2018.

13) The Company does not have a pharmaceutical rebate receivable.

D) Going Concern

The Company does not have any going concern items to disclose.

2. Accounting Changes and Corrections of Errors

The Company did not have any material accounting changes or corrections of errors for the years ended December 31, 2018 and 2017.

3. Business Combinations and Goodwill

1-4) None

4. Discontinued Operations

1-4) None

5. Investments

A) The Company does not have any Mortgage Loans, including Mezzanine Real Estate Loans.

B) The Company does not have any Debt Restructuring to disclose.

C) The Company does not have any Reverse Mortgages.

D)

1) Prepayment assumptions for single class and multi-class mortgage-backed/asset-backed securities were obtained from broker dealer survey values or internal estimates.

2) The Company does not have any loan-backed securities with a recognized other than temporary impairment.

3) The Company does not have any loan-backed securities with a recognized other than temporary impairment.

4) The Company does not have any loan-backed securities with a recognized other than temporary impairment.

5) The Company does not have any additional loan-backed securities with a recognized other than temporary impairment.

E) The Company does not have any repurchase agreements or securities lending transactions.

F) The Company does not have any repurchase agreements transactions accounted for as secured borrowing

G) The Company does not have any reverse repurchase agreements transactions accounted for as secured borrowing

H) The Company does not have any repurchase agreements transactions accounted for as a sale.

Notes to Financial Statements

I) The Company does not have any reverse repurchase agreements transactions accounted for as a sale.

J) The Company does not own any real estate.

K) The Company does not have any investments in low-income housing tax credits (LIHTC).

L)

(1) Restricted Assets

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted from Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted from Prior Year	3 Increase/(Decrease) (1 minus 2)	4 Total Current Year Nonadmited Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmited) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets
a. Subject to contractual obligation for which liability is not shown	$ -	$ -	$ -	$ -	$ -	0%	$ -
b. Collateral held under security lending agreements	$ -	$ -	$ -	$ -	$ -	0%	$ -
c. Subject to repurchase agreements	$ -	$ -	$ -	$ -	$ -	0%	$ -
d. Subject to reverse repurchase agreements	$ -	$ -	$ -	$ -	$ -	0%	$ -
e. Subject to dollar repurchase agreements	$ -	$ -	$ -	$ -	$ -	0%	$ -
f. Subject to dollar reverse repurchase agreements	$ -	$ -	$ -	$ -	$ -	0%	$ -
g. Placed under option contracts	$ -	$ -	$ -	$ -	$ -	0%	$ -
h. Letter stock or securities restricted as to sale – excluding FHLB capital stock	$ -	$ -	$ -	$ -	$ -	0%	$ -
i. FHLB capital stock	$ -	$ -	$ -	$ -	$ -	0%	$ -
j. On deposit with states	$ 6,064,923	$ 12,634,000	$ (6,569,077)	$ -	$ 6,064,923	4%	$ 0
k. On deposit with other regulatory bodies	$ -	$ -	$ -		$ -	0%	$ -
l. Pledged as collateral to FHLB (including assets backing funding agreements)	$ -	$ -	$ -		$ -	0%	$ -
m. Pledged as collateral not captured in other categories	$ -	$ -	$ -		$ -	0%	$ -
n. Other restricted assets	$ -	$ -	$ -		$ -	0%	$ -
o. Total Restricted Assets	$ 6,064,923	$ 12,634,000	$ (6,569,077.00)	$ -	$ 6,064,923.00	4%	$ 0

(2) The Company does not have any assets pledged as collateral.

(3) The Company does not have any other restricted assets.

(4) The Company does not have any assets pledged as collateral.

M) The Company does not have any investments in working capital finance.

N) The Company does not have any investments in offsetting or netting of assets and liabilities.

O) The Company does not have any investments in structured notes.

6. Joint Ventures, Partnerships and Limited Liability Companies

A-B) None

7. Investment Income

A) All investment income due and accrued with amounts that are over 90 days past due are excluded from surplus.

B) The Company did not exclude any investment income due and accrued.

8. Derivative Instruments

A-F) None

9. Income Taxes

A) The components of deferred tax assets (DTAs) and deferred tax liabilities (DTLs) are as follows:

Notes to Financial Statements

All the Company's deferred tax assets for the years ended December 31, 2018 and 2017 are ordinary in nature.

1.

	(1) 12/31/2018	(2) 12/31/2017	(3) (Col 1 - 2) Change
a) Gross Deferred Tax Assets	$ 907,359	$ 1,158,778	$ (251,419)
b) Statutory Valuation Allowance Adjustments	-	-	-
c) Adjusted Gross Deferred Tax Assets (1a-1b)	907,359	1,158,778	(251,419)
d) Deferred Tax Assets Non-admitted	-	-	-
e) Subtotal Net Admitted Deferred Tax Asset (1c-1d)	907,359	1,158,778	(251,419)
f) Deferred Tax Liabilities	-	-	-
g) Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e – 1f)	$ 907,359	$ 1,158,778	$ (251,419)

2.

	(1) 12/31/2018	(2) 12/31/2017	(3) (Col 1 - 2) Change
a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 907,359	$ 1,158,778	$ (251,419)
b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from (a) above) after application of the threshold limitation	-	-	-
1) Adjusted Gross Deferred Tax Assets Expected to be Realized Following the Balance Sheet Date	-	-	-
2) Adjusted Gross Tax Assets Allowed per Limitation Threshold	16,391,299	17,467,485	(1,076,186)
c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from (a) and (b) above) offset by gross deferred tax liabilities	-	-	-
d) Deferred tax assets admitted as the result of application of SSAP 101. Total a) + b) + c)	$ 907,359	$ 1,158,778	$ (251,419)

3.

	2018	2017
a) Ratio Percentage Used to Determine Recovery Period and Threshold Limitations Amount	363%	399%
b) Amount of Adjusted Capital and Surplus Used to Determine Recovery Period and Threshold Limitation in 2b)2 Above.	$ 109,275,328	$ 116,347,444

4) The Company does not currently employ tax planning strategies to recognize the admission of deferred tax assets.

Notes to Financial Statements

	12/31/2018		12/31/2017		Change	
	(1)	(2)	(3)	(4)	(5) (Col 1 - 3)	(6) (Col 2 - 4)
Impact of Tax-Planning Strategies	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
a) Determination Of Adjusted Gross Deferred Tax Assets And Net Admitted Deferred Tax Assets, By Tax Character As A Percentage.						
i. Adjusted Gross DTAs Amount From Note 9A1(c)						
ii. Percentage Of Adjusted Gross DTAs By Tax Character Attributable To The Impact Of Tax Planning Strategies						
iii. Net Admitted Adjusted Gross DTAs Amount From Note 9A1(e)						
iv. Percentage Of Net Admitted Adjusted Gross DTAs By Tax Character Admitted Because Of The Impact Of Tax Planning Strategies						
b) Does the Company's tax–planning strategies include the use of reinsurance?	Yes _____	No X				

B) The Company has no unrecognized deferred tax liabilities as of December 31, 2018.

C) Current income taxes incurred consist of the following major components:

	(1) 12/31/2018	(2) 12/31/2017	(3) (Col 1 - 2) Change
1. Current Income Tax			
a) Federal	$ 6,493,266	$ 21,560,979	$ (15,067,713)
b) Federal income tax on net capital gains	-	-	-
c) Utilization of capital loss carry-forwards	-	-	-
d) Other	-	-	-
e) Federal income taxes incurred	6,493,266	21,560,979	(15,067,713)
2. Deferred Tax Assets:			
a. Discounting of unpaid losses	41,182	73,379	(32,197)
b. Unearned premium reserve	5,980	12,215	(6,235)
c. Fixed assets	46,583	45,847	736
d. Receivables - nonadmitted	705,238	956,024	(250,786)
e. Other	108,377	71,313	37,064
f. Total net deferred tax assets	907,359	1,158,778	(251,419)
g. Nonadmitted deferred tax assets	-	-	-
h. Admitted deferred tax assets	$ 907,359	$ 1,158,778	$ (251,419)
3. Deferred Tax Liabilities	-	-	-
4. Net deferred tax assets/liabilities	907,359	1,158,778	(251,419)

D) The Company's provision for federal income taxes differs from the federal statutory rate of 21% applied to net income before federal taxes. The effective rate applied to the changes in temporary differences was 21%.

	12/31/2018	12/31/2017	(Col 1 - 2) Change
Provision computed at statutory rate	$ 3,181,681	$ 10,578,103	$ (7,396,422)
Change in non-admitted assets	280,372	387,256	(106,884)
Change in effective tax rate	-	-	-
Affordable Care Act Assessment	3,273,200	-	3,273,200
Amortization	9,431	15,719	(6,288)
Total	6,744,685	10,981,078	(4,236,393)
Federal income taxes incurred	6,493,266	10,700,059	(15,067,713)
Change in effective tax rate	-	(65,501)	-
Change in deferred income taxes	251,419	346,520	(95,101)
Total statutory income taxes	$ 6,744,685	$ 10,981,078	$ (15,162,814)

E)

Notes to Financial Statements

1) The Company does not have operating losses or tax credit carry forwards.

2) The amount of federal income taxes incurred and available for recoupment in the event of future net losses is $6,493,266 at December 31, 2018.

3) The Company does not have any protective tax deposits under section 6603 of the Internal Revenue Code.

F)

1) DentaQuest Group, Inc. (“DentaQuest”) files a consolidated tax return. The members of the DentaQuest federal consolidated income tax return consisted of: DentaQuest Group, Inc., Pacific Dental Network, Inc., California Dental Network, Inc., DentaQuest of Florida, Inc., DSM USA Insurance Company, Inc. and the Company.

2) DentaQuest allocates a share of the total taxes paid to the Company. The rate of federal tax for DentaQuest for 2018 and 2017 was 21%. The Company's tax sharing agreement with DentaQuest calls for the Company to pay taxes to its immediate parent company, DentaQuest, LLC (“DQ, LLC” or the “Parent”) apportioned based on its percentage of consolidated pretax income. For the years ended December 31, 2018 and 2017, Federal corporate income tax expenses amounted to approximately $6,493,266 and $10,700,059 respectively.

G) Not applicable to the Company.

10. Information Concerning Parent, Subsidiaries and Affiliates

A) The Company has entered into an agreement with DQ, LLC pursuant to which DQ, LLC provides various services to the Company such as information technology, facilities and equipment, human resources services, executive and managerial support, legal services, regulatory filing and compliance services, accounting services, cash management services, actuarial and underwriting services, sales and marketing services, enrollment services, claims processing services, billing and collection services, customer services, provider relations and credentialing services, and additional other services. DQ, LLC collects and pays monies related to the Company’s operations.

On August 18, 2011, the Company’s ultimate parent, Dental Service of Massachusetts, Inc. (“DSM”) entered into a Corporate Guarantee (the “Guarantee”) of the Managed Care Contract between the Company and HHSC. Pursuant to the HHSC Contract, which became operational on March 1, 2012 with an initial term through August 31, 2015, the Company now provides dental benefits on a capitated basis to approximately 1,900,000 participants in the Texas Medicaid and CHIP programs. Pursuant to the Guarantee, the DSM unconditionally guarantees DentaQuest USA’s performance of all of its obligations under the HHSC Contract.

DQ, LLC also collects and pays monies on behalf of the Company in relation to federal and state income taxes to DentaQuest, the upstream affiliate with whom the Company has a tax-sharing agreement.

DQ, LLC also collects and disburses monies on behalf of the Company from/to sibling affiliates.

The details of the Company’s tax sharing agreement with DentaQuest are disclosed in Note 9.

On October 11, 2016, the DSM formed Catalyst Institute, Inc. (“Catalyst”), a Massachusetts charitable corporation with no members and with a board of directors comprised of the same individuals serving on DSM’s board. As such, Catalyst was effectively a sister entity to the DSM. On January 11, 2017, Catalyst obtained its 501 (c) (4) exemption from the Internal Revenue Service. On January 1, 2018, Catalyst became the sole member of DSM. On June 6, 2018, as authorized by the Massachusetts Division of Insurance (“DOI”), the Company transferred ownership of DQG to its sole member, Catalyst. As such, Catalyst is now the ultimate parent company of DQ USA.

B) During the year ended December 31, 2018, the following transactions took place between the Company and DQ, LLC: Revenues collected were $323,316,139, claims paid were $286,851,705, salaries and general administrative costs were $68,754,904, federal and state income taxes were $7,114,875, and other amounts paid were $23,325. The amounts recorded

for income taxes are subsequently settled with DentaQuest, which subsequently settles the payment with the IRS and state governments.

During 2018, the Company paid $32,411,724 to DQ, LLC to settle amounts due.

C) There were no changes in the method of establishing the terms from that used in the preceding period.

D) For the years ended December 31, 2018 and 2017, the Company had a total payable to DQ, LLC of $9,209,396 and $7,824,054, respectively.

E) In 2007, DQ, LLC (formerly, co-borrower with DentaQuest Ventures, LLC ("DQV")) and DentaQuest Group, Inc. ("DQ Group") as "Parent Guarantor" entered into a Credit Agreement with a group of lenders providing for a $200 million revolving credit facility and, together with all of the subsidiaries of DQ Group, a Guarantee and Collateral Agreement (together with the Credit Agreement, the "Credit Facility"). Under the Guarantee and Collateral Agreement, substantially all of the assets of the Parent Guarantor, the Co-Borrowers and their subsidiaries were pledged as collateral against any borrowings under the Credit Facility. Upon closing of the Credit Facility, DQV borrowed $140,000,000 and purchased the equity interest of an outside investor for $110,000,000.

On June 23, 2011, DQ, LLC entered into an Amended and Restated Credit Agreement and an Amended and Restated Guarantee and Collateral Agreement with Bank of America, N.A. Under the terms of these amended and restated agreements, the amount of the facility was reduced to $150,000,000 and the Company was newly defined as an "Excluded Insurance Subsidiary." As such, the Company is no longer a guarantor of the obligations of DQ LLC and is no longer required to pledge its assets in support of the borrowers to the lenders. The stock of the Company remained pledged by DQ, LLC as security for its obligations pursuant to the Amended and Restated Guarantee and Collateral Agreement.

On June 24, 2014, DQ, LLC entered into a second Amended and Restated Credit Agreement with Bank of America, N.A. Under the terms of this agreement, the pledge of the stock of the Company by DQ, LLC was released and the Amended and Restated Guarantee and Collateral Agreement was terminated.

F) Expenses representing the Company's proportion of direct expenses funded by DQ, LLC are allocated to the Company using a blend of proportionate membership and level of services performed. Allocated expenses totaled approximately $68,754,904 and $68,130,999 for the years ended December 31, 2018 and December 31, 2017, respectively. The types of costs allocated during both years are described in the first paragraph of 10 B).

G) The Company is a wholly-owned subsidiary of DQ, LLC, a Delaware limited liability company. The ultimate for-profit parent of DQ, LLC is DentaQuest, incorporated under the laws of the state of Delaware, which has its principal place of business in Boston, Massachusetts. DentaQuest is a wholly-owned subsidiary of DSM, a not-for-profit corporation incorporated under Chapter 176E of the Massachusetts General Laws.

H) Not applicable to the Company.

I) Not applicable to the Company.

J) Not applicable to the Company.

K) Not applicable to the Company.

L) Not applicable to the Company.

M) Not applicable to the Company.

N) Not applicable to the Company.

11. Debt

A) The Company has no debt.

B) The Company has no FHLB (Federal Home Loan Bank) agreements.

Notes to Financial Statements

12. Retirement Plans

A-I) The Company had no retirement plans, deferred compensation, postemployment benefits, compensated absences or other postretirement benefit plans.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi- Reorganizations

1) The Company has 700,000 shares authorized of common stock, 700,000 shares issued and 700,000 shares outstanding, with par value of $2.86 per share.

2) The Company has no preferred stock outstanding.

3) Pursuant to Texas Insurance Code Section 403.001, the Company may not pay a dividend except from surplus profits arising from the business.

4) During 2018 the Company paid ordinary dividends in the amount of $19,500,000 to DQ, LLC.

5) Within the limitations of (3) above, there are no restrictions placed on the portion of Company profits that may be paid as ordinary dividends to stockholders.

6) Under the laws of the State of Texas, the Company is required to maintain a minimum surplus of $1,400,000. On May 14, 2010, the State of Texas, Commissioner of Insurance issued a consent order requiring the Company to make an initial additional deposit of approximately $7,100,000 million into a restricted account with the Comptroller of Public Accounts for the State of Texas to satisfy certain of its statutory obligations with regard to the pledge of assets. The funds in the restricted account were not subject to the asset pledge under the Credit Facility. As of December 31, 2011, additional deposits had been made to this restricted account and the carrying value of these restricted securities was $14,500,000 at December 31, 2011. On April 13, 2012, another consent order was issued releasing the Company from most of the requirements of the previous order. The Company was given permission to withdraw approximately $7.25 million of the approximately $13.1 million on special deposit at that date. On November 20, 2014 the Company made an additional deposit in the amount of $5,183,000 to replace securities on deposit which had matured. In 2018, the Company was able to redeem $7,250,000 of securities from the state of Texas. There is currently $5,183,000 on deposit with the State of Texas.

   The Company has four other restricted deposits. One deposit is with the State of Georgia Office of Commissioner of Insurance in the approximate amount of $100,000 in relation to the Company's extended license in the State of Georgia. Another deposit is maintained by the Commonwealth of Massachusetts, Department of State Treasurer in the approximate amount of $101,000 in relation to the Company's extended license in the Commonwealth of Massachusetts. On January 18, 2018, the Company made a third deposit in the amount of $438,000 in relation to the Company's extended license in the state of North Carolina. On January 19, 2018, the Company made a deposit in the amount of $243,000 in the state of Nevada in relation to extending the Company's license in the state.

7) Not applicable to the Company.

8) Not applicable to the Company.

9) Not applicable to the Company.

10) The portion of unassigned funds (surplus) represented or reduced by unrealized gains or loss is $14,268.

11) Not applicable to the Company.

12) Not applicable to the Company.

13) Not applicable to the Company.

14. Contingencies

A) The Company has no material contingent liabilities.

B) The Company has not been advised of any assessments.

C) The Company has no gain contingencies.

D) The Company has no extra contractual obligations or bad faith losses stemming from lawsuits.

E) At December 31, 2018, there were no legal actions currently pending involving the Company.

F) The company has no other contingencies.

15. Leases

A – B) Not applicable to the Company.

16. Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

For the years ended December 31, 2018 and 2017, the Company held cash in certain bank accounts in excess of the federally insured limit. The Company has not experienced any credit losses with respect to its cash equivalents and believes its credit risk to be negligible.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A) The Company did not sell or transfer any receivables reported as sales.

B) The Company did not sell or transfer any financial assets.

C) There were no wash sales.

18. Gain or Loss to the Reporting Entity from Uninsured A&H Plans and the Uninsured Portion of Partially Insured Plans

A – C) The Company had no uninsured accident and health plans or uninsured portions of partially insured plans.

19. Direct Premiums Written/Produced by Managing General Agents/Third Party Administrators

The Company had no direct premiums written or produced by a Managing General Agent or Third Party Administrator.

20. Fair Value Measurements

A)

1) The Company does not report at fair value in the statement of financial position.

2) The Company had no Level 3 investments as of December 31, 2018.

3) The Company had no transfers between levels during 2018.

4) Not applicable to the Company.

5) The Company had no derivative assets and liabilities at December 31, 2018.

B) None

C)

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	Level (3)
Bonds	$ 53,009,884	$ 54,056,501	$ 8,978,898	$ 45,077,603	$ -
Common Stock	-	-	-	-	-
Perpetual Preferred Stock	-	-	-	-	-
Mortgage Loans	-	-	-	-	-
Total	$ 53,009,884	$ 54,056,501	$ 8,978,898	$ 45,077,603	$ -

D) Not applicable to the Company.

Notes to Financial Statements

E) Not applicable to the Company.

21. Other Items

A) The Company has no unusual or infrequent items to report.

B) The Company has no troubled debt restructuring.

C) Other Disclosures – none

D) The Company has not had any business interruption insurance recoveries.

E) The Company has not been involved in state transferable tax credits.

F) The Company has not had any subprime-mortgage-related risk exposure.

G) The Company has no retained asset accounts for beneficiaries.

H) The Company has no insurance-linked securities.

22. Events Subsequent

On January 1, 2018, the Company was subject to an annual fee under Section 9010 of the Federal Affordable Care Act (ACA). This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2018, the Company had written health insurance subject to the ACA assessment, and expects to conduct health insurance business in 2019; however, the federal government has suspended the ACA assessment for 2019, so the Company estimates its portion of the annual health insurance industry fee to be $0.

		Current Year		Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the federal Affordable Care Act (YES/NO)?		Yes		
B. ACA fee assessment payable for the upcoming year	$	-	$	14,666,000
C. ACA fee assessment paid	$	19,660,266	$	-
D. Premium written subject to ACA	$	768,963,667	$	803,066,544
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	$	110,182,687		
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	$	110,182,687		
G. Authorized Control Level (Five-Year Historical Line 15)	$	29,439,296		
H. Would reporting the ACA assessment as of December 31, 2017, have triggered an RBC action level (YES/NO)?		No		

23. Reinsurance

A) The Company has no ceded reinsurance.

B) The Company has no uncollectible reinsurance.

C) The Company has not commutated any reinsurance.

D) The Company has no ceded reinsurance.

Notes to Financial Statements

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

A) The Company estimates accrued retrospective premium adjustments for its HHSC dental insurance business based upon the loss ratio, net of operating expenses.

B) The Company records accrued retrospective premium as an adjustment to earned premium.

C) The amount of net premiums written by the Company at December 31, 2018 that are subject to retrospective rating features was $753 million, that represented 98% of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

D) Medical loss ratio rebates required pursuant to the Public Health Service Act.

	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Other Categories with Rebates	5 Total
Prior Reporting					
(1) Medical loss ratio rebates incurred	$ -	$ -	$ -	$ (3,831,436)	$ (3,831,436)
(2) Medical loss ratio rebates paid	$ -	$ -	$ -	$ 3,809,759	$ 3,809,759
(3) Medical loss ratio	$ -	$ -	$ -	$ 3,664,645	$ 3,664,645
(4) Plus reinsurance	XXX	XXX	XXX	XXX	$ -
(5) Less reinsurance	XXX	XXX	XXX	XXX	$ -
(6) Rebates unpaid net of	XXX	XXX	XXX	XXX	$ -
Current Reporting					
(1) Medical loss ratio	$ -	$ -	$ -	$ (4,486,394)	$ (4,486,394)
(2) Medical loss ratio	$ -	$ -	$ -	$ 454,003	$ 454,003
(3) Medical loss ratio	$ -	$ -	$ -	$ 7,791,313	$ 7,791,313
(4) Plus reinsurance	XXX	XXX	XXX	XXX	$ -
(5) Less reinsurance	XXX	XXX	XXX	XXX	$ -
(6) Rebates unpaid net of	XXX	XXX	XXX	XXX	$ 7,791,313

E) Risk Sharing Provisions of the Affordable Care Act (ACA)

Notes to Financial Statements

1) Did the reporting entity write accident and health insurance premium that Yes

2) Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets,

a. Permanent ACA Risk Adjustment Program

	AMOUNT
Assets	
1. Premium adjustments receivable due to ACA Risk	$ -
Liabilities	
2. Risk adjustment user fees payable for ACA Risk	$ -
3. Premium adjustments payable due to ACA Risk	$ -
Operations (Revenue & Expense)	
4. Reported as revenue in premium for accident and	$ -
5. Reported in expenses as ACA Risk Adjustment user	$ -

b. Transitional ACA Reinsurance Program

Assets	
1. Amounts recoverable for claims paid due to ACA	$ -
2. Amounts recoverable for claims unpaid due to ACA	$ -
3. Amounts receivable relating to uninsured plans for	$ -
Liabilities	
4. Liabilities for contributions payable due to ACA	$ -
5. Ceded reinsurance premiums payable due to ACA	$ -
6. Liabilities for amounts held under uninsured plans	$ -
Operations (Revenue & Expense)	
7. Ceded reinsurance premiums due to ACA	$ -
8. Reinsurance recoveries (income statement) due to	$ -
9. ACA Reinsurance contributions – not reported as	$ -

c. Temporary ACA Risk Corridors Program

Assets	
1. Accrued retrospective premium due to ACA Risk	$ -
Liabilities	
2. Reserve for rate credits or policy experience rating	$ -
Operations (Revenue & Expense)	
3. Effect of ACA Risk Corridors on net premium	$ -
4. Effect of ACA Risk Corridors on change in	$ -

3) Roll-forward of prior year ACA risk-sharing provision

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 – 3 +7)	Cumulative Balance from Prior Years (Col 2 – 4 +8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
A. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable	-	-		-	-	-		-	A	-	-
2. Premium adjustments (payable)	-	-	-	-	-	-	-	-	B	-	-
3. Subtotal ACA Risk Sharing Adjustment Program	-	-	-	-	-	-	-	-	-	-	-
B. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid		-		-	-	-		-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)		-		-	-	-		-	D	-	-
3. Amounts receivable relating to uninsured plans		-		-	-	-		-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premiums		-		-	-	-		-	F	-	-
5. Ceded Reinsurance premiums payable		-		-	-	-		-	G	-	-
6. Liability for amounts held under uninsured plans		-		-	-	-		-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-	-	-	-
C. Temporary ACA Risk Corridors Program											
1. Accrued restrospective premium		-		-	-	-		-	I	-	-
2. Reserve for rate credits or policy experience rating refunds		-		-	-	-		-	J	-	-
Program	-	-	-	-	-	-	-	-	-	-	-
D. Total for ACA Risk-Sharing Provisions	-	-	-	-	-	-	-	-		-	-

Explanations of Adjustments
A - N/A

4) Roll-forward of Risk Corridors Asset and Liability Balances by Program Benefit Year

Notes to Financial Statements

Risk Corridors Program Year	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments		Ref	Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 – 3 +7)	Cumulative Balance from Prior Years (Col 2 – 4 +8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)		Receivable	(Payable)
a. 2014											
1. Accrued retrospective premium		-		-	-	-		-	A	-	-
2. Reserve for rate credits or policy experience rating refunds		-		-	-	-		-	B	-	-
b. 2015											
1. Accrued retrospective premium		-		-	-	-		-	C	-	-
2. Reserve for rate credits or policy experience rating refunds		-		-	-	-		-	D	-	-
c. 2016											
1. Accrued retrospective premium		-		-	-	-		-	E	-	-
2. Reserve for rate credits or policy experience rating refunds		-		-	-	-		-	F	-	-
d. 2017											
1. Accrued retrospective premium		-		-	-	-		-	H	-	-
2. Reserve for rate credits or policy experience rating refunds		-		-	-	-		-	I	-	-
e. Total for Risk Corridors	-	-	-	-	-	-	-	-		-	-

Explanations of Adjustments
A - N/A

5) ACA Risk Corridors Receivable as of Reporting Date

Risk Corridors Receivable as of Reporting Date	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-admissions) (1-2-3)	5 Non-admitted Amount	6 Net Admitted Asset (4-5)
a. 2014						
b. 2015						
c. 2016						
d. 2017						
e. Total (a+b+c)	-	-	-	-	-	-

24E(5)d (Column 4) should equal
24E(3)c1 (Column 9)
24E(5)d (Column 6) should equal
24E(2)c1

25. Change in Insured Claims and Claim Adjustment Expenses

Reserves for claims and claims adjustment expenses as of December 31, 2018 and 2017 were $26,399,000 and $36,563,000, respectively. During the year ended December 31, 2018 and 2017 $31,746,712 and $38,849,000 was paid for incurred claims and claim adjustment expenses attributable to insured events of prior years.

26. Intercompany Pooling Arrangements

The Company is not part of a group of affiliated insurers that utilizes a pooling arrangement.

27. Structured Settlements

Not Applicable.

28. Health Care Receivables

Not Applicable.

29. Participating Policies

The Company did not have any participating policies.

30. Premium Deficiency Reserves

The Company did not have any premium deficiency reserves.

31. Anticipated Salvage and Subrogation

There is no salvage and subrogation to disclose.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes[X] No[ ]
If yes, complete Schedule Y, Parts 1, 1A and 2.

1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes[X] No[ ] N/A[ ]

1.3 State Regulating? Texas

1.4 Is the reporting entity publicly traded or a member of a publicly traded group? Yes[ ] No[X]

1.5 If the response to 1.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group.

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes[ ] No[X]

2.2 If yes, date of change:

3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. 12/31/2014

3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. 12/31/2014

3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). 06/07/2016

3.4 By what department or departments?
Texas Department of Insurance

3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with departments? Yes[ ] No[ ] N/A[X]

3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes[ ] No[ ] N/A[X]

4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business? Yes[ ] No[X]
4.12 renewals? Yes[ ] No[X]

4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business? Yes[ ] No[X]
4.22 renewals? Yes[ ] No[X]

5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes[ ] No[X]
If yes, complete and file the merger history data file with the NAIC.

5.2 If yes, provide the name of the entity, NAIC company code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes[ ] No[X]

6.2 If yes, give full information:

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? Yes[ ] No[X]

7.2 If yes,
7.21 State the percentage of foreign control 0.000%
7.22 State the nationality(s) of the foreign person(s) or entity(s); or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact and identify the type of entity(s) (e.g., individual, corporation, government, manager or attorney-in-fact).

1 Nationality	2 Type of Entity

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes[ ] No[X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes[ ] No[X]

8.4 If response to 8.3 is yes, please provide the names and locations (city and state of the main office) of any affiliates regulated by a federal financial regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC) and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC
		No	No	No	No

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Ernst & Young, LLP 200 Clarendon Street, Boston, MA 02116

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes[ ] No[X]

10.2 If response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes[ ] No[X]

10.4 If response to 10.3 is yes, provide information related to this exemption:

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes[ ] No[ ] N/A[X]

10.6 If the response to 10.5 is no or n/a please explain:
An Audit Committee has been established at the ultimate parent company, Catalyst Institute, Inc.

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?

GENERAL INTERROGATORIES (Continued)

Milliman, Inc. 111 Monument Circle, Suite 601 Indianapolis, IN 46204-5128

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes[ ] No[X]
12.11 Name of real estate holding company
12.12 Number of parcels involved 0
12.13 Total book/adjusted carrying value $..... 0
12.2 If yes, provide explanation

13. FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:
13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?
13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes[ ] No[ ] N/A[X]
13.3 Have there been any changes made to any of the trust indentures during the year? Yes[ ] No[ ] N/A[X]
13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes[ ] No[ ] N/A[X]

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes[X] No[ ]
a. Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
b. Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
c. Compliance with applicable governmental laws, rules and regulations;
d. The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
e. Accountability for adherence to the code.
14.11 If the response to 14.1 is no, please explain:
14.2 Has the code of ethics for senior managers been amended? Yes[ ] No[X]
14.21 If the response to 14.2 is yes, provide information related to amendment(s).
14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes[ ] No[X]
14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes[ ] No[X]
15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount
.....	.....	.....	.....

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the Board of Directors or a subordinate committee thereof? Yes[X] No[ ]

17. Does the reporting entity keep a complete permanent record of the proceedings of its Board of Directors and all subordinate committees thereof? Yes[X] No[ ]

18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person? Yes[X] No[ ]

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes[ ] No[X]

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
20.11 To directors or other officers $..... 0
20.12 To stockholders not officers $..... 0
20.13 Trustees, supreme or grand (Fraternal only) $..... 0
20.2 Total amount of loans outstanding at end of year (inclusive of Separate Accounts, exclusive of policy loans):
20.21 To directors or other officers $..... 0
20.22 To stockholders not officers $..... 0
20.23 Trustees, supreme or grand (Fraternal only) $..... 0

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes[ ] No[X]
21.2 If yes, state the amount thereof at December 31 of the current year:
21.21 Rented from others $..... 0
21.22 Borrowed from others $..... 0
21.23 Leased from others $..... 0
21.24 Other $..... 0

22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes[ ] No[X]
22.2 If answer is yes:
22.21 Amount paid as losses or risk adjustment $..... 0
22.22 Amount paid as expenses $..... 0
22.23 Other amounts paid $..... 0

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes[ ] No[X]
23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $..... 0

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03) Yes[ ] No[X]
24.02 If no, give full and complete information, relating thereto
All investments are maintained by the Company's Custodians with the exception of deposits that are held by state regulators.
24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)
24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes[ ] No[ ] N/A[X]
24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. $..... 0
24.06 If answer to 24.04 is no, report amount of collateral for other programs. $..... 0
24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes[ ] No[ ] N/A[X]
24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes[ ] No[ ] N/A[X]

GENERAL INTERROGATORIES (Continued)

24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending? Yes[ ] No[ ] N/A[X]

24.10 For the reporting entity's security lending program, state the amount of the following as of December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2.	$ 0
24.102 Total book/adjusted carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2.	$ 0
24.103 Total payable for securities lending reported on the liability page.	$ 0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes[X] No[ ]

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21	Subject to repurchase agreements	$ 0
25.22	Subject to reverse repurchase agreements	$ 0
25.23	Subject to dollar repurchase agreements	$ 0
25.24	Subject to reverse dollar repurchase agreements	$ 0
25.25	Placed under option agreements	$ 0
25.26	Letter stock or securities restricted as to sale - excluding FHLB Capital Stock	$ 0
25.27	FHLB Capital Stock	$ 0
25.28	On deposit with states	$ 6,064,923
25.29	On deposit with other regulatory bodies	$ 0
25.30	Pledged as collateral - excluding collateral pledged to an FHLB	$ 0
25.31	Pledged as collateral to FHLB - including assets backing funding agreements	$ 0
25.32	Other	$ 0

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes[ ] No[X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes[ ] No[ ] N/A[X]
If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes[ ] No[X]

27.2 If yes, state the amount thereof at December 31 of the current year. $ 0

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section I, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes[X] No[ ]

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
State Street Bank & Trust	801 Pennsylvania Avenue, Kansas City, MO, 64105

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes[ ] No[X]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Investment management - Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. [" that have access to the investment accounts"; " handle securities"]

1 Name of Firm or Individual	2 Affiliation
State Street Global Advisors	U
Conning Asset Management	U
Income Research Group & Management	U
Prime Buchholz & Associates	U
Gregory P. Winn	I

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets? Yes[X] No[ ]

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's assets? Yes[ ] No[X]

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

GENERAL INTERROGATORIES (Continued)

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
112861	State Street Global Advisors	571474TGEMMWANRLN572	SEC	
107423	Conning Asset Management		SEC	OS
104863	Income Research & Management		SEC	OS
106455	Prime Buchholz & Associates		SEC	OS

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D - Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b)(1)])? Yes[ ] No[X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 Total		

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

		1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1	Bonds	54,056,501	53,009,884	(1,046,617)
30.2	Preferred stocks			
30.3	Totals	54,056,501	53,009,884	(1,046,617)

30.4 Describe the sources or methods utilized in determining the fair values:
The fair values are obtained from the custodian, State Street Bank & Trust, on a monthly basis

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes[X] No[ ]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes[X] No[ ] N/A[ ]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes[X] No[ ]

32.2 If no, list exceptions:

33. By self-designation 5GI securities, the reporting entity is certifying the following elements for each self-designated 5GI security:
   a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
   b. Issuer or obligor is current on all contracted interest and principal payments.
   c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

Has the reporting-entity self-designated 5GI securities? Yes[ ] No[X]

34. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
   a. The security was purchased prior to January 1, 2018.
   b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security
   c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as an NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.
   d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.

Has the reporting entity self-designated PLGI securities? Yes[ ] No[X]

OTHER

35.1 Amount of payments to Trade Associations, Service Organizations and Statistical or Rating Bureaus, if any? $ 0

35.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to Trade Associations, Service Organizations and Statistical or Rating Bureaus during the period covered by this statement.

1 Name	2 Amount Paid

36.1 Amount of payments for legal expenses, if any? $ 0

36.2 List the name of the firm and the amount paid if any such payments represented 25% or more of the total payments for legal expenses during the period covered by this statement.

GENERAL INTERROGATORIES (Continued)

1 Name	2 Amount Paid

37.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or department of government, if any? $ 0

37.2 List the name of firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid

GENERAL INTERROGATORIES (Continued)

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes[ ] No[X]
1.2 If yes, indicate premium earned on U.S. business only: $ 0
1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? $ 0
1.31 Reason for excluding:
1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above. $ 0
1.5 Indicate total incurred claims on all Medicare Supplement insurance. $ 0
1.6 Individual policies - Most current three years:
1.61 TOTAL Premium earned $ 0
1.62 TOTAL Incurred claims $ 0
1.63 Number of covered lives 0
All years prior to most current three years:
1.64 TOTAL Premium earned $ 0
1.65 TOTAL Incurred claims $ 0
1.66 Number of covered lives 0
1.7 Group policies - Most current three years:
1.71 TOTAL Premium earned $ 0
1.72 TOTAL Incurred claims $ 0
1.73 Number of covered lives 0
All years prior to most current three years:
1.74 TOTAL Premium earned $ 0
1.75 TOTAL Incurred claims $ 0
1.76 Number of covered lives 0

2. Health Test

		1 Current Year	2 Prior Year
2.1	Premium Numerator	768,963,667	803,066,544
2.2	Premium Denominator	768,963,667	803,066,544
2.3	Premium Ratio (2.1 / 2.2)	1.000	1.000
2.4	Reserve Numerator	34,190,102	43,752,125
2.5	Reserve Denominator	34,190,102	43,752,125
2.6	Reserve Ratio (2.4 / 2.5)	1.000	1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes[ ] No[X]
3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes[X] No[ ]
4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes[ ] No[X] N/A[ ]

5.1 Does the reporting entity have stop-loss reinsurance? Yes[ ] No[X]
5.2 If no, explain:
The company does not have stop-loss reinsurance; risk is limited within company's agreements.
5.3 Maximum retained risk (see instructions):
5.31 Comprehensive Medical $ 0
5.32 Medical Only $ 0
5.33 Medicare Supplement $ 0
5.34 Dental & Vision $ 0
5.35 Other Limited Benefit Plan $ 0
5.36 Other $ 0

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes[X] No[ ]
7.2 If no, give details:

8. Provide the following information regarding participating providers:
8.1 Number of providers at start of reporting year 9,755
8.2 Number of providers at end of reporting year 9,835

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes[ ] No[X]
9.2 If yes, direct premium earned:
9.21 Business with rate guarantees between 15-36 months 0
9.22 Business with rate guarantees over 36 months 0

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes[ ] No[X]
10.2 If yes:
10.21 Maximum amount payable bonuses $ 0
10.22 Amount actually paid for year bonuses $ 0
10.23 Maximum amount payable withholds $ 0
10.24 Amount actually paid for year withholds $ 0

11.1 Is the reporting entity organized as:
11.12 A Medical Group/Staff Model, Yes[ ] No[X]
11.13 An Individual Practice Association (IPA), or, Yes[ ] No[X]
11.14 A Mixed Model (combination of above)? Yes[ ] No[X]
11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes[X] No[ ]
11.3 If yes, show the name of the state requiring such minimum capital and surplus.
Texas requires $700,000 in Capital and $700,000 in Surplus for a total Minimum Capital and Surplus of $1,400,000
11.4 If yes, show the amount required. $ 1,400,000
11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes[ ] No[X]
11.6 If the amount is calculated, show the calculation.

12. List service areas in which the reporting entity is licensed to operate:

1 Name of Service Area
State of Texas
State of Georgia
State of Massachusetts
State of Louisiana
State of Utah
State of Colorado
State of Tennessee
State of Oklahoma
State of Indiana
State of New Hampshire
State of Rhode Island

GENERAL INTERROGATORIES (Continued)

1 Name of Service Area
State of California
State of Michigan
State of Nevada
State of North Carolina
State of South Carolina

13.1 Do you act as a custodian for health savings accounts? Yes[ ] No[X]
13.2 If yes, please provide the amount of custodial funds held as of the reporting date: $ 0
13.3 Do you act as an administrator for health savings accounts? Yes[ ] No[X]
13.4 If yes, please provide the balance of the funds administered as of the reporting date: $ 0

14.1 Are any of the captive affiliates reported on Schedule S, Part 3, as authorized reinsurers? Yes[ ] No[ ] N/A[X]
14.2 If the answer to 14.1 is yes, please provide the following:

1	2	3	4	Assets Supporting Reserve Credit		
				5	6	7
Company Name	NAIC Company Code	Domiciliary Jurisdiction	Reserve Credit	Letters of Credit	Trust Agreements	Other

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded)
15.1 Direct Premium Written $ 0
15.2 Total incurred claims $ 0
15.2 Number of covered lives 0

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without Secondary Guarantee)
Universal Life (with or without Secondary Guarantee)
Variable Universal Life (with or without Secondary Guarantee)

16. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? Yes[X] No[ ]
16.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? Yes[ ] No[X]

FIVE-YEAR HISTORICAL DATA

	1 2018	2 2017	3 2016	4 2015	5 2014
BALANCE SHEET (Pages 2 and 3)					
1. TOTAL Admitted Assets (Page 2, Line 28)	159,072,823	171,181,888	192,988,319	205,298,612	196,681,028
2. TOTAL Liabilities (Page 3, Line 24)	48,890,136	53,675,666	67,584,333	83,833,148	93,335,516
3. Statutory minimum capital and surplus requirement	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000
4. TOTAL Capital and Surplus (Page 3, Line 33)	110,182,687	117,506,222	125,403,986	121,465,464	103,345,512
INCOME STATEMENT (Page 4)					
5. TOTAL Revenues (Line 8)	821,456,388	852,530,745	912,824,207	868,452,564	800,704,760
6. TOTAL Medical and Hospital Expenses (Line 18)	742,761,138	762,196,143	805,876,944	782,118,223	705,359,587
7. Claims adjustment expenses (Line 20)	11,561,692	11,073,839	10,772,749	9,514,843	9,447,659
8. TOTAL Administrative Expenses (Line 21)	52,669,929	50,447,488	49,075,857	43,345,396	43,039,337
9. Net underwriting gain (loss) (Line 24)	14,463,629	28,813,275	47,098,656	33,474,102	42,858,176
10. Net investment gain (loss) (Line 27)	687,234	1,409,876	820,202	1,198,671	343,440
11. TOTAL Other Income (Lines 28 plus 29)					
12. Net income or (loss) (Line 32)	8,657,597	19,523,092	26,357,880	17,897,859	24,074,076
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	16,313,722	357,446	19,267,996	23,690,258	9,825,294
RISK-BASED CAPITAL ANALYSIS					
14. TOTAL Adjusted Capital	110,182,687	117,506,222	125,403,986	121,465,464	103,345,512
15. Authorized control level risk-based capital	29,439,296	29,174,176	30,824,123	29,843,651	26,959,952
ENROLLMENT (Exhibit 1)					
16. TOTAL Members at End of Period (Column 5, Line 7)	1,934,970	2,047,245	1,988,814	1,894,995	1,817,505
17. TOTAL Members Months (Column 6, Line 7)	23,625,408	24,050,937	23,276,324	21,996,406	20,657,733
OPERATING PERCENTAGE (Page 4)					
(Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. TOTAL Hospital and Medical plus other non-health (Lines 18 plus Line 19)	90.4	89.4	88.3	90.1	88.1
20. Cost containment expenses	0.1	0.1	0.1	0.1	0.1
21. Other claims adjustment expenses	1.3	1.2	1.1	1.0	1.1
22. TOTAL Underwriting Deductions (Line 23)	98.2	96.6	94.8	96.1	94.6
23. TOTAL Underwriting Gain (Loss) (Line 24)	1.8	3.4	5.2	3.9	5.4
UNPAID CLAIMS ANALYSIS					
(U&I Exhibit, Part 2B)					
24. TOTAL Claims Incurred for Prior Years (Line 13, Column 5)	33,679,600	42,622,569	37,352,729	31,639,178	26,499,584
25. Estimated liability of unpaid claims-[prior year (Line 13, Column 6)]	35,878,958	43,234,378	38,333,054	25,958,693	29,398,992
INVESTMENTS IN PARENT, SUBSIDIARIES AND AFFILIATES					
26. Affiliated bonds (Sch. D Summary, Line 12, Column 1)					
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Column 1)					
28. Affiliated common stocks (Sch. D Summary, Line 24, Column 1)					
29. Affiliated short-term investments (subtotal included in Sch. DA Verification, Col. 5, Line 10)					
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. TOTAL of Above Lines 26 to 31					
33. TOTAL Investment in Parent Included in Lines 26 to 31 above					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3 - Accounting Changes and Correction of Errors? Yes[ ] No[ ] N/A[X]

If no, please explain:

ANNUAL STATEMENT FOR THE YEAR **2018** OF THE **DentaQuest USA Insurance Company, Inc.**

12307201843005000 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **CALIFORNIA** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18. Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843006100 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **COLORADO** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3				Federal Employees Health Benefits Plan			
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only		Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services	125,610					125,610				
18. Amount Incurred for Provision of Health Care Services	137,610					137,610				

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843011100 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **GEORGIA** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3				Federal Employees Health Benefits Plan			
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only		Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services	617,684					617,684				
18. Amount Incurred for Provision of Health Care Services	653,769					653,769				

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843015000 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **INDIANA** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18. Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

ANNUAL STATEMENT FOR THE YEAR **2018** OF THE **DentaQuest USA Insurance Company, Inc.**

12307201843019000 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **LOUISIANA** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18. Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843022100 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **MASSACHUSETTS** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3				Federal Employees Health Benefits Plan			
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only		Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services	141					141				
18. Amount Incurred for Provision of Health Care Services	141					141				

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843023000 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **MICHIGAN** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18. Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843029000 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **NEVADA** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18. Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

ANNUAL STATEMENT FOR THE YEAR **2018** OF THE **DentaQuest USA Insurance Company, Inc.**

12307201843030000 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **NEW HAMPSHIRE** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18. Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843034100 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **NORTH CAROLINA** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3				Federal Employees Health Benefits Plan			
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only		Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services	200,461					200,461				
18. Amount Incurred for Provision of Health Care Services	211,833					211,833				

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

ANNUAL STATEMENT FOR THE YEAR **2018** OF THE **DentaQuest USA Insurance Company, Inc.**

12307201843037000 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **OKLAHOMA** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18. Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843040000 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **RHODE ISLAND** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services										
18. Amount Incurred for Provision of Health Care Services										

NONE

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

ANNUAL STATEMENT FOR THE YEAR **2018** OF THE **DentaQuest USA Insurance Company, Inc.**

12307201843041100 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **SOUTH CAROLINA** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3				Federal Employees Health Benefits Plan			
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only		Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year										
2. First Quarter										
3. Second Quarter										
4. Third Quarter										
5. Current Year										
6. Current Year Member Months										
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)										
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services	80,488					80,488				
18. Amount Incurred for Provision of Health Care Services	82,488					82,488				

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843043100 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **TENNESSEE** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3				Federal Employees Health Benefits Plan			
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only		Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year	72,359					72,359				
2. First Quarter	71,476					71,476				
3. Second Quarter	65,589					65,589				
4. Third Quarter	40,057					40,057				
5. Current Year	40,851					40,851				
6. Current Year Member Months	664,790					664,790				
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)	13,612,926					13,612,926				
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services	15,636,751					15,636,751				
18. Amount Incurred for Provision of Health Care Services	13,992,900					13,992,900				

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843044100 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **TEXAS** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3				Federal Employees Health Benefits Plan			
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only		Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year	1,970,821					1,970,821				
2. First Quarter	1,936,304					1,936,304				
3. Second Quarter	1,905,233					1,905,233				
4. Third Quarter	1,889,920					1,889,920				
5. Current Year	1,894,119					1,894,119				
6. Current Year Member Months	22,928,950					22,928,950				
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)	754,929,586					754,929,586				
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services	733,283,812					733,283,812				
18. Amount Incurred for Provision of Health Care Services	727,306,758					727,306,758				

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843045100 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **UTAH** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year	4,065					4,065				
2. First Quarter	4,000					4,000				
3. Second Quarter	4,032					4,032				
4. Third Quarter										
5. Current Year										
6. Current Year Member Months	31,668					31,668				
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)	421,155					421,155				
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services	386,639					386,639				
18. Amount Incurred for Provision of Health Care Services	375,639					375,639				

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

12307201843059100 2018 Document Code: 430

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION: 2. LOCATION:

NAIC Group Code 4512 BUSINESS IN THE STATE OF **GRAND TOTAL** DURING THE YEAR NAIC Company Code 12307

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
TOTAL Members at end of:										
1. Prior Year	2,047,245					2,047,245				
2. First Quarter	2,011,780					2,011,780				
3. Second Quarter	1,974,854					1,974,854				
4. Third Quarter	1,929,977					1,929,977				
5. Current Year	1,934,970					1,934,970				
6. Current Year Member Months	23,625,408					23,625,408				
TOTAL Member Ambulatory Encounters for Year:										
7. Physician										
8. Non-Physician										
9. TOTAL										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b)	768,963,667					768,963,667				
13. Life Premiums Direct										
14. Property/Casualty Premiums Written										
15. Health Premiums Earned										
16. Property/Casualty Premiums Earned										
17. Amount Paid for Provision of Health Care Services	750,331,586					750,331,586				
18. Amount Incurred for Provision of Health Care Services	742,761,138					742,761,138				

(a) For health business: number of persons insured under PPO managed care products .....0 and number of persons insured under indemnity only products .....0.
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $.....0

30 Grand Total

SCHEDULE S - PART 7

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

		1 As Reported (net of ceded)	2 Restatement Adjustments	3 Restated (gross of ceded)
ASSETS (Page 2, Col. 3)				
1.	Cash and invested assets (Line 12)	124,949,205		124,949,205
2.	Accident and health premiums due and unpaid (Line 15)	3,183,308		3,183,308
3.	Amounts recoverable from reinsurers (Line 16.1)			
4.	Net credit for ceded reinsurance	X X X		
5.	All other admitted assets (Balance)	30,940,310		30,940,310
6.	TOTAL Assets (Line 28)	159,072,823		159,072,823
LIABILITIES, CAPITAL AND SURPLUS (Page 3)				
7.	Claims unpaid (Line 1)	25,313,198		25,313,198
8.	Accrued medical incentive pool and bonus payments (Line 2)	1,085,591		1,085,591
9.	Premiums received in advance (Line 8)	4,764,426		4,764,426
10.	Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19, first inset amount plus second inset amount)			
11.	Reinsurance in unauthorized companies (Line 20 minus inset amount)			
12.	Reinsurance with Certified Reinsurers (Line 20 inset amount)			
13.	Funds held under reinsurance treaties with Certified Reinsurers (Line 19 third inset amount)			
14.	All other liabilities (Balance)	17,726,921		17,726,921
15.	TOTAL Liabilities (Line 24)	48,890,136		48,890,136
16.	TOTAL Capital and Surplus (Line 33)	110,182,687	X X X	110,182,687
17.	TOTAL Liabilities, Capital and Surplus (Line 34)	159,072,823		159,072,823
NET CREDIT FOR CEDED REINSURANCE				
18.	Claims unpaid			
19.	Accrued medical incentive pool			
20.	Premiums received in advance			
21.	Reinsurance recoverable on paid losses			
22.	Other ceded reinsurance recoverables			
23.	TOTAL Ceded Reinsurance Recoverables			
24.	Premiums receivable			
25.	Funds held under reinsurance treaties with authorized and unauthorized reinsurers			
26.	Unauthorized reinsurance			
27.	Reinsurance with Certified Reinsurers			
28.	Funds held under reinsurance treaties with Certified Reinsurers			
29.	Other ceded reinsurance payables/offsets			
30.	TOTAL Ceded Reinsurance Payables/Offsets			
31.	TOTAL Net Credit for Ceded Reinsurance			

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

ALLOCATED BY STATES AND TERRITORIES

State, Etc.	1 Active Status (a)	Direct Business Only 2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefits Plan Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/ Casualty Premiums	8 Total Columns 2 Through 7	9 Deposit - Type Contracts
1. Alabama (AL)	N								
2. Alaska (AK)	N								
3. Arizona (AZ)	N								
4. Arkansas (AR)	N								
5. California (CA)	L								
6. Colorado (CO)	L								
7. Connecticut (CT)	N								
8. Delaware (DE)	N								
9. District of Columbia (DC)	N								
10. Florida (FL)	N								
11. Georgia (GA)	L								
12. Hawaii (HI)	N								
13. Idaho (ID)	N								
14. Illinois (IL)	N								
15. Indiana (IN)	L								
16. Iowa (IA)	N								
17. Kansas (KS)	N								
18. Kentucky (KY)	N								
19. Louisiana (LA)	L								
20. Maine (ME)	N								
21. Maryland (MD)	N								
22. Massachusetts (MA)	L								
23. Michigan (MI)	L								
24. Minnesota (MN)	N								
25. Mississippi (MS)	N								
26. Missouri (MO)	N								
27. Montana (MT)	N								
28. Nebraska (NE)	N								
29. Nevada (NV)	L								
30. New Hampshire (NH)	L								
31. New Jersey (NJ)	N								
32. New Mexico (NM)	N								
33. New York (NY)	N								
34. North Carolina (NC)	L								
35. North Dakota (ND)	N								
36. Ohio (OH)	N								
37. Oklahoma (OK)	L								
38. Oregon (OR)	N								
39. Pennsylvania (PA)	N								
40. Rhode Island (RI)	L								
41. South Carolina (SC)	L								
42. South Dakota (SD)	N								
43. Tennessee (TN)	L	13,612,926						13,612,926	
44. Texas (TX)	L	754,929,586						754,929,586	
45. Utah (UT)	L	421,155						421,155	
46. Vermont (VT)	N								
47. Virginia (VA)	N								
48. Washington (WA)	N								
49. West Virginia (WV)	N								
50. Wisconsin (WI)	N								
51. Wyoming (WY)	N								
52. American Samoa (AS)	N								
53. Guam (GU)	N								
54. Puerto Rico (PR)	N								
55. U.S. Virgin Islands (VI)	N								
56. Northern Mariana Islands (MP)	N								
57. Canada (CAN)	N								
58. Aggregate other alien (OT)	XXX								
59. Subtotal	XXX	768,963,667						768,963,667	
60. Reporting entity contributions for Employee Benefit Plans	XXX								
61. TOTAL (Direct Business)	XXX	768,963,667						768,963,667	
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX								
58999. TOTALS (Lines 58001 through 58003 plus 58998) (Line 58 above)	XXX								

(a) Active Status Counts:

L - Licensed or Chartered - Licensed insurance carrier or domiciled RRG 16
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state
N - None of the above - Not allowed to write business in the state 41
R - Registered - Non-domiciled RRGs
Q - Qualified - Qualified or accredited reinsurer

Explanation of basis of allocation by state, premiums by state, etc.: All premiums written within the state of Texas.

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN ALLOCATED BY STATES AND TERRITORIES

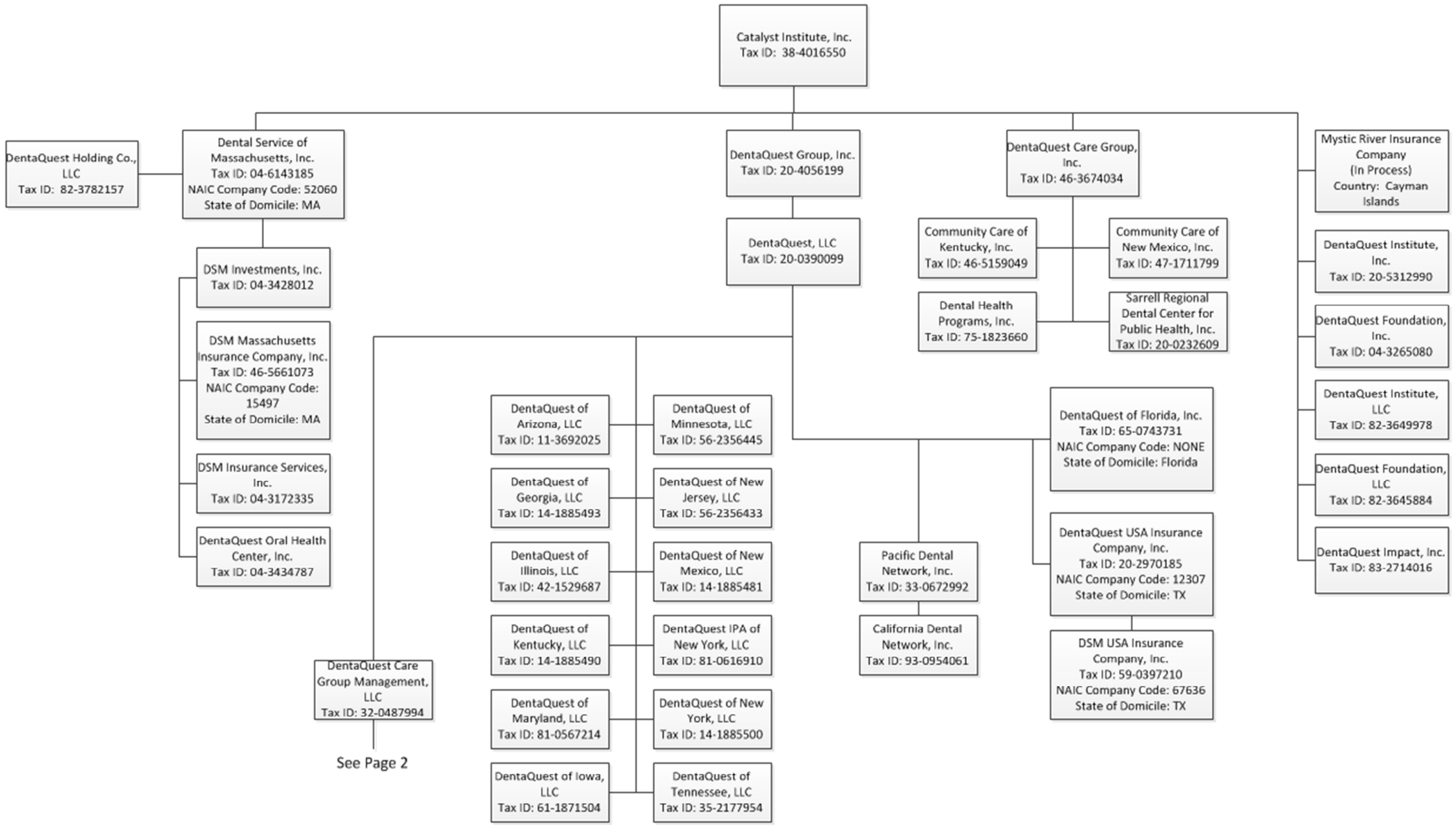
		Direct Business only					
	States, Etc.	1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts	6 Totals
1.	Alabama (AL)						
2.	Alaska (AK)						
3.	Arizona (AZ)						
4.	Arkansas (AR)						
5.	California (CA)						
6.	Colorado (CO)						
7.	Connecticut (CT)						
8.	Delaware (DE)						
9.	District of Columbia (DC)						
10.	Florida (FL)						
11.	Georgia (GA)						
12.	Hawaii (HI)						
13.	Idaho (ID)						
14.	Illinois (IL)						
15.	Indiana (IN)						
16.	Iowa (IA)						
17.	Kansas (KS)						
18.	Kentucky (KY)						
19.	Louisiana (LA)						
20.	Maine (ME)						
21.	Maryland (MD)						
22.	Massachusetts (MA)						
23.	Michigan (MI)						
24.	Minnesota (MN)						
25.	Mississippi (MS)						
26.	Missouri (MO)						
27.	Montana (MT)						
28.	Nebraska (NE)						
29.	Nevada (NV)						
30.	New Hampshire (NH)						
31.	New Jersey (NJ)						
32.	New Mexico (NM)						
33.	New York (NY)						
34.	North Carolina (NC)						
35.	North Dakota (ND)						
36.	Ohio (OH)						
37.	Oklahoma (OK)						
38.	Oregon (OR)						
39.	Pennsylvania (PA)						
40.	Rhode Island (RI)						
41.	South Carolina (SC)						
42.	South Dakota (SD)						
43.	Tennessee (TN)						
44.	Texas (TX)						
45.	Utah (UT)						
46.	Vermont (VT)						
47.	Virginia (VA)						
48.	Washington (WA)						
49.	West Virginia (WV)						
50.	Wisconsin (WI)						
51.	Wyoming (WY)						
52.	American Samoa (AS)						
53.	Guam (GU)						
54.	Puerto Rico (PR)						
55.	U.S. Virgin Islands (VI)						
56.	Northern Mariana Islands (MP)						
57.	Canada (CAN)						
58.	Aggregate other alien (OT)						
59.	TOTALS						

NONE

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER

MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

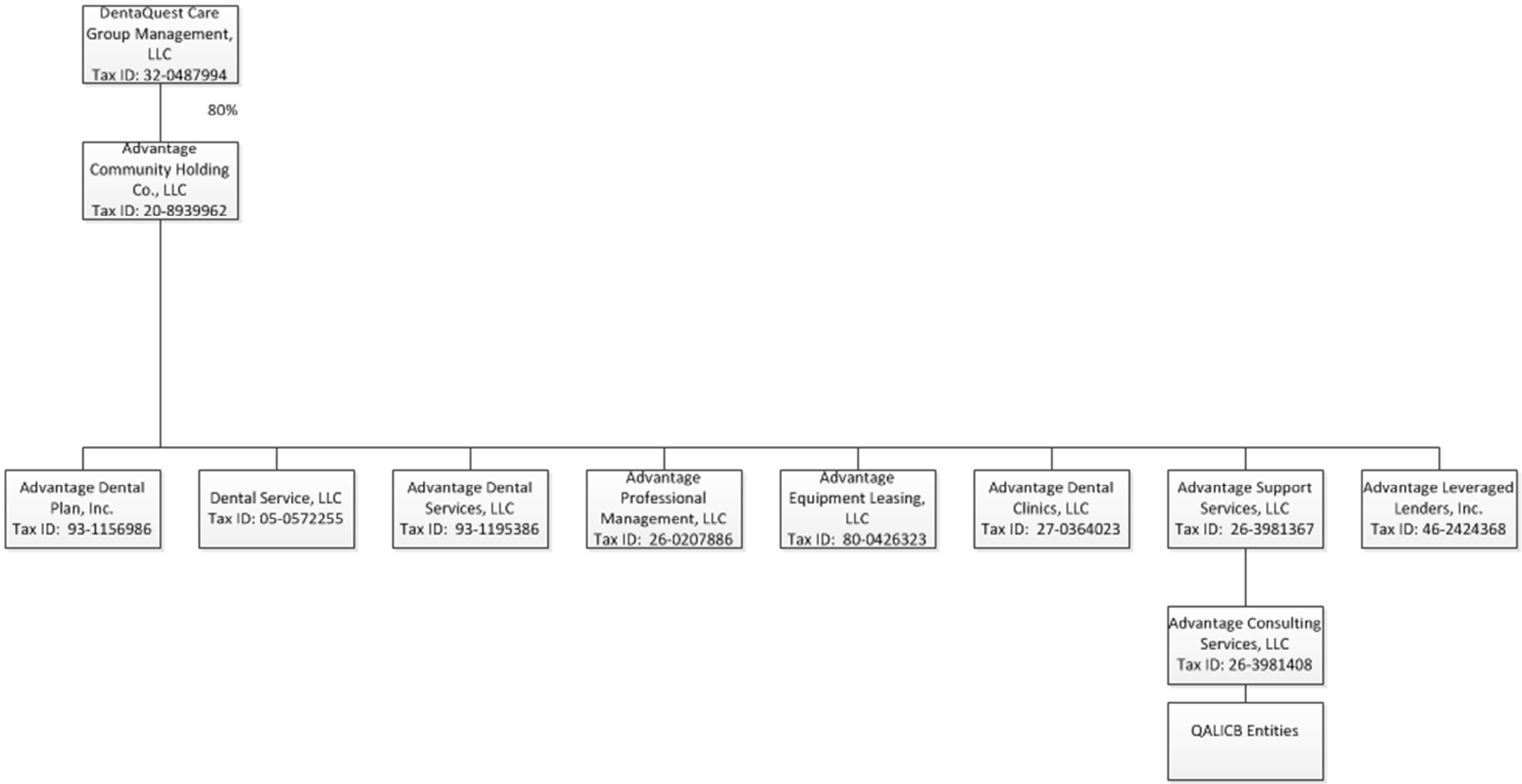


SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER

MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

40.1



DentaQuest Care Group Management, LLC owns an 80% share in Advantage Community Holding Company, LLC. The remaining 20% is owned by a non-affiliated company, Advantage Consolidated, LLC, which was the sole owner prior to September 2016.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	FEDERAL RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity / Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies) / Person(s)	Is an SCA Filing Required? (Y/N)	*
4512	DENTAQUEST GROUP	52060	04-6143185				DENTAL SERV OF MA INC	MA	UIP	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	12307	20-2970185				DENTAQUEST USA INS CO INC	TX	UDP	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	20-4056199				DENTAQUEST GROUP, INC.	DE	UIP	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	81-0616910				DENTAQUEST IPA OF NEW YORK, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	11-3692025				DENTAQUEST OF ARIZONA, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	65-0743731				DENTAQUEST OF FLORIDA, INC.	FL	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	14-1885493				DENTAQUEST OF GEORGIA, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	42-1529687				DENTAQUEST OF ILLINOIS, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	14-1885490				DENTAQUEST OF KENTUCKY, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	81-0567214				DENTAQUEST OF MARYLAND, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	56-2356445				DENTAQUEST OF MINNESOTA, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	56-2356433				DENTAQUEST OF NEW JERSEY, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	14-1885481				DENTAQUEST OF NEW MEXICO, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	14-1885500				DENTAQUEST OF NEW YORK, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	35-2177954				DENTAQUEST OF TENNESSEE, LLC	WI	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	04-3434787				DENTAQUEST ORAL HEALTH CENTER, INC.	MA	NIA	DSM INVESTMENTS, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	20-0390099				DENTAQUEST, LLC	DE	UDP	DQ MASSACHUSETTS BUSINESS TRUST	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	20-4056067				DQ MASSACHUSETTS BUSINESS TRUST	MA	UIP	DENTAQUEST MANAGEMENT, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	04-3172335				DSM INSURANCE SERVICES, INC.	MA	NIA	DSM INVESTMENTS, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	04-3428012				DSM INVESTMENTS, INC.	MA	NIA	DENTAL SERV OF MA INC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	67636	59-0397210				DSM USA INSURANCE COMPANY, INC.	PA	DS	DENTAQUEST USA INSURANCE COMPANY, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	46-3674034				DENTAQUEST CARE GROUP, INC.	MA	NIA	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	20-0232609				SARRELL REGIONAL DENTAL CENTER FOR PUBLIC HEALTH, INC	AL	NIA	DENTAQUEST CARE GROUP, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	75-1823660				DENTAL HEALTH PROGRAMS, INC.	MA	NIA	DENTAQUEST CARE GROUP, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	20-5312990				DENTAQUEST INSTITUTE, INC.	MA	NIA	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	15497	46-5661073				DSM MASSACHUSETTS INSURANCE COMPANY, INC.	MA	NIA	DSM INVESTMENTS, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	46-5159049				COMMUNITY CARE OF KENTUCKY, INC.	KY	NIA	DENTAQUEST CARE GROUP, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	33-0672992				PACIFIC DENTAL NETWORK, INC.	CA	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	93-0954061				CALIFORNIA DENTAL NETWORK, INC.	CA	NIA	PACIFIC DENTAL NETWORK, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	47-1711799				COMMUNITY CARE OF NEW MEXICO, INC.	NY	NIA	DENTAQUEST CARE GROUP, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	20-8939962				ADVANTAGE COMMUNITY HOLDINGS CO., LLC	OR	NIA	DENTAQUEST CARE GROUP MANAGEMENT, LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	93-1156986				ADVANTAGE DENTAL PLAN, INC.	OR	IA	ADVANTAGE COMMUNITY HOLDING CO., LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	26-0207886				ADVANTAGE PROFESSIONAL MANAGEMENT, LLC	OR	NIA	ADVANTAGE COMMUNITY HOLDING CO., LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	93-1195386				ADVANTAGE DENTAL SERVICES, LLC	OR	NIA	ADVANTAGE COMMUNITY HOLDING CO., LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	80-0426323				ADVANTAGE EQUIPMENT LEASING, LLC	OR	NIA	ADVANTAGE COMMUNITY HOLDING CO., LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	26-3981367				ADVANTAGE SUPPORT SERVICES, LLC	OR	NIA	ADVANTAGE COMMUNITY HOLDING CO., LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	27-0364023				ADVANTAGE DENTAL CLINICS, LLC	OR	NIA	ADVANTAGE COMMUNITY HOLDING CO., LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	FEDERAL RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity / Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies) / Person(s)	Is an SCA Filing Required? (Y/N)	*
4512	DENTAQUEST GROUP	00000	46-2124368				ADVANTAGE LEVERAGED LENDERS, INC.	OR	NIA	ADVANTAGE COMMUNITY HOLDING CO., LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	26-3981408				ADVANTAGE CONSULTING SERVICES, LLC	OR	NIA	ADVANTAGE SUPPORT SERVICES, LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	32-0487994				DENTAQUEST CARE GROUP MANAGEMENT, LLC	DE	NIA	DENTAQUEST, LLC	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	04-3265080				DENTAQUEST FOUNDATION, INC	MA	NIA	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	05-0572255				DENTAL SERVICE, LLC	WA	NIA	ADVANTAGE COMMUNITY HOLDING COMPANY, LLC	Ownership	80.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	82-3649978				DENTAQUEST INSTITUTE, LLC	MA	NIA	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	82-3645884				DENTAQUEST FOUNDATION, LLC	MA	NIA	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	38-4016550				CATALYST INSTITUTE, INC.	MA	NIA	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
4512	DENTAQUEST GROUP	00000	83-2714016				DENTAQUEST IMPACT, INC.	MA	NIA	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	
	DENTAQUEST GROUP	00000					MYSTIC RIVER INSURANCE COMPANY		NIA	CATALYST INSTITUTE, INC.	Ownership	100.0	CATALYST INSTITUTE,INC.	N	
	DENTAQUEST GROUP	00000	82-3782157				DENTAQUEST HOLDING CO, LLC	DE	NIA	DENTAL SERVICE OF MASSACHUSETTS, INC.	Ownership	100.0	CATALYST INSTITUTE, INC.	N	

Asterisk	Explanation
0000001	

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/(Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/ (Liability)
00000	04-3172335	DSM INSURANCE SERVICES, INC										
67636	59-0397210	DSM USA INS CO INC					(83,159)				(83,159)	
00000	65-0743731	DENTAQUEST OF FLORIDA INC					123,171				123,171	
12307	20-2970185	DENTAQUEST USA INS CO INC		(19,500,000)			5,022,775				(14,477,225)	
00000	35-2177954	DENTAQUEST OF TENNESSEE LLC										
15497	46-5661073	DSM MA INS CO INC					115,976				115,976	
00000	04-3172335	DSM INSURANCE SERVICES, INC					(968,929)				(968,929)	
00000	33-0672992	PACIFIC DENTAL NETWORK INC										
00000	20-0390099	DENTAQUEST LLC		19,500,000			(5,990,536)				13,509,464	
00000	20-5312990	DENTAQUEST INSTITUTE INC										
00000	04-3428012	DSM INVESTMENTS, INC.										
00000	04-3434787	DENTAQUEST ORAL HEALTH CENTER, INC.										
47006	93-1156986	ADVANTAGE DENTAL PLAN, INC					169,033				169,033	
52060	04-6143185	DENTAL SERV OF MA INC		(257,328,207)			1,611,669				(255,716,538)	
00000	38-4016550	CATALYST INSTITUTE, INC.		257,328,207							257,328,207	
9999999 Control Totals									XXX			

Schedule Y Part 2 Explanation:

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

	Response
The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.	
MARCH FILING	
1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	Yes
2. Will an actuarial opinion be filed by March 1?	Yes
3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	Yes
4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required by March 1?	Yes
APRIL FILING	
5. Will Management's Discussion and Analysis be filed by April 1?	Yes
6. Will the Supplemental Investment Risks Interrogatories be filed by April 1?	Yes
7. Will the Accident and Health Policy Experience Exhibit be filed by April 1?	See Explanation
JUNE FILING	
8. Will an audited financial report be filed by June 1?	Yes
9. Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	Yes
AUGUST FILING	
10. Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?	Yes
The following supplemental reports are required to be filed as part of your statement filing if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but it is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.	
MARCH FILING	
11. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	See Explanation
12. Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	No
13. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	No
14. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	No
15. Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	No
16. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	No
17. Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be file electronically with the NAIC by March 1?	No
18. Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	No
19. Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	No
APRIL FILING	
20. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	No
21. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	No
22. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	No
23. Will the regulator only (non-public) Supplemental Health Care Exhibit's Allocation Report be filed with the state of domicile and the NAIC by April 1?	No
24. Will the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit be filed with the state of domicile and the NAIC by April 1?	No
25. Will the Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (if required) be filed with the state of domicile and the NAIC by April 1?	No
AUGUST FILING	
26. Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	Yes

Explanation:

7. Not applicable to this Company.
11. Not applicable to this company

Bar Code:

Health Life Supplement - March

12307201820500000 2018 Document Code: 205

Schedule SIS

12307201842000000 2018 Document Code: 420

Actuarial Opinion on Participating and Non-Participating Policies

12307201837100000 2018 Document Code: 371

Statement of Non-Guaranteed Elements for Exhibit 5

12307201837000000 2018 Document Code: 370

Medicare Part D Coverage Supplement

12307201836500000 2018 Document Code: 365

Approval for Relief related to five-year rotation for lead Audit Partner

12307201822400000 2018 Document Code: 224

Approval for Relief related to one-year cooling off period for inde. CPA

12307201822500000 2018 Document Code: 225

Approval for Relief related to Require. for Audit Committees

12307201822600000 2018 Document Code: 226

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES (continued)

LTC Supplemental Interrogatories

12307201830600000 2018 Document Code: 306

Health Life Supplement - April

12307201821100000 2018 Document Code: 211

Supplemental Health Care Exhibit

12307201821600000 2018 Document Code: 216

Supplemental Health Care Exhibit's Expense Allocation Report

12307201821700000 2018 Document Code: 217

LHA Guaranty Association Reconciliation

12307201829000000 2018 Document Code: 290

LHA Guaranty Association Adjustment Exhibit

12307201830000000 2018 Document Code: 300

OVERFLOW PAGE FOR WRITE-INS

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols.1-2)	4 Net Admitted Assets
1104.				
1105.				
1197. Summary of remaining write-ins for Line 11 (Lines 1104 through 1196)				
2504. Colorado Division Fees	111,071		111,071	
2597. Summary of remaining write-ins for Line 25 (Lines 2504 through 2596)	111,071		111,071	

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings 1 Amount	Gross Investment Holdings 2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1.	Bonds:						
	1.1 U.S. treasury securities	8,297,975	6.485	8,297,975		8,297,975	6.641
	1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
	1.21 Issued by U.S. government agencies	188,695	0.147	188,695		188,695	0.151
	1.22 Issued by U.S. government sponsored agencies						
	1.3 Non-U.S. government (including Canada, excluding mortgage-backed securities)						
	1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:						
	1.41 States, territories and possessions general obligations	308,625	0.241	308,625		308,625	0.247
	1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	351,032	0.274	351,032		351,032	0.281
	1.43 Revenue and assessment obligations	1,917,187	1.498	1,917,187		1,917,187	1.534
	1.44 Industrial development and similar obligations						
	1.5 Mortgage-backed securities (includes residential and commercial MBS):						
	1.51 Pass-through securities:						
	1.511 Issued or Guaranteed by GNMA	823,688	0.644	823,688		823,688	0.659
	1.512 Issued or Guaranteed by FNMA and FHLMC	7,950,356	6.213	7,950,356		7,950,356	6.363
	1.513 All other						
	1.52 CMOs and REMICs:						
	1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	7,621,439	5.956	7,621,439		7,621,439	6.100
	1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	609,711	0.476	609,711		609,711	0.488
	1.523 All other	2,965,126	2.317	2,965,126		2,965,126	2.373
2.	Other debt and other fixed income securities (excluding short term):						
	2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	22,106,943	17.277	22,106,943		22,106,943	17.693
	2.2 Unaffiliated Non-U.S. securities (including Canada)	234,801	0.183	234,801		234,801	0.188
	2.3 Affiliated securities						
3.	Equity interests:						
	3.1 Investments in mutual funds						
	3.2 Preferred stocks:						
	3.21 Affiliated						
	3.22 Unaffiliated						
	3.3 Publicly traded equity securities (excluding preferred stocks):						
	3.31 Affiliated						
	3.32 Unaffiliated						
	3.4 Other equity securities:						
	3.41 Affiliated	12,172,661	9.513	9,163,401		9,163,401	7.334
	3.42 Unaffiliated						
	3.5 Other equity interests including tangible personal property under lease:						
	3.51 Affiliated						
	3.52 Unaffiliated						
4.	Mortgage loans:						
	4.1 Construction and land development						
	4.2 Agricultural						
	4.3 Single family residential properties						
	4.4 Multifamily residential properties						
	4.5 Commercial loans						
	4.6 Mezzanine real estate loans						
5.	Real estate investments:						
	5.1 Property occupied by company						
	5.2 Property held for production of income (including $.....0 of property acquired in satisfaction of debt)						
	5.3 Property held for sale (including $.....0 property acquired in satisfaction of debt)						
6.	Contract loans						
7.	Derivatives						
8.	Receivables for securities						
9.	Securities Lending (Line 10, Asset Page reinvested collateral)				X X X	X X X	X X X
10.	Cash, cash equivalents and short-term investments	62,409,752	48.774	62,409,752		62,409,752	49.948
11.	Other invested assets						
12.	TOTAL Invested assets	127,957,992	100.000	124,948,732		124,948,732	100.000

SCHEDULE A - VERIFICATION BETWEEN YEARS

Real Estate

1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition (Part 2, Column 6)		
	2.2 Additional investment made after acquisition (Part 2, Column 9)		
3.	Current year change in encumbrances:		
	3.1 TOTALS, Part 1, Column 13		
	3.2 TOTALS, Part 3, Column 11		
4.	TOTAL gain (loss) on disposals, Part 3, Column 18		
5.	Deduct amounts received on disposals, Part 3, Column 15		
6.	TOTAL foreign exchange change in book/adjusted		
	6.1 TOTALS, Part 1, Column 15		
	6.2 TOTALS, Part 3, Column 13		
7.	Deduct current year's other-than-temporary impairment recognized:		
	7.1 TOTALS, Part 1, Column 12		
	7.2 TOTALS, Part 3, Column 10		
8.	Deduct current year's depreciation:		
	8.1 TOTALS, Part 1, Column 11		
	8.2 TOTALS, Part 3, Column 9		
9.	Book/adjusted carrying value at the end of current period (Lines 1 + 2 + 3 + 4 - 5 + 6 - 7 - 8)		
10.	Deduct total nonadmitted amounts		
11.	Statement value at end of current period (Lines 9 minus 10)		

NONE

SCHEDULE B - VERIFICATION BETWEEN YEARS

Mortgage Loans

1.	Book value/recorded investment excluding accrued interest, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition (Part 2, Column 7)		
	2.2 Additional investment made after acquisition (Part 2, Column 8)		
3.	Capitalized deferred interest and other:		
	3.1 TOTALS, Part 1, Column 12		
	3.2 TOTALS, Part 3, Column 11		
4.	Accrual of discount		
5.	Unrealized valuation increase (decrease):		
	5.1 TOTALS, Part 1, Column 9		
	5.2 TOTALS, Part 3, Column 8		
6.	TOTAL gain (loss) on disposals, Part 3, Column 18		
7.	Deduct amounts received on disposals, Part 3, Col		
8.	Deduct amortization of premium and mortgage inte		
9.	TOTAL foreign exchange change in book value/rec		
	interest		
	9.1 TOTALS, Part 1, Column 13		
	9.2 TOTALS, Part 3, Column 13		
10.	Deduct current year's other-than-temporary impairment recognized:		
	10.1 TOTALS, Part 1, Column 11		
	10.2 TOTALS, Part 3, Column 10		
11.	Book value/recorded investment excluding accrued interest at end of current period (Lines 1 + 2 + 3 + 4 + 5 + 6 - 7 - 8 + 9 - 10)		
12.	TOTAL valuation allowance		
13.	Subtotal (Lines 11 plus 12)		
14.	Deduct total nonadmitted amounts		
15.	Statement value of mortgages owned at end of current period (Line 13 minus Line 14)		

NONE

SCHEDULE BA - VERIFICATION BETWEEN YEARS

Other Long-Term Invested Assets

1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition (Part 2, Column 8)		
	2.2 Additional investment made after acquisition (Part 2, Column 9)		
3.	Capitalized deferred interest and other:		
	3.1 TOTALS, Part 1, Column 16		
	3.2 TOTALS, Part 3, Column 12		
4.	Accrual of discount		
5.	Unrealized valuation increase (decrease):		
	5.1 TOTALS, Part 1, Column 13		
	5.2 TOTALS, Part 3, Column 9		
6.	TOTAL gain (loss) on disposals, Part 3, Column 19		
7.	Deduct amounts received on disposals, Part 3, Col		
8.	Deduct amortization of premium and depreciation		
9.	TOTAL foreign exchange change in book/adjusted carrying value:		
	9.1 TOTALS, Part 1, Column 17		
	9.2 TOTALS, Part 3, Column 14		
10.	Deduct current year's other-than-temporary impairment recognized:		
	10.1 TOTALS, Part 1, Column 15		
	10.2 TOTALS, Part 3, Column 11		
11.	Book/adjusted carrying value at end of current period (Lines 1 + 2 + 3 + 4 + 5 + 6 - 7 - 8 + 9 - 10)		
12.	Deduct total nonadmitted amounts		
13.	Statement value at end of current period (Line 11 minus Line 12)		

NONE

SCHEDULE D - VERIFICATION BETWEEN YEARS

Bonds and Stocks

1.	Book/adjusted carrying value, December 31 of prior year		63,749,421
2.	Cost of bonds and stocks acquired, Part 3, Column 7		17,019,323
3.	Accrual of Discount		63,594
4.	Unrealized valuation increase (decrease):		
	4.1 Part 1, Column 12	8,665	
	4.2 Part 2, Section 1, Column 15		
	4.3 Part 2, Section 2, Column 13		
	4.4 Part 4, Column 11	(2,589)	6,076
5.	TOTAL gain (loss) on disposals, Part 4, Column 19		(909,494)
6.	Deduction consideration for bonds and stocks disposed of, Part 4, Column 7		25,478,447
7.	Deduct amortization of premium		392,840
8.	TOTAL foreign exchange change in book/adjusted carrying value:		
	8.1 Part 1, Column 15		
	8.2 Part 2, Section 1, Column 19		
	8.3 Part 2, Section 2, Column 16		
	8.4 Part 4, Column 15		
9.	Deduct current year's other-than-temporary impairment recognized:		
	9.1 Part 1, Column 14		
	9.2 Part 2, Section 1, Column 17		
	9.3 Part 2, Section 2, Column 14		
	9.4 Part 4, Column 13		
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees, Notes 5R, Line 5R(2)		
11.	Book/adjusted carrying value at end of current period (Lines 1 + 2 + 3 + 4 + 5 - 6 - 7 + 8 - 9 + 10)		54,057,634
12.	Deduct total nonadmitted amounts		
13.	Statement value at end of current period (Line 11 minus Line 12)		54,057,634

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description			1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
BONDS	1.	United States	13,243,388	13,096,802	13,316,273	12,649,021
Governments	2.	Canada				
(Including all obligations guaranteed	3.	Other Countries				
by governments)	4.	TOTALS	13,243,388	13,096,802	13,316,273	12,649,021
U.S. States, Territories and Possessions (Direct and guaranteed)	5.	TOTALS	308,625	303,669	311,245	285,000
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6.	TOTALS	351,032	350,871	351,067	350,000
U.S. Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	7.	TOTALS	15,420,494	15,069,255	15,448,159	14,804,880
Industrial and Miscellaneous,	8.	United States	24,499,295	23,951,906	24,784,062	23,972,895
SVO Identified Funds, Bank Loans and	9.	Canada	134,943	146,544	134,925	135,000
Hybrid Securities (unaffiliated)	10.	Other Countries	99,858	90,836	99,846	100,000
	11.	TOTALS	24,734,096	24,189,286	25,018,833	24,207,895
Parent, Subsidiaries and Affiliates	12.	TOTALS				
	13.	TOTAL Bonds	54,057,634	53,009,884	54,445,577	52,296,796
PREFERRED STOCKS	14.	United States				
Industrial and Miscellaneous (unaffiliated)	15.	Canada				
	16.	Other Countries				
	17.	TOTALS				
Parent, Subsidiaries and Affiliates	18.	TOTALS				
	19.	TOTAL Preferred Stocks				
COMMON STOCKS	20.	United States				
Industrial and Miscellaneous (unaffiliated)	21.	Canada				
	22.	Other Countries				
	23.	TOTALS				
Parent, Subsidiaries and Affiliates	24.	TOTALS				
	25.	TOTAL Common Stocks				
	26.	TOTAL Stocks				
	27.	TOTAL Bonds and Stocks	54,057,634	53,009,884	54,445,577	

SCHEDULE D - PART 1A - SECTION 1

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Column 7 as a % of Line 11.7	9 Total From Column 7 Prior Year	10 % From Column 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
1. U.S. Governments												
1.1 NAIC 1	528,923	3,964,489	3,856,179	2,541,169	2,351,494	XXX	13,242,255	24.50	17,718,279	27.79	13,242,254	
1.2 NAIC 2						XXX						
1.3 NAIC 3						XXX						
1.4 NAIC 4						XXX						
1.5 NAIC 5						XXX						
1.6 NAIC 6						XXX						
1.7 TOTALS	528,923	3,964,489	3,856,179	2,541,169	2,351,494	XXX	13,242,255	24.50	17,718,279	27.79	13,242,254	
2. All Other Governments												
2.1 NAIC 1						XXX						
2.2 NAIC 2						XXX						
2.3 NAIC 3						XXX						
2.4 NAIC 4						XXX						
2.5 NAIC 5						XXX						
2.6 NAIC 6						XXX						
2.7 TOTALS						XXX						
3. U.S. States, Territories and Possessions, etc., Guaranteed												
3.1 NAIC 1			145,640	162,984		XXX	308,625	0.57	165,162	0.26	308,625	
3.2 NAIC 2						XXX						
3.3 NAIC 3						XXX						
3.4 NAIC 4						XXX						
3.5 NAIC 5						XXX						
3.6 NAIC 6						XXX						
3.7 TOTALS			145,640	162,984		XXX	308,625	0.57	165,162	0.26	308,625	
4. U.S. Political Subdivisions of States, Territories & Possessions, Guaranteed												
4.1 NAIC 1			149,636	151,396	50,000	XXX	351,032	0.65	179,725	0.28	351,032	
4.2 NAIC 2						XXX						
4.3 NAIC 3						XXX						
4.4 NAIC 4						XXX						
4.5 NAIC 5						XXX						
4.6 NAIC 6						XXX						
4.7 TOTALS			149,636	151,396	50,000	XXX	351,032	0.65	179,725	0.28	351,032	
5. U.S. Special Revenue & Special Assessment Obligations etc., Non-Guaranteed												
5.1 NAIC 1	1,631,421	5,287,072	4,400,289	3,390,671	711,040	XXX	15,420,494	28.53	18,576,157	29.14	15,420,494	
5.2 NAIC 2						XXX						
5.3 NAIC 3						XXX						
5.4 NAIC 4						XXX						
5.5 NAIC 5						XXX						
5.6 NAIC 6						XXX						
5.7 TOTALS	1,631,421	5,287,072	4,400,289	3,390,671	711,040	XXX	15,420,494	28.53	18,576,157	29.14	15,420,494	

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Column 7 as a % of Line 11.7	9 Total From Column 7 Prior Year	10 % From Column 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
6. Industrial and Miscellaneous (unaffiliated)												
6.1 NAIC 1	2,030,145	9,236,378	3,294,588	997,089	1,808,245	XXX	17,366,445	32.13	20,512,419	32.18	14,908,476	2,457,970
6.2 NAIC 2	150,042	2,221,696	3,197,453	825,000	950,920	XXX	7,345,112	13.59	6,495,146	10.19	6,584,991	760,122
6.3 NAIC 3			22,539			XXX	22,539	0.04	102,055	0.16	22,539	
6.4 NAIC 4						XXX						
6.5 NAIC 5						XXX						
6.6 NAIC 6						XXX						
6.7 TOTALS	2,180,188	11,458,074	6,514,580	1,822,089	2,759,165	XXX	24,734,096	45.76	27,109,620	42.53	21,516,005	3,218,092
7. Hybrid Securities												
7.1 NAIC 1						XXX						
7.2 NAIC 2						XXX						
7.3 NAIC 3						XXX						
7.4 NAIC 4						XXX						
7.5 NAIC 5						XXX						
7.6 NAIC 6						XXX						
7.7 TOTALS						XXX						
8. Parent, Subsidiaries and Affiliates												
8.1 NAIC 1						XXX						
8.2 NAIC 2						XXX						
8.3 NAIC 3						XXX						
8.4 NAIC 4						XXX						
8.5 NAIC 5						XXX						
8.6 NAIC 6						XXX						
8.7 TOTALS						XXX						
9. SVO Identified Funds												
9.1 NAIC 1	XXX	XXX	XXX	XXX	XXX							
9.2 NAIC 2	XXX	XXX	XXX	XXX	XXX							
9.3 NAIC 3	XXX	XXX	XXX	XXX	XXX							
9.4 NAIC 4	XXX	XXX	XXX	XXX	XXX							
9.5 NAIC 5	XXX	XXX	XXX	XXX	XXX							
9.6 NAIC 6	XXX	XXX	XXX	XXX	XXX							
9.7 TOTALS	XXX	XXX	XXX	XXX	XXX							
10. Bank Loans												
10.1 NAIC 1						XXX			XXX	XXX		
10.2 NAIC 2						XXX			XXX	XXX		
10.3 NAIC 3						XXX			XXX	XXX		
10.4 NAIC 4						XXX			XXX	XXX		
10.5 NAIC 5						XXX			XXX	XXX		
10.6 NAIC 6						XXX			XXX	XXX		
10.7 TOTALS						XXX			XXX	XXX		

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values By Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Column 7 as a % of Line 11.7	9 Total From Column 7 Prior Year	10 % From Column 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
11. Total Bonds Current Year												
11.1 NAIC 1	(d) 4,190,489	18,487,938	11,846,333	7,243,309	4,920,780		46,688,850	86.37	XXX	XXX	44,230,880	2,457,970
11.2 NAIC 2	(d) 150,042	2,221,696	3,197,453	825,000	950,920		7,345,112	13.59	XXX	XXX	6,584,991	760,122
11.3 NAIC 3	(d)		22,539				22,539	0.04	XXX	XXX	22,539	
11.4 NAIC 4	(d)								XXX	XXX		
11.5 NAIC 5	(d)						(c)		XXX	XXX		
11.6 NAIC 6	(d)						(c)		XXX	XXX		
11.7 TOTALS	4,340,532	20,709,634	15,066,325	8,068,310	5,871,700		(b) 54,056,501	100.00	XXX	XXX	50,838,409	3,218,092
11.8 Line 11.7 as a % of Column 7	8.03	38.31	27.87	14.93	10.86		100.00	XXX	XXX	XXX	94.05	5.95
12. Total Bonds Prior Year												
12.1 NAIC 1	6,270,915	22,961,611	15,729,375	7,311,215	4,878,625		XXX	XXX	57,151,741	89.65	55,777,153	1,374,588
12.2 NAIC 2	114,303	1,692,486	3,229,958	396,792	1,061,608		XXX	XXX	6,495,146	10.19	6,164,536	330,610
12.3 NAIC 3		26,805		75,251			XXX	XXX	102,055	0.16	102,055	
12.4 NAIC 4							XXX	XXX				
12.5 NAIC 5							XXX	XXX	(c)			
12.6 NAIC 6							XXX	XXX	(c)			
12.7 TOTALS	6,385,218	24,680,902	18,959,333	7,783,257	5,940,233		XXX	XXX	(b) 63,748,943	100.00	62,043,744	1,705,198
12.8 Line 12.7 as a % of Col. 9	10.02	38.72	29.74	12.21	9.32		XXX	XXX	100.00	XXX	97.33	2.67
13. Total Publicly Traded Bonds												
13.1 NAIC 1	3,959,111	16,807,666	11,573,160	7,114,583	4,776,360		44,230,880	81.82	55,777,153	87.50	44,230,880	XXX
13.2 NAIC 2	150,042	1,988,478	2,933,010	771,822	741,639		6,584,991	12.18	6,164,536	9.67	6,584,991	XXX
13.3 NAIC 3			22,539				22,539	0.04	102,055	0.16	22,539	XXX
13.4 NAIC 4												XXX
13.5 NAIC 5												XXX
13.6 NAIC 6												XXX
13.7 TOTALS	4,109,153	18,796,144	14,528,708	7,886,405	5,517,999		50,838,409	94.05	62,043,744	97.33	50,838,409	XXX
13.8 Line 13.7 as a % of Col. 7	8.08	36.97	28.58	15.51	10.85		100.00	XXX	XXX	XXX	100.00	XXX
13.9 Line 13.7 as a % of Line 11.7, Col. 7, Section 11	7.60	34.77	26.88	14.59	10.21		94.05	XXX	XXX	XXX	94.05	XXX
14. Total Privately Placed Bonds												
14.1 NAIC 1	231,379	1,680,272	273,173	128,727	144,420		2,457,970	4.55	1,374,588	2.16	XXX	2,457,970
14.2 NAIC 2		233,219	264,444	53,178	209,281		760,122	1.41	330,610	0.52	XXX	760,122
14.3 NAIC 3											XXX	
14.4 NAIC 4											XXX	
14.5 NAIC 5											XXX	
14.6 NAIC 6											XXX	
14.7 TOTALS	231,379	1,913,490	537,617	181,905	353,701		3,218,092	5.95	1,705,198	2.67	XXX	3,218,092
14.8 Line 14.7 as a % of Col. 7	7.19	59.46	16.71	5.65	10.99		100.00	XXX	XXX	XXX	XXX	100.00
14.9 Line 14.7 as a % of Line 11.7, Col. 7, Section 11	0.43	3.54	0.99	0.34	0.65		5.95	XXX	XXX	XXX	XXX	5.95

(a) Includes $.....3,218,092 freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.
(b) Includes $.....0 current year of bonds with Z designations, $.....0 prior year of bonds with Z designations, $.....0 prior year of bonds with Z* designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement. "Z*" means the SVO could not evaluate the obligation because valuation procedures for the security class is under regulatory review.
(c) Includes $.....0 current year of bonds with 5GI designations, $.....0 prior year of bonds with 5* or 5GI designations and $.....0 current year, $.....0 prior year of bonds with 6* designations. "5GI" means the NAIC designation was assigned by the SVO in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6*" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.
(d) Includes the following amount of short-term and cash equivalent bonds by NAIC designation: NAIC 1 $.....0; NAIC 2 $.....0; NAIC 3 $.....0; NAIC 4 $.....0; NAIC 5 $.....0; NAIC 6 $.....0.

SCHEDULE D - PART 1A - SECTION 2

Maturity Distribution of All Bonds Owned December 31, At Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Column 7 as a % of Line 11.7	9 Total From Column 7 Prior Year	10 % From Column 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
1. U.S. Governments												
1.1 Issuer Obligations	138,731	2,828,429	3,007,611	2,083,279	2,292,028	XXX	10,350,077	19.15	14,494,406	22.74	10,350,077	
1.2 Residential Mortgage-Backed Securities	390,193	1,136,060	848,569	457,890	59,466	XXX	2,892,177	5.35	3,223,873	5.06	2,892,177	
1.3 Commercial Mortgage-Backed Securities						XXX						
1.4 Other Loan-Backed and Structured Securities						XXX						
1.5 TOTALS	528,923	3,964,489	3,856,179	2,541,169	2,351,494	XXX	13,242,254	24.50	17,718,279	27.79	13,242,254	
2. All Other Governments												
2.1 Issuer Obligations						XXX						
2.2 Residential Mortgage-Backed Securities						XXX						
2.3 Commercial Mortgage-Backed Securities						XXX						
2.4 Other Loan-Backed and Structured Securities						XXX						
2.5 TOTALS						XXX						
3. U.S. States, Territories and Possessions, Guaranteed												
3.1 Issuer Obligations			145,640	162,984		XXX	308,625	0.57	165,162	0.26	308,625	
3.2 Residential Mortgage-Backed Securities						XXX						
3.3 Commercial Mortgage-Backed Securities						XXX						
3.4 Other Loan-Backed and Structured Securities						XXX						
3.5 TOTALS			145,640	162,984		XXX	308,625	0.57	165,162	0.26	308,625	
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed												
4.1 Issuer Obligations			149,636	151,396	50,000	XXX	351,032	0.65	179,725	0.28	351,032	
4.2 Residential Mortgage-Backed Securities						XXX						
4.3 Commercial Mortgage-Backed Securities						XXX						
4.4 Other Loan-Backed and Structured Securities						XXX						
4.5 TOTALS			149,636	151,396	50,000	XXX	351,032	0.65	179,725	0.28	351,032	
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed												
5.1 Issuer Obligations	110,293	454,789		974,357	377,749	XXX	1,917,187	3.55	2,306,467	3.62	1,917,187	
5.2 Residential Mortgage-Backed Securities	1,521,128	4,832,283	4,400,289	2,416,314	333,291	XXX	13,503,306	24.98	16,269,689	25.52	13,503,306	
5.3 Commercial Mortgage-Backed Securities						XXX						
5.4 Other Loan-Backed and Structured Securities						XXX						
5.5 TOTALS	1,631,421	5,287,072	4,400,289	3,390,671	711,040	XXX	15,420,494	28.53	18,576,157	29.14	15,420,494	
6. Industrial and Miscellaneous												
6.1 Issuer Obligations	329,065	7,194,842	5,219,952	1,602,309	2,700,807	XXX	17,046,976	31.54	16,963,453	26.61	15,078,035	1,968,941
6.2 Residential Mortgage-Backed Securities	86,547	299,814	166,604	51,594	5,152	XXX	609,711	1.13	922,309	1.45	326,983	282,728
6.3 Commercial Mortgage-Backed Securities	421,986	1,900,264	436,049	153,620	53,207	XXX	2,965,126	5.49	4,348,876	6.82	2,562,971	402,155
6.4 Other Loan-Backed and Structured Securities	1,342,589	2,063,154	691,975	14,566		XXX	4,112,283	7.61	4,874,983	7.65	3,548,016	564,267
6.5 TOTALS	2,180,188	11,458,074	6,514,580	1,822,089	2,759,165	XXX	24,734,096	45.76	27,109,620	42.53	21,516,005	3,218,092
7. Hybrid Securities												
7.1 Issuer Obligations						XXX						
7.2 Residential Mortgage-Backed Securities						XXX						
7.3 Commercial Mortgage-Backed Securities						XXX						
7.4 Other Loan-Backed and Structured Securities						XXX						
7.5 TOTALS						XXX						
8. Parent, Subsidiaries and Affiliates												
8.1 Issuer Obligations						XXX						
8.2 Residential Mortgage-Backed Securities						XXX						
8.3 Commercial Mortgage-Backed Securities						XXX						
8.4 Other Loan-Backed and Structured Securities						XXX						
8.5 TOTALS						XXX						

SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Column 7 as a % of Line 11.7	9 Total From Column 7 Prior Year	10 % From Column 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
9. SVO Identified Funds												
9.1 Exchange Traded Funds - as Identified by the SVO	XXX	XXX	XXX	XXX	XXX							
9.2 Bond Mutual Funds - as Identified by the SVO	XXX	XXX	XXX	XXX	XXX							
9.3 TOTALS	XXX	XXX	XXX	XXX	XXX							
10. Bank Loans												
10.1 Bank Loans - Issued						XXX			XXX	XXX		
10.2 Bank Loans - Acquired						XXX			XXX	XXX		
10.3 TOTALS						XXX			XXX	XXX		
11. Total Bonds Current Year												
11.1 Issuer Obligations	578,089	10,478,060	8,522,839	4,974,326	5,420,583	XXX	29,973,897	55.45	XXX	XXX	28,004,956	1,968,941
11.2 Residential Mortgage-Backed Securities	1,997,868	6,268,157	5,415,463	2,925,797	397,910	XXX	17,005,195	31.46	XXX	XXX	16,722,467	282,728
11.3 Commercial Mortgage-Backed Securities	421,986	1,900,264	436,049	153,620	53,207	XXX	2,965,126	5.49	XXX	XXX	2,562,971	402,155
11.4 Other Loan-Backed and Structured Securities	1,342,589	2,063,154	691,975	14,566		XXX	4,112,283	7.61	XXX	XXX	3,548,016	564,267
11.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX				XXX	XXX		
11.6 Bank Loans						XXX			XXX	XXX		
11.7 TOTALS	4,340,532	20,709,634	15,066,325	8,068,310	5,871,700		54,056,501	100.00	XXX	XXX	50,838,409	3,218,092
11.8 Line 11.7 as a % of Col. 7	8.03	38.31	27.87	14.93	10.86		100.00	XXX	XXX	XXX	94.05	5.95
12. Total Bonds Prior Year												
12.1 Issuer Obligations	1,361,033	10,822,733	11,011,312	5,246,124	5,668,010	XXX	XXX	XXX	34,109,212	53.51	32,522,008	1,587,204
12.2 Residential Mortgage-Backed Securities	3,001,654	8,578,589	6,195,011	2,368,394	272,223	XXX	XXX	XXX	20,415,871	32.03	20,415,871	
12.3 Commercial Mortgage-Backed Securities	543,536	2,661,151	1,142,817	1,372		XXX	XXX	XXX	4,348,876	6.82	4,348,876	
12.4 Other Loan-Backed and Structured Securities	1,478,994	2,618,429	610,193	167,368		XXX	XXX	XXX	4,874,983	7.65	4,756,990	117,994
12.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX		XXX	XXX				
12.6 Bank Loans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
12.7 TOTALS	6,385,218	24,680,902	18,959,333	7,783,257	5,940,233		XXX	XXX	63,748,943	100.00	62,043,744	1,705,198
12.8 Line 12.7 as a % of Col. 9	10.02	38.72	29.74	12.21	9.32		XXX	XXX	100.00	XXX	97.33	2.67
13. Total Publicly Traded Bonds												
13.1 Issuer Obligations	578,089	9,257,709	8,146,866	4,921,148	5,101,145	XXX	28,004,956	51.81	32,522,008	51.02	28,004,956	XXX
13.2 Residential Mortgage-Backed Securities	1,970,088	6,129,300	5,343,815	2,886,474	392,791	XXX	16,722,467	30.94	20,415,871	32.03	16,722,467	XXX
13.3 Commercial Mortgage-Backed Securities	382,588	1,739,971	352,131	64,217	24,063	XXX	2,562,971	4.74	4,348,876	6.82	2,562,971	XXX
13.4 Other Loan-Backed and Structured Securities	1,178,388	1,669,164	685,898	14,566		XXX	3,548,016	6.56	4,756,990	7.46	3,548,016	XXX
13.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX							XXX
13.6 Bank Loans						XXX			XXX	XXX		XXX
13.7 TOTALS	4,109,153	18,796,144	14,528,708	7,886,405	5,517,999		50,838,409	94.05	62,043,744	97.33	50,838,409	XXX
13.8 Line 13.7 as a % of Col. 7	8.08	36.97	28.58	15.51	10.85		100.00	XXX	XXX	XXX	100.00	XXX
13.9 Line 13.7 as a % of Line 11.7, Col. 7, Section 11	7.60	34.77	26.88	14.59	10.21		94.05	XXX	XXX	XXX	94.05	XXX
14. Total Privately Placed Bonds												
14.1 Issuer Obligations		1,220,351	375,974	53,178	319,438	XXX	1,968,941	3.64	1,587,204	2.49	XXX	1,968,941
14.2 Residential Mortgage-Backed Securities	27,780	138,857	71,648	39,324	5,119	XXX	282,728	0.52			XXX	282,728
14.3 Commercial Mortgage-Backed Securities	39,398	160,293	83,918	89,403	29,143	XXX	402,155	0.74			XXX	402,155
14.4 Other Loan-Backed and Structured Securities	164,201	393,990	6,077			XXX	564,267	1.04	117,994	0.19	XXX	564,267
14.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX						XXX	
14.6 Bank Loans						XXX			XXX	XXX	XXX	
14.7 TOTALS	231,379	1,913,490	537,617	181,905	353,701		3,218,092	5.95	1,705,198	2.67	XXX	3,218,092
14.8 Line 14.7 as a % of Col. 7	7.19	59.46	16.71	5.65	10.99		100.00	XXX	XXX	XXX	XXX	100.00
14.9 Line 14.7 as a % of Line 11.7, Col. 7, Section 11	0.43	3.54	0.99	0.34	0.65		5.95	XXX	XXX	XXX	XXX	5.95

SCHEDULE DA - VERIFICATION BETWEEN YEARS

Short-Term Investments

		1 Total	2 Bonds	3 Mortgage Loans	4 Other Short-term Investment Assets (a)	5 Investments in Parent, Subsidiaries and Affiliates
1.	Book/adjusted carrying value, December 31 of prior year	110,163			110,163	
2.	Cost of short-term investments acquired					
3.	Accrual of discount					
4.	Unrealized valuation increase (decrease)	193			193	
5.	TOTAL gain (loss) on disposals					
6.	Deduct consideration received on disposals					
7.	Deduct amortization of premium					
8.	TOTAL foreign exchange change in book/adjusted carrying value					
9.	Deduct current year's other-than-temporary impairment recognized					
10.	Book adjusted carrying value at end of current period (Lines 1 + 2 + 3 + 4 + 5 - 6 - 7 + 8 - 9)	110,356			110,356	
11.	Deduct total nonadmitted amounts					
12.	Statement value at end of current period (Line 10 minus Line 11)	110,356			110,356	

(a) Indicate the category of such assets, for example, joint ventures, transportation equipment: 0

SI11 Schedule DB Part A Verification . . . . . NONE

SI11 Schedule DB Part B Verification . . . . . NONE

SI12 Schedule DB Part C Sn 1 - Rep. (Syn Asset) Transactions . . . . . NONE

SI13 Schedule DB Part C Sn 2 - Rep. (Syn Asset) Transactions . . . . . NONE

SI14 Schedule DB Verification . . . . . NONE

SCHEDULE E - PART 2 - VERIFICATION BETWEEN YEARS

(Cash Equivalents)

		1 Total	2 Bonds	3 Money Market Mutual Funds	4 Other (a)
1.	Book/adjusted carrying value, December 31 of prior year	1,339,109		1,339,109	
2.	Cost of cash equivalents acquired	23,813,694	344,557	23,469,137	
3.	Accrual of discount	861	861		
4.	Unrealized valuation increase (decrease)				
5.	TOTAL gain (loss) on disposals	17	17		
6.	Deduct consideration received on disposals	23,595,744	345,435	23,250,309	
7.	Deduct amortization of premium				
8.	TOTAL foreign exchange change in book/adjusted carrying value				
9.	Deduct current year's other-than-temporary impairment recognized				
10.	Book/adjusted carrying value at end of current period (Lines 1 + 2 + 3 + 4 + 5 - 6 - 7 + 8 - 9)	1,557,937	0	1,557,937	
11.	Deduct total nonadmitted amounts				
12.	Statement value at end of current period (Lines 10 minus 11)	1,557,937	0	1,557,937	

(a) Indicate the category of such investments, for example, joint ventures, transportation equipment:

E01 Schedule A - Part 1 Real Estate Owned . . . . . NONE

E02 Schedule A - Part 2 Real Estate Acquired . . . . . NONE

E03 Schedule A - Part 3 Real Estate Disposed . . . . . NONE

E04 Schedule B Part 1 - Mortgage Loans Owned . . . . . NONE

E05 Schedule B Part 2 - Mortgage Loans Acquired . . . . . NONE

E06 Schedule B Part 3 - Mortgage Loans Disposed . . . . . NONE

E07 Schedule BA Part 1 - Long-Term Invested Assets Owned . . . . . NONE

E08 Schedule BA Part 2 - Long-Term Invested Assets Acquired . . . . . NONE

E09 Schedule BA Part 3 - Long-Term Invested Assets Disposed . . . . . NONE

SCHEDULE D - PART 1

Showing all Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	FOREIGN	Bond CHAR	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of Interest	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
U.S. Governments - Issuer Obligations																					
83162CYW7	SMALL BUS ADMIN GTD DEV PTC			2	1	188,515	96.2930	192,155	199,553	188,695		180			2.590	2.994	MS	1,723	2,640	08/01/2018	09/01/2037
83162CQX4	SMALL BUSINESS ADMINISTRATION				1	64,110	103.4200	59,598	57,627	62,087		(433)			5.230	3.008	MS	1,005	3,630	10/08/2014	03/01/2027
83162CTN3	SMALL BUSINESS ADMINISTRATION			4	1	332,827	101.6520	325,949	320,652	330,377		(604)			3.210	2.551	MS	3,431	11,090	11/24/2014	09/01/2030
83162CTU7	SMALL BUSINESS ADMINISTRATION			4	1	85,685	103.9020	83,891	80,740	84,991		(246)			3.890	2.809	JJ	1,570	3,639	12/11/2014	01/01/2031
83162CVR1	SMALL BUSINESS ADMINISTRATION			4	1	317,426	102.1900	314,930	308,181	316,391		(369)			3.150	2.676	JJ	4,854	11,151	11/25/2014	07/01/2033
83162CUG6	SMALL BUSINESS ADMINISTRATION SBAP			4	1	52,720	100.4480	52,343	52,109	52,599		(29)			2.850	2.662	MS	495	1,650	03/16/2015	09/01/2031
83162CVY6	SMALL BUSINESS ADMINISTRATION SBAP			4	1	337,539	101.9880	329,228	322,810	336,040		(585)			3.380	2.648	JD	1,334	12,053	12/22/2015	12/01/2033
912810FP8	UNITED STATES TREAS BDS				1	253,739	127.0470	241,389	190,000	246,387		(3,932)			5.375	2.535	FA	3,857	10,213	02/10/2017	02/15/2031
912810PX0	UNITED STATES TREAS BDS				1	509,233	124.4730	517,808	416,000	506,576		(2,657)			4.500	3.032	MN	2,431	16,965	11/29/2018	05/15/2038
912810QC5	UNITED STATES TREAS BDS				1	479,004	124.6170	467,314	375,000	466,327		(3,189)			4.500	2.941	FA	6,375	16,875	11/04/2014	08/15/2039
912810RS9	UNITED STATES TREAS BDS				1	626,893	90.1840	625,877	694,000	629,738		1,493			2.500	3.022	MN	2,253	17,350	08/30/2017	05/15/2046
912810RX8	UNITED STATES TREAS BDS				1	154,910	99.5700	149,355	150,000	154,760		(108)			3.000	2.857	MN	584	4,500	08/07/2017	05/15/2047
912810SA7	UNITED STATES TREAS BDS				1	83,214	99.4650	84,545	85,000	83,238		25			3.000	3.133	FA	963	1,275	05/03/2018	02/15/2048
912810SD1	UNITED STATES TREAS BDS				1	109,521	99.5270	116,447	117,000	109,546		25			3.000	3.368	FA	1,326		11/29/2018	08/15/2048
9128283F5	UNITED STATES TREAS NTS				1	460,481	96.5980	465,602	482,000	462,067		1,585			2.250	2.800	MN	1,408	10,845	04/27/2018	11/15/2027
9128283W8	UNITED STATES TREAS NTS				1	52,574	100.5160	53,273	53,000	52,593		20			2.750	2.866	FA	551	729	06/28/2018	02/15/2028
9128284N7	UNITED STATES TREAS NTS				1	370,173	101.5350	385,833	380,000	370,312		139			2.875	3.217	MN	1,418	5,463	11/05/2018	05/15/2028
9128284S6	UNITED STATES TREAS NTS				1	502,603	101.0900	508,483	503,000	502,637		33			2.750	2.787	MN	1,216	6,916	08/30/2018	05/31/2023
9128284V9	UNITED STATES TREAS NTS				1	535,941	101.5470	553,431	545,000	536,132		191			2.875	3.096	FA	5,918		10/11/2018	08/15/2028
9128285D8	UNITED STATES TREAS NTS				1	355,763	101.6250	362,801	357,000	355,813		51			2.875	2.972	MS	2,622		11/29/2018	09/30/2023
912828N30	UNITED STATES TREAS NTS				1	320,493	98.5900	320,418	325,000	321,310		817			2.125	2.439	JD	19	6,906	01/23/2018	12/31/2022
912828V98	UNITED STATES TREAS NTS				1	219,717	97.1020	214,595	221,000	219,862		126			2.250	2.333	FA	1,878	4,724	11/06/2017	02/15/2027
9128282L3	UNITED STATES TREAS NTS TIPS				1	311,612	98.0720	306,337	312,360	322,041	7,743	100			0.375	0.409	JJ	559	1,197	08/11/2017	07/15/2027
9128283R9	UNITED STATES TREAS NTS TIPS				1	277,037	97.8380	278,838	285,000	277,332	231	64			0.500	1.096	JJ	675		12/17/2018	01/15/2028
912810FT0	US TREASURY N/B				1	975,579	123.2580	907,179	736,000	952,816		(9,487)			4.500	2.414	FA	12,512	33,120	06/29/2017	02/15/2036
912828VB3	US TREASURY N/B				1	493,172	96.8980	508,715	525,000	508,056		3,620			1.750	2.550	MN	1,174	9,188	09/19/2014	05/15/2023
912828P46	US TREASURY N/B 02/26 1.625				1	366,624	93.6090	367,883	393,000	372,013		2,665			1.625	2.462	FA	2,413	6,386	12/20/2016	02/15/2026
912810RK6	US TREASURY N/B 02/45 2.5				1	313,775	90.6250	290,000	320,000	314,106		156			2.500	2.614	FA	3,022	8,000	11/07/2016	02/15/2045
912810RM2	US TREASURY N/B 05/45 3				1	538,103	99.8090	476,089	477,000	534,313		(1,560)			3.000	2.402	MN	1,828	14,310	09/22/2016	05/15/2045
912828P87	UNITED STATES TREAS NTS - NV				1	243,248		243,244	250,000	243,244	461						MN	956	(1,731)	01/19/2018	02/28/2021
912828P87	UNITED STATES TREAS NTS- NC				1	437,677		437,678	450,000	437,678	669						MN	1,720	(5,777)	01/18/2018	02/28/2021
0199999 Subtotal - U.S. Governments - Issuer Obligations						10,369,909	XXX	10,241,227	9,983,032	10,350,077	9,104	(11,909)			XXX	XXX	XXX	72,090	213,305	XXX	XXX
U.S. Governments - Residential Mortgage-Backed Securities																					
38374MU98	GNMA 2006 17 TW			4	1	163,185	112.3660	158,286	140,866	154,946		(2,777)			6.000	3.547	MON	587	8,484	10/09/2014	04/20/2036
38374MWZ8	GNMA 2006 7 NC			4	1	3,660	100.2770	3,450	3,440	3,634		(7)			5.500	4.576	MON	16	217	10/17/2014	08/20/2035
3617AGWQ0	GNMA PASS-THRU C SINGLE FAMILY			4	1	198,182	100.9260	190,919	189,167	197,816		(168)			2.750	2.251	MON	434	6,638	08/02/2017	07/20/2047
36196JLD6	GNMA PASS-THRU C SINGLE FAMILY			4	1	142,523	100.9260	137,731	136,468	142,405		(112)			3.000	2.518	MON	341	4,794	11/09/2017	05/20/2047
36179RZV4	GNMA PASS-THRU M SINGLE FAMILY			4	1	81,238	104.8590	82,566	78,740	81,235		(3)			4.500	3.807	MON	295	300	11/01/2018	02/20/2046
36202EJZ3	GNMA PASS-THRU M SINGLE FAMILY			4	1	33,456	112.9250	33,159	29,364	33,216		(81)			6.000	2.603	MON	147	1,935	10/01/2014	07/20/2036
3622AAAE4	GNMA PASS-THRU X PLATINUM 30YR			4	1	45,693	104.5170	45,968	43,982	45,687		(6)			4.500	3.932	MON	165	167	11/01/2018	01/15/2042
36178DXU0	GNMA PASS-THRU X SINGLE FAMILY			4	1	217,864	99.0470	210,911	212,940	217,864		0			3.000	2.662	MON	532	6,465	08/23/2017	02/15/2043
36200NTS0	GNMA PASS-THRU X SINGLE FAMILY			4	1	52,014	105.9730	49,771	46,965	51,292		(171)			4.500	2.473	MON	176	2,379	10/15/2014	06/15/2034
36296Q2B4	GNMA PASS-THRU X SINGLE FAMILY			4	1	54,602	104.5440	51,466	49,229	54,174		(78)			4.000	1.216	MON	164	2,259	02/20/2015	07/15/2039
38373V2C3	GNMA REMIC TRUST 2002-80			4	1	53,457	107.4850	52,235	48,598	53,259		139			5.500	3.089	MON	223	2,711	11/01/2014	11/20/2032
38373S7F8	GNMA REMIC TRUST 2003-29			4	1	41,638	107.0850	39,656	37,032	41,036		(10)			5.500	2.886	MON	228	2,072	10/09/2014	04/16/2033
38373YD92	GNMA REMIC TRUST 2003-4			4	1	78,327	107.4680	76,656	71,329	77,993		(216)			5.500	3.111	MON	327	3,977	03/22/2017	01/20/2033
38374BDZ3	GNMA REMIC TRUST 2003-62			4	1	44,603	107.5670	43,419	40,365	43,221		(57)			5.000	3.304	MON	168	2,055	10/02/2014	07/20/2033
38374GSA1	GNMA REMIC TRUST 2004-37			4	1	39,795	110.2330	39,277	35,631	39,403		(96)			6.000	3.483	MON	166	2,172	10/02/2014	04/17/2034
38374JSK3	GNMA REMIC TRUST 2004-82			4	1	104,339	108.2210	103,238	95,396	104,203		323			5.000	2.878	MON	397	4,845	03/01/2015	10/20/2034
38374JPX8	GNMA REMIC TRUST 2004-88			4	1	106,175	107.8680	101,690	94,273	105,077		(217)			5.000	2.360	MON	393	4,784	08/16/2016	10/20/2034
38374J6G6	GNMA REMIC TRUST 2004-93			4	1	108,474	108.2050	104,282	96,375	103,732		(1,278)			5.000	3.246	MON	402	4,830	10/02/2015	11/16/2034
38374KWQ2	GNMA REMIC TRUST 2005-16			4	1	92,250	110.5010	90,611	82,000	87,903		(897)			5.000	3.759	MON	342	4,100	10/10/2014	02/20/2035
38374KXC2	GNMA REMIC TRUST 2005-16			4	1	224,927	108.2060	218,542	201,969	219,589		(423)			5.000	3.022	MON	842	10,248	10/15/2014	02/20/2035
38374K2D4	GNMA REMIC TRUST 2005-33			4	1	47,033	107.7990	45,987	42,660	46,746		(37)			5.500	3.290	MON	189	2,387	11/13/2014	04/16/2035
38374KLR2	GNMA REMIC TRUST 2005-6			4	1	50,415	108.3060	49,979	46,147	50,298		123			5.000	2.931	MON	192	2,344	11/01/2014	10/20/2034
38374LG88	GNMA REMIC TRUST 2005-63			4	1	31,217	109.5220	31,223	28,508	30,904		(29)			5.000	3.140	MON	119	1,448	10/02/2014	08/20/2035
38374MAY5	GNMA REMIC TRUST 2005-77			4	1	28,736	101.3810	27,131	26,762	28,108		(433)			5.500	0.965	MON	123	1,529	10/09/2014	02/17/2033
38374MSY6	GNMA REMIC TRUST 2005-98			4	1	81,426	110.6580	78,694	71,114	78,856		(126)			5.500	3.016	MON	326	3,967	10/14/2014	12/20/2035
38374MN96	GNMA REMIC TRUST 2006-20			4	1	281,461	116.2220	261,499	225,000	263,137		(4,468)			6.000	3.595	MON	1,125	13,500	02/19/2016	04/20/2036
38375JCC7	GNMA REMIC TRUST 2006-69			4	1	105,181	106.2730	100,929	94,972	105,035		(55)			5.500	2.986	MON	435	5,304	12/22/2015	12/20/2036
38375KEX6	GNMA REMIC TRUST 2007-33			4	1	111,759	109.9080	107,866	98,142	108,852		(332)			5.500	2.946	MON	510	5,491	10/09/2014	06/20/2037
38375LPU8	GNMA REMIC TRUST 2007-59			4	1	75,675	100.8830	77,115	76,440	75,892		60			2.970	3.193	MON	69	1,895	05/26/2015	10/20/2037

SCHEDULE D - PART 1

Showing all Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	FOREIGN	Bond CHAR	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of Interest	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
3837424J9	GNMA REMIC TRUST 2008-56			4	1	57,636	111.1860	56,492	50,809	57,432		(13)			6.000	3.036	MON	254	3,097	11/03/2014	06/20/2038
38375XPA6	GNMA REMIC TRUST 2008-74			4	1	53,030	110.8310	52,026	46,942	52,516		(91)			6.000	3.326	MON	235	2,852	10/17/2014	08/16/2038
38376TW99	GNMA REMIC TRUST 2010-4			4	1	73,523	102.6710	70,880	69,036	72,896		(403)			4.000	1.887	MON	230	2,818	11/01/2014	01/16/2039
38375XZ72	GOVERNMENT NATIONAL MORTGAGE A			4	1	62,868	111.9120	61,920	55,329	63,821		(86)			6.000	2.533	MON	231	3,377	11/03/2014	08/20/2038
0299999 Subtotal - U.S. Governments - Residential Mortgage-Backed Securities						2,946,364	XXX	2,855,576	2,665,989	2,892,177		(12,025)			XXX	XXX	XXX	10,382	125,437	XXX	XXX
0599999 Subtotal - U.S. Governments						13,316,272	XXX	13,096,802	12,649,021	13,242,254	9,104	(23,934)			XXX	XXX	XXX	82,472	338,742	XXX	XXX
U.S. States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations																					
64966MQM4	NEW YORK N Y			1	1FE	145,286	95.1150	142,673	150,000	145,640		355			2.950	3.328	AO	1,106	4,400	01/19/2018	10/01/2028
677521CW4	OHIO STATE			1	1FE	165,960	119.2570	160,997	135,000	162,984		(2,177)			5.442	3.165	MS	2,449	7,347	08/16/2017	09/01/2029
1199999 Subtotal - U.S. States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations						311,245	XXX	303,669	285,000	308,625		(1,822)			XXX	XXX	XXX	3,555	11,747	XXX	XXX
1799999 Subtotal - U.S. States, Territories and Possessions (Direct and Guaranteed)						311,245	XXX	303,669	285,000	308,625		(1,822)			XXX	XXX	XXX	3,555	11,747	XXX	XXX
U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations																					
4423313C6	HOUSTON TEX TAXABLE PENSION OBLG			1	1FE	149,601	100.6550	150,983	150,000	149,636		35			3.425	3.489	MS	1,713	3,553	01/31/2018	03/01/2027
467107CL0	JACKSON CNTY MICH				1FE	151,466	100.6410	150,962	150,000	151,396		(69)			3.829	3.778	JD	479	5,536	01/30/2018	12/01/2032
91481CAB6	UNIVERSITY OF PENNSYLVAN				1FE	50,000	97.8540	48,927	50,000	50,000					4.008	4.048	FA	757	1,347	11/29/2017	08/15/2047
1899999 Subtotal - U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations						351,067	XXX	350,871	350,000	351,032		(34)			XXX	XXX	XXX	2,948	10,437	XXX	XXX
2499999 Subtotal - U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)						351,067	XXX	350,871	350,000	351,032		(34)			XXX	XXX	XXX	2,948	10,437	XXX	XXX
U.S. Special Revenue, Special Assessment - Issuer Obligations																					
254845GQ7	DISTRICT COLUMBIA WTR & SWR AU			1	1FE	193,040	121.5890	182,384	150,000	191,773		(941)			5.522	3.851	AO	2,071	8,283	08/23/2017	10/01/2044
341271AA2	FLORIDA ST BRD ADMIN FIN CORP				1FE	111,811	99.7100	109,681	110,000	110,293		(578)			2.163	1.633	JJ	1,190	2,379	05/03/2016	07/01/2019
485429Y32	KANSAS ST DEV FIN AUTH REV				1FE	95,000	99.4700	94,497	95,000	95,000					2.608	2.625	AO	523	2,478	08/13/2015	04/15/2020
60636AMR1	MISSOURI ST HEALTH & EDL FACS			1	1FE	154,853	95.9110	143,867	150,000	154,583		(199)			3.471	3.262	JJ	2,401	5,207	08/21/2017	01/15/2036
645913AY0	NEW JERSEY ECONOMIC DEV AUTH S				1FE	232,895	96.0000	258,240	269,000	259,789		7,691			0.010	3.195	MAT	580		03/18/2015	02/15/2020
64971XBB3	NEW YORK N Y CITY TRANSITIONAL			1	1FE	151,775	97.7270	146,591	150,000	151,622		(113)			3.430	3.344	FA	2,144	4,916	08/23/2017	08/01/2030
73474TAP5	PORT MORROW ORE TRANSMISSION F			1	1FE	142,251	88.1850	132,278	150,000	142,660		300			2.987	3.385	MS	1,494	4,481	08/17/2017	09/01/2036
7599113H1	REGIONAL TRANSN AUTH ILL				1FE	100,000	99.9930	99,993	100,000	100,000					3.013	3.036	MN	502	1,264	05/09/2018	05/29/2020
76541VSU2	RICHMOND VA				1FE	147,705	95.4590	143,189	150,000	147,908		148			3.000	3.170	JJ	2,075	4,513	08/16/2017	07/15/2030
79467BAR6	SALES TAX SECURITIZATION CORP			1	1FE	75,000	90.3390	67,754	75,000	75,000					3.587	3.619	JJ	1,345	1,472	12/07/2017	01/01/2043
798170AN6	SAN JOSE CALIF REDEV AGY SUCCE				1FE	48,852	94.1270	47,064	50,000	48,919		63			3.375	3.615	FA	703	1,031	12/08/2017	08/01/2034
88213AKJ3	TEXAS A & M UNIV REV				1FE	153,272	96.7460	145,119	150,000	153,005		(197)			3.286	3.114	MN	630	4,929	08/21/2017	05/15/2031
882724ER4	TEXAS ST FOR PREVIOUS ISSUES S				1FE	137,933	89.7300	134,595	150,000	138,353		420			3.000	3.632	FA	1,875	2,750	02/08/2018	08/01/2036
91412GE92	UNIVERSITY CALIF REVS FOR PREV GE				1FE	148,206	94.4010	141,602	150,000	148,283		56			3.552	3.665	MN	681	5,328	08/15/2017	05/15/2039
2599999 Subtotal - U.S. Special Revenue, Special Assessment - Issuer Obligations						1,892,591	XXX	1,846,850	1,899,000	1,917,187		6,651			XXX	XXX	XXX	18,212	49,030	XXX	XXX
U.S. Special Revenue, Special Assessment - Residential Mortgage-Backed Securities																					
3133TSGY3	FEDERAL HOME LN MTG CORP			4	1	64,939	101.8910	65,310	64,098	64,751		(49)			0.903	0.664	MON	48	1,753	10/21/2014	05/15/2029
3128MMF99	FHLMC PC GOLD COMB 15			4	1	24,315	101.6950	22,543	22,167	23,254		(329)			6.000	1.565	MON	111	1,387	10/09/2014	06/01/2022
3132J4HV4	FHLMC PC GOLD COMB 20			4	1	174,945	99.0250	170,129	171,804	174,779		(109)			2.500	2.235	MON	358	5,190	06/01/2017	09/01/2036
31296YJM6	FHLMC PC GOLD COMB 30			4	1	34,271	109.4090	32,999	30,161	33,882		(87)			7.000	3.138	MON	176	2,118	10/01/2014	05/01/2034
31335BA22	FHLMC PC GOLD COMB 30			4	1	192,871	105.8220	185,519	175,312	192,292		(453)			4.350	2.608	MON	636	8,896	08/10/2017	08/01/2044
31335BA89	FHLMC PC GOLD COMB 30			4	1	144,128	97.9530	140,498	143,434	144,128		0			3.000	2.979	MON	359	4,343	08/22/2017	02/01/2047
3132HRMV9	FHLMC PC GOLD PC 30YR			4	1	159,268	98.2190	154,739	157,545	159,225		(44)			3.000	2.881	MON	394	4,381	01/01/2018	01/01/2043
3132WHJY2	FHLMC PC GOLD PC 30YR			4	1	211,161	97.7220	205,619	210,413	211,146		(12)			3.000	2.995	MON	526	6,365	05/24/2017	10/01/2046
3128MAEB1	FHLMC PC GOLD COMB 30			4	1	182,542	98.3310	183,980	187,102	182,573		32			3.000	3.394	MON	468	1,890	08/07/2018	06/01/2043
31335BLX2	FHLMC PC GOLD COMB 30			4	1	141,215	103.8910	137,473	132,324	141,086		(129)			4.500	3.401	MON	496	5,023	02/01/2018	12/01/2045
3132H7D84	FHLMC PC GOLD H LTV 30			4	1	175,815	98.0980	178,179	181,633	175,875		60			3.000	3.592	MON	454	3,220	05/09/2018	11/01/2043
3132GSKA6	FHLMC PC GOLD PC 30YR			4	1	211,868	102.8940	205,478	199,698	211,211		(241)			3.500	2.643	MON	582	8,088	08/01/2015	04/01/2042
31335AWT1	FHLMC PCGOLD COMB 30			4	1	189,996	100.5410	185,401	184,404	189,906		(91)			3.500	3.128	MON	538	5,978	01/01/2018	07/01/2046
3137FCLD4	FHLMC REMIC SERIES			4	1	66,946	99.6710	64,786	65,000	66,764		(173)			3.286	2.975	MON	178	2,136	12/12/2017	11/25/2027
3133THM53	FHLMC REMIC SERIES 2112			4	1	62,531	108.5510	59,920	55,200	61,571		(287)			6.000	2.520	MON	276	3,385	10/21/2014	01/15/2029
3133TRJM8	FHLMC REMIC SERIES 2283			4	1	41,232	105.3130	38,835	36,876	39,933		(329)			6.500	2.452	MON	200	2,484	10/21/2014	12/15/2023
31394RLM9	FHLMC REMIC SERIES 2752			4	1	125,293	109.9760	124,593	113,291	124,807		(121)			5.500	3.272	MON	519	6,329	12/22/2015	02/15/2034
31395TYA6	FHLMC REMIC SERIES 2973			4	1	96,105	115.3710	99,219	86,000	92,308		(451)			5.500	4.734	MON	394	4,730	10/03/2014	05/15/2035
31396AFT6	FHLMC REMIC SERIES 3028			4	1	61,921	107.9320	59,307	54,949	61,465		(150)			5.500	2.677	MON	252	3,084	03/01/2015	09/15/2035
31396AGC2	FHLMC REMIC SERIES 3028			4	1	141,474	117.3620	154,377	131,540	159,051		6,175			5.500	1.323	MON	603	3	02/25/2016	09/15/2035
31397JXC3	FHLMC REMIC SERIES 3344			4	1	65,560	100.2930	65,896	65,703	64,853		37			2.855	3.228	MON	83	1,560	10/09/2014	07/15/2037
31398Q4F1	FHLMC REMIC SERIES 3664			4	1	70,837	102.4930	68,757	67,085	70,318		(329)			4.000	2.497	MON	224	2,721	10/03/2014	11/15/2037
3137A7RM4	FHLMC REMIC SERIES 3817			4	1	60,685	102.0910	57,331	56,157	59,702		(682)			4.500	1.051	MON	211	2,615	10/15/2014	10/15/2037

SCHEDULE D - PART 1

Showing all Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	FOREIGN	Bond CHAR	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of Interest	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
3137A7YA2	FHLMC REMIC SERIES 3827			4	1	126,282	101.6870	123,770	121,717	125,085		(452)			3.500	2.520	MON	355	4,260	10/09/2014	11/15/2025
3137AHGR3	FHLMC REMIC SERIES 3959			4	1	51,507	105.2270	50,126	47,636	51,313		(73)			4.500	3.036	MON	179	2,195	10/03/2014	11/15/2041
3137APGD6	FHLMC REMIC SERIES 4029			4	1	81,755	102.2270	78,845	77,128	81,349		(231)			3.500	2.203	MON	225	2,743	10/15/2014	04/15/2041
3137AQXY9	FHLMC REMIC SERIES 4058			4	1	161,413	104.0570	152,001	146,075	153,107		(1,404)			4.500	3.350	MON	548	6,573	10/09/2014	06/15/2027
3137B4UV6	FHLMC REMIC SERIES 4248			4	1	108,951	99.3740	107,197	107,872	108,671		(114)			3.000	2.716	MON	270	3,250	10/15/2014	06/15/2030
3137B8CD7	FHLMC REMIC SERIES 4301			4	1	57,955	100.4490	55,909	55,659	57,420		(171)			3.500	2.283	MON	162	1,989	11/01/2014	07/15/2032
3137B8JJ7	FHLMC REMIC SERIES 4315			4	1	87,918	107.1300	84,757	79,116	86,563		(262)			5.000	3.063	MON	330	4,008	10/01/2014	08/15/2041
3137B95Z4	FHLMC REMIC SERIES 4316			4	1	126,954	104.3060	118,464	113,573	122,071		(1,153)			4.500	1.608	MON	426	5,165	10/20/2014	04/15/2025
3137BC5W4	FHLMC REMIC SERIES 4361			4	1	226,276	91.7980	227,636	247,974	233,737		861			3.000	3.623	MON	620	7,439	10/03/2014	10/15/2035
3137BCMT2	FHLMC REMIC SERIES 4363			4	1	96,471	103.6320	93,544	90,265	94,967		(276)			4.000	2.555	MON	301	3,677	10/02/2014	05/15/2033
3137BLAC2	FHLMC REMIC SERIES K-048			4	1	158,426	101.0830	151,625	150,000	156,856		(1,017)			3.284	2.512	MON	411	4,926	08/22/2017	06/25/2025
3137BSRE5	FHLMC REMIC SERIES K-059			4	1	155,689	99.2950	148,942	150,000	154,807		(603)			3.120	2.660	MON	390	4,680	08/22/2017	09/25/2026
3137BTUM1	FHLMC REMIC SERIES K-061			4	1	158,695	100.6620	150,993	150,000	157,426		(863)			3.347	2.665	MON	418	5,020	08/24/2017	11/25/2026
3137BUX60	FHLMC REMIC SERIES K-062			4	1	159,393	101.1070	151,660	150,000	158,030		(921)			3.413	2.680	MON	427	5,119	08/23/2017	12/25/2026
3137BXQY1	FHLMC REMIC SERIES K-064			4	1	157,049	99.7690	149,654	150,000	156,046		(680)			3.000	2.470	MON	375	4,836	08/23/2017	03/25/2027
3137F1G44	FHLMC REMIC SERIES K-065			4	1	157,418	99.7970	149,695	150,000	156,406		(710)			3.243	2.682	MON	405	4,864	08/24/2017	04/25/2027
3137F2LJ3	FHLMC REMIC SERIES K-066			4	1	102,995	98.8590	98,859	100,000	102,559		(277)			3.117	2.798	MON	260	3,117	08/09/2017	06/25/2027
3137FDER9	FHLMC REMIC SERIES K-1504			4	1	64,823	100.4930	63,869	63,556	64,696		(127)			3.176	2.766	MON	168	1,854	01/11/2018	11/25/2028
3137FCKD5	FHLMC REMIC SERIES K-GS1 20271025			4	1	85,138	97.9620	83,268	85,000	85,125		(12)			3.000	3.022	MON	213	2,550	12/05/2017	10/25/2027
3137B04Y7	FHLMC REMIC SERIES K-SMC			4	1	199,750	98.5690	197,139	200,000	199,887		26			2.615	2.662	MON	436	5,230	12/30/2014	01/25/2023
3137FCJG0	FHLMC SERIES FRESR 2017-SR01 2027			4	1	70,696	96.6910	67,684	70,000	70,602		(89)			3.089	2.971	MON	180	2,162	12/06/2017	11/25/2027
3138L3AM7	FNMA PASS-THRU BLLN MULTI 7+			4	1	175,569	99.3720	175,861	176,973	176,193		160			2.570	2.836	MON	379	4,619	10/07/2014	03/01/2023
3138L7QN9	FNMA PASS-THRU BLLN MULTI 7+			4	1	95,583	102.1890	95,090	93,053	95,172		(148)			3.070	2.567	MON	238	3,373	12/22/2015	10/01/2029
31415CM53	FNMA PASS-THRU INT 15 YEAR			4	1	43,329	103.4540	40,429	39,079	41,629		(517)			5.500	1.720	MON	179	2,211	10/20/2014	05/01/2023
31371LDG1	FNMA PASS-THRU LNG 30 YEAR			4	1	235,667	106.1840	225,606	212,467	233,577		(910)			4.500	2.369	MON	797	10,797	02/01/2016	10/01/2033
3138EKY74	FNMA PASS-THRU LNG 30 YEAR			4	1	151,665	102.8240	146,323	142,304	151,300		(205)			3.500	2.518	MON	415	5,772	12/08/2015	10/01/2041
3138ELJT1	FNMA PASS-THRU LNG 30 YEAR			4	1	142,462	100.7760	136,083	135,035	142,167		(151)			3.500	2.763	MON	394	4,782	06/01/2016	07/01/2043
3138ENTM1	FNMA PASS-THRU LNG 30 YEAR			4	1	44,827	106.1550	42,840	40,356	44,626		(90)			4.500	2.713	MON	151	2,050	01/06/2015	01/01/2042
3138EPAB0	FNMA PASS-THRU LNG 30 YEAR			4	1	104,624	104.5540	100,436	96,061	104,223		(156)			4.000	2.583	MON	320	4,386	11/01/2015	06/01/2042
3138EPMM3	FNMA PASS-THRU LNG 30 YEAR			4	1	165,371	102.4710	158,789	154,960	164,641		(382)			3.500	2.291	MON	452	6,285	04/01/2016	03/01/2039
3138EPS54	FNMA PASS-THRU LNG 30 YEAR			4	1	72,128	106.0950	68,805	64,853	71,834		(137)			4.500	2.718	MON	243	3,294	09/01/2015	04/01/2042
3138ERCJ7	FNMA PASS-THRU LNG 30 YEAR			4	1	287,054	106.1560	277,181	261,107	286,251		(489)			5.000	3.378	MON	1,088	13,201	02/01/2017	07/01/2044
3138ET4W3	FNMA PASS-THRU LNG 30 YEAR			4	1	98,257	104.0330	97,643	93,858	98,227		(30)			4.500	3.799	MON	352	2,141	06/04/2018	05/01/2046
3138ETC53	FNMA PASS-THRU LNG 30 YEAR			4	1	196,021	102.5060	184,297	179,791	195,694		(251)			4.000	2.715	MON	599	7,300	07/12/2016	12/01/2045
3138W8AC6	FNMA PASS-THRU LNG 30 YEAR			4	1	71,375	100.7810	70,039	69,496	71,254		(36)			3.500	3.167	MON	203	2,459	10/01/2014	04/01/2043
3138WDKQ3	FNMA PASS-THRU LNG 30 YEAR			4	1	278,218	100.3780	268,166	267,156	277,663		(195)			3.000	2.475	MON	668	9,404	02/01/2016	11/01/2044
3138WFCF1	FNMA PASS-THRU LNG 30 YEAR			4	1	136,384	102.1780	129,792	127,026	136,123		(139)			3.500	2.479	MON	370	5,152	04/01/2016	07/01/2045
3138X0AW8	FNMA PASS-THRU LNG 30 YEAR			4	1	307,317	100.7800	296,134	293,842	306,592		(289)			3.000	2.396	MON	735	10,393	12/15/2014	07/01/2043
3140J5W62	FNMA PASS-THRU LNG 30 YEAR			4	1	197,520	100.8200	192,137	190,575	197,448		(123)			3.000	2.550	MON	476	6,734	10/27/2017	07/01/2047
3140J5ZV4	FNMA PASS-THRU LNG 30 YEAR			4	1	241,162	106.1610	231,791	218,339	240,201		(852)			4.350	2.311	MON	791	11,092	09/12/2017	11/01/2044
3140J7UL7	FNMA PASS-THRU LNG 30 YEAR			4	1	76,815	103.6270	75,811	73,158	76,793		(22)			4.500	3.753	MON	274	2,697	04/09/2018	11/01/2047
31410LR87	FNMA PASS-THRU LNG 30 YEAR			4	1	136,375	105.3260	132,081	125,402	136,104		(160)			4.500	3.133	MON	470	5,715	02/01/2017	11/01/2045
31417LCN3	FNMA PASS-THRU LNG 30 YEAR			4	1	107,098	102.8140	103,879	101,036	106,768		(153)			3.500	2.606	MON	295	4,074	12/01/2015	09/01/2039
31418MZ39	FNMA PASS-THRU LNG 30 YEAR			4	1	245,373	107.1070	231,839	216,456	244,031		(699)			4.500	2.229	MON	812	10,978	02/20/2015	02/01/2040
31418UED2	FNMA PASS-THRU LNG 30 YEAR			4	1	120,954	104.7430	115,798	110,555	120,461		(242)			4.000	2.541	MON	369	5,035	02/01/2016	06/01/2040
31418M5K4	FNMA PASS-THRU MEGA MULTI 7			4	1	75,827	101.1720	69,345	68,541	70,151		(1,445)			4.392	0.003	MON	251	3,319	10/17/2014	02/01/2020
3138WKPU3	FNMA PASS-THRU INT 20 YEAR			4	1	148,765	101.4300	144,481	142,444	148,559		(204)			3.000	2.323	MON	356	5,047	12/05/2017	04/01/2037
3138EP2K9	FNMA PASS-THRU INT 20 YEAR 4.000			4	1	191,945	103.5290	186,618	180,256	191,499		(410)			4.000	2.838	MON	601	7,003	12/01/2017	07/01/2035
3138XYS96	FNMA PASS-THRU LNG 30 YEAR			4	1	933,026	102.6230	947,506	923,288	932,992		(34)			4.000	3.904	MON	3,078	6,227	10/04/2018	07/01/2044
3140H1V98	FNMA PASS-THRU LNG 30 YEAR			4	1	170,120	101.9590	168,965	165,718	170,091		(30)			4.000	3.670	MON	552	4,447	04/10/2018	03/01/2048
31410LTX0	FNMA PASS-THRU LNG 30 YEAR 4.000 2			4	1	258,259	102.4510	260,518	254,286	258,244		(15)			4.000	3.829	MON	848	1,289	10/01/2018	08/01/2046
31418CXN9	FNMA PASS-THRU LNG 30 YEAR 4.000 2			4	1	386,935	101.9590	388,028	380,573	386,937		2			4.000	3.817	MON	1,269	6,378	07/25/2018	06/01/2048
31374CQU3	FNMA PASS-THRU MEGA SF LT			4	1	169,365	104.7380	161,515	154,209	168,803		(291)			4.500	2.897	MON	578	7,045	08/26/2016	02/01/2044
31393UXJ7	FNMA REMIC TRUST 2003-128			4	1	63,841	102.1020	60,883	59,629	62,566		(280)			4.500	0.390	MON	224	2,749	10/21/2014	01/25/2024
31393XZV2	FNMA REMIC TRUST 2004-17			4	1	79,620	110.0260	78,921	71,730	88,242		(1,835)			5.500	0.277	MON	66	3,988	11/01/2014	04/25/2034
31396LUS7	FNMA REMIC TRUST 2006-105			4	1	101,574	108.7220	98,081	90,213	99,507		(83)			5.500	3.369	MON	413	5,032	10/21/2014	11/25/2036
31396KWU2	FNMA REMIC TRUST 2006-79			4	1	161,850	114.2020	148,462	130,000	148,318		(3,309)			6.500	3.294	MON	704	8,450	09/29/2014	08/25/2036
31397SHK3	FNMA REMIC TRUST 2011-31			4	1	178,117	102.2740	178,980	175,000	176,744		(376)			3.500	3.305	MON	510	6,125	09/26/2014	04/25/2031
3136A9N61	FNMA REMIC TRUST 2012-120			4	1	97,518	101.5750	95,302	93,824	97,297		(15)			3.500	2.886	MON	274	3,331	11/01/2014	10/25/2042
3136A35F4	FNMA REMIC TRUST 2012-28			4	1	30,288	106.7210	28,900	27,080	30,080		(119)			6.500	3.075	MON	147	1,820	10/10/2014	06/25/2039
3136A54N3	FNMA REMIC TRUST 2012-51			4	1	46,574	116.2150	47,701	41,046	46,570		92			7.000	3.861	MON	239	2,932	10/07/2014	05/25/2042
3136A7K76	FNMA REMIC TRUST 2012-92			4	1	66,288	101.1450	64,662	63,930	65,817		(145)			3.500	2.538	MON	186	2,292	09/26/2014	04/25/2037
3136AGUU4	FNMA REMIC TRUST 2013-100			4	1	193,373	104.8750	185,562	176,936	191,109		(946)			4.500	2.589	MON	664	8,095	03/01/2015	11/25/2041
3136AGNB4	FNMA REMIC TRUST 2013-103			4	1	41,634	103.1010	39,517	38,328	40,977		(363)			4.500	1.831	MON	144	1,774	03/01/2015	03/25/2038
3136AGZ21	FNMA REMIC TRUST 2013-117			4	1	150,379	100.9090	145,298	143,990	148,135		(756)			3.500	2.134	MON	420	5,084	11/01/2014	11/25/2026

SCHEDULE D - PART 1

Showing all Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	FOREIGN	Bond CHAR	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of Interest	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
3136ACJP7	FNMA REMIC TRUST 2013-17			4	1	86,895	103.9770	85,717	82,439	86,380		(58)			4.000	2.961	MON	275	3,352	11/01/2014	03/25/2033
3136ACTJ0	FNMA REMIC TRUST 2013-20			4	1	103,479	104.2230	101,655	97,536	102,698		(145)			4.000	2.865	MON	325	3,966	10/01/2014	03/25/2033
3136ACWD9	FNMA REMIC TRUST 2013-20			4	1	67,326	103.8430	65,897	63,459	66,802		(92)			4.000	2.895	MON	212	2,573	10/01/2014	03/25/2033
3136ADFU8	FNMA REMIC TRUST 2013-31			4	1	117,773	104.4360	116,775	111,815	117,032		(121)			4.000	2.991	MON	373	4,526	11/01/2014	04/25/2033
3136ADGY9	FNMA REMIC TRUST 2013-31			4	1	56,404	105.1310	56,466	53,710	56,085		(32)			4.000	3.133	MON	179	2,183	11/01/2014	01/25/2033
3136ADY45	FNMA REMIC TRUST 2013-43			4	1	88,462	100.9650	87,184	86,351	88,178		(55)			3.500	3.079	MON	252	3,057	11/01/2014	05/25/2033
3136AGJN3	FNMA REMIC TRUST 2013-94			4	1	83,318	102.8210	80,299	78,096	82,438		(373)			4.000	2.256	MON	260	3,198	10/16/2014	01/25/2040
3136AJT97	FNMA REMIC TRUST 2014-29			4	1	69,146	102.7150	67,802	66,010	68,815		(13)			3.750	3.007	MON	206	2,527	11/01/2014	01/25/2044
3136AMST7	FNMA REMIC TRUST 2015-M3			4	1	151,500	98.2070	147,310	150,000	150,835		(136)			2.723	2.648	MON	340	4,084	02/12/2015	10/25/2024
3136AV6R5	FNMA REMIC TRUST 2017-T1			4	1	119,850	95.4240	114,365	119,850	119,850					2.898	2.937	MON	289	3,473	04/19/2017	06/25/2027
31358HM28	FNMA SERIES 91100			4	1	39,498	103.2000	36,314	35,188	40,979		2,994			7.000	(5.785)	MON	205	2,544	04/01/2015	08/25/2021
2699999 Subtotal - U.S. Special Revenue, Special Assessment - Residential Mortgage-Backed Securities						13,555,569	XXX	13,222,405	12,905,880	13,503,307		(21,119)			XXX	XXX	XXX	40,693	445,190	XXX	XXX
3199999 Subtotal - U.S. Special Revenue, Special Assessment						15,448,159	XXX	15,069,255	14,804,880	15,420,494		(14,468)			XXX	XXX	XXX	58,905	494,220	XXX	XXX
Industrial & Miscellaneous (Unaffiliated) - Issuer Obligations																					
90131HBQ7	21ST CENTY FOX AMER INC				2FE	124,741	124.1830	124,183	100,000	122,706		(588)			6.150	4.567	FA	2,323	6,150	05/01/2015	02/15/2041
00287YAT6	ABBVIE INC			1	2FE	50,147	99.0510	49,526	50,000	50,059		(42)			2.500	2.427	MN	163	1,250	11/15/2016	05/14/2020
00287YAP4	ABBVIE INC SR UNSECURED 11/22 3.2				2FE	49,470	98.5070	49,254	50,000	49,689		75			3.200	3.402	MN	244	1,600	12/22/2015	11/06/2022
00440EAM9	ACE INA HLDG INC				1FE	57,777	101.2930	50,647	50,000	50,806		(1,738)			5.900	2.339	JD	131	2,950	11/04/2014	06/15/2019
00751YAB2	ADVANCE AUTO PARTS INC				2FE	26,471	101.5270	25,382	25,000	25,669		(205)			4.500	3.595	JJ	519	1,125	11/12/2014	01/15/2022
00912XAV6	AIR LEASE CORP			1	2FE	14,510	89.4380	13,416	15,000	14,584		42			3.625	4.064	AO	136	544	03/15/2017	04/01/2027
015271AL3	ALEXANDRIA REAL ESTATE EQ INC			1	2FE	99,813	96.2550	96,255	100,000	99,839		22			3.450	3.509	AO	585	3,258	11/09/2017	04/30/2025
02361DAL4	AMEREN ILLINOIS CO				1FE	125,565	98.2030	124,718	127,000	126,279		184			2.700	2.885	MS	1,143	3,429	12/19/2014	09/01/2022
02377DAA0	AMERICAN AIRLS INC SER 2017-2B			1	2FE	94,945	96.7230	91,834	94,945	94,945					3.700	3.734	AO	742	3,704	09/26/2017	04/15/2027
026874DG9	AMERICAN INTL GROUP INC			1	2FE	61,242	99.6610	59,797	60,000	60,705		(312)			3.300	2.756	MS	660	1,980	04/05/2017	03/01/2021
03027XAD2	AMERICAN TOWER CORP NEW			1	2FE	32,374	103.4440	31,033	30,000	31,782		(310)			5.000	3.750	FA	567	1,500	01/23/2017	02/15/2024
03076CAH9	AMERIPRISE FINL INC			1	1FE	63,163	93.1160	58,663	63,000	63,129		(15)			2.875	2.866	MS	533	1,811	09/01/2016	09/15/2026
031162AZ3	AMGEN INC				2FE	67,685	100.2000	60,120	60,000	60,167		(1,968)			5.700	2.370	FA	1,425	3,420	12/21/2015	02/01/2019
032511BC0	ANADARKO PETE CORP				2FE	31,394	101.0300	25,258	25,000	25,318	32	(1,519)			8.700	2.496	MS	640	2,175	11/04/2014	03/15/2019
03350WAC3	ANDEAVOR LOG LP & TESORO LOG F			1	2FE	49,911	94.4010	47,201	50,000	49,919		7			4.250	4.318	JD	177	2,143	11/16/2017	12/01/2027
03522AAD2	ANHEUSER-BUSCH COS LLC ANHEU 144A			2	2FE	94,407	94.5550	94,555	100,000	94,504		97			3.650	4.619	FA	1,521		11/08/2018	02/01/2026
03522AAE0	ANHEUSER-BUSCH COS LLC ANHEU 144A			2	2FE	53,168	92.7400	51,007	55,000	53,178		10			4.700	5.053	FA	1,077		11/08/2018	02/01/2036
03522AAF7	ANHEUSER-BUSCH COS LLC ANHEU 144A			1	2FE	209,257	92.7390	203,098	219,000	209,281		24			4.900	5.275	FA	4,471		11/08/2018	02/01/2046
036752AC7	ANTHEM INC			1	2FE	39,987	97.4200	38,968	40,000	39,989		2			3.350	3.383	JD	112	1,377	11/14/2017	12/01/2024
037411AX3	APACHE CORP				2FE	38,053	99.8290	36,937	37,000	37,364		(167)			3.625	3.161	FA	559	1,341	12/22/2015	02/01/2021
03765HAA9	APOLLO MGMT HLDGS LP 144A			1	1FE	111,486	100.0280	112,031	112,000	111,530		44			4.000	4.129	MN	386	2,240	06/05/2018	05/30/2024
037735CM7	APPALACHIAN POWER CO				2FE	80,811	125.7590	75,455	60,000	78,589		(594)			7.000	4.619	AO	1,050	4,200	12/22/2015	04/01/2038
037833AS9	APPLE INC				1FE	67,296	100.4740	65,308	65,000	66,408		(239)			3.450	3.031	MN	343	2,243	12/22/2015	05/06/2024
037833CU2	APPLE INC			1	1FE	115,890	97.5640	113,174	116,000	115,914		15			2.850	2.886	MN	459	3,306	05/04/2017	05/11/2024
04010LAV5	ARES CAP CORP			1	2FE	99,621	95.2110	95,211	100,000	99,666		45			4.250	4.359	MS	1,417	2,715	01/08/2018	03/01/2025
00206RGD8	AT&T INC				2FE	81,251	96.9990	80,509	83,000	81,268		16			3.956	4.523	MJSD	182		12/14/2018	06/12/2024
00206RBA9	AT+T INC				2FE	95,965	98.0480	88,243	90,000	95,470		(127)			5.550	5.161	FA	1,887	4,995	12/30/2015	08/15/2041
00206RCN0	AT+T INC SR UNSECURED 05/25 3.4				2FE	151,437	94.1650	147,839	157,000	153,035		539			3.400	3.888	MN	682	5,338	01/08/2016	05/15/2025
04686JAA9	ATHENE HOLDING LTD		C	1	2FE	99,846	90.8360	90,836	100,000	99,858		12			4.125	4.187	JJ	1,936	2,063	01/09/2018	01/12/2028
049560AJ4	ATMOS ENERGY CORP				1FE	62,889	101.0940	50,547	50,000	50,641		(3,069)			8.500	2.243	MS	1,251	4,250	11/14/2014	03/15/2019
05348EAU3	AVALONBAY CMNTYS INC MTN BE			1	1FE	47,257	99.4010	44,730	45,000	46,680		(260)			3.500	2.826	MN	201	1,575	09/27/2016	11/15/2024
059165EE6	BALTIMORE GAS & ELEC CO				1FE	49,589	98.0150	49,008	50,000	49,797		53			2.800	2.940	FA	529	1,400	11/12/2014	08/15/2022
06051GHD4	BANK AMER CORP SR GLBL NT 144A 28			1,2	1FE	59,673	93.4150	56,049	60,000	59,699		25			3.419	3.510	JD	68	2,051	12/15/2017	12/20/2028
06051GEU9	BANK OF AMERICA CORP				1FE	275,358	98.4860	275,761	280,000	277,411		588			3.300	3.580	JJ	4,363	9,240	12/22/2015	01/11/2023
06051GFF1	BANK OF AMERICA CORP				1FE	70,478	100.5540	68,377	68,000	69,490		(254)			4.000	3.570	AO	680	2,720	11/24/2014	04/01/2024
06051GFX2	BANK OF AMERICA CORP SR UNSECURED				1FE	30,657	96.2340	29,833	31,000	30,688		31			3.500	3.692	AO	217	669	02/23/2018	04/19/2026
06406HCW7	BANK OF NEW YORK MELLON				1FE	25,259	99.4800	24,870	25,000	25,039		(56)			2.300	2.082	MS	176	575	12/04/2014	09/11/2019
072863AD5	BAYLOR SCOTT + WHITE HOL SECURED 1				1FE	199,000	96.2780	191,593	199,000	199,000					1.947	1.956	MN	495	3,875	04/06/2016	11/15/2021
05531FAV5	BB+T CORPORATION SR UNSECURED 05/2				1FE	206,785	97.3730	201,562	207,000	206,896		43			2.050	2.083	MN	601	4,244	05/05/2016	05/10/2021
084670BR8	BERKSHIRE HATHAWAY INC DEL			1	1FE	230,594	98.1680	224,805	229,000	230,171		(261)			2.750	2.638	MS	1,854	6,298	05/22/2017	03/15/2023
09247XAL5	BLACKROCK INC				1FE	26,496	101.0830	25,271	25,000	25,899		(158)			3.500	2.774	MS	250	875	01/28/2015	03/18/2024
096630AD0	BOARDWALK PIPELINES LP			1	2FE	31,421	101.4070	30,422	30,000	31,108		(160)			4.950	4.287	JD	66	1,485	01/05/2017	12/15/2024
096630AF5	BOARDWALK PIPELINES LP			1	2FE	35,584	92.3310	32,316	35,000	35,506		(48)			4.450	4.292	JJ	718	1,558	05/10/2017	07/15/2027
097023AU9	BOEING CO				1FE	83,513	126.5800	82,277	65,000	80,485		(808)			6.125	3.952	FA	1,504	3,981	12/22/2015	02/15/2033
10112RAW4	BOSTON PPTYS LTD PARTNERSHIP			1	2FE	31,859	99.6330	29,890	30,000	31,336		(241)			3.800	2.873	FA	475	1,140	10/18/2016	02/01/2024
10112RAU8	BOSTON PROPERTIES LP				2FE	183,013	100.1780	175,312	175,000	179,902		(1,109)			3.850	3.139	FA	2,807	6,738	02/11/2016	02/01/2023
11120VAA1	BRIXMOR OPERATING PRTSHP LP			1	2FE	29,872	96.6610	28,998	30,000	29,898		15			3.850	3.952	FA	481	1,155	03/01/2017	02/01/2025
115637AS9	BROWN FORMAN CORP			1	1FE	19,911	99.5760	19,915	20,000	19,919		9			3.500	3.604	AO	148	387	03/22/2018	04/15/2025
115637AP5	BROWN FORMAN CORP SR UNSECURED 07/				1FE	8,831	105.1420	9,463	9,000	8,841		3			4.500	4.669	JJ	187	405	06/24/2015	07/15/2045

SCHEDULE D - PART 1

Showing all Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	FOREIGN	Bond CHAR	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of Interest	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
118230AK7	BUCKEYE PARTNERS LP SR UNSECURED 0				2FE	22,724	97.2700	24,318	25,000	23,541		278			4.150	5.716	JJ	519	1,038	11/19/2015	07/01/2023
12189LAS0	BURLINGTN NORTH SANTA FE				1FE	81,647	107.8160	80,862	75,000	81,141		(131)			4.900	4.409	AO	919	3,675	11/24/2014	04/01/2044
14040HAY1	CAPITAL ONE FINANCIAL CO				2FE	109,810	102.4770	102,477	100,000	104,313		(1,612)			4.750	2.996	JJ	2,190	4,750	08/26/2016	07/15/2021
14040HBU8	CAPITAL ONE FINL CORP				2FE	103,876	97.3120	101,204	104,000	103,898		22			3.200	3.252	JJ	1,396	1,664	01/25/2018	01/30/2023
14149YAY4	CARDINAL HEALTH INC				2FE	24,721	96.5010	24,125	25,000	24,850		33			3.200	3.382	MS	236	800	11/10/2014	03/15/2023
14149YBH0	CARDINAL HEALTH INC			1	2FE	40,000	93.9060	37,562	40,000	40,000					3.079	3.103	JD	55	1,232	06/01/2017	06/15/2024
144141DC9	CAROLINA PWR & LT CO				1FE	60,469	98.6510	59,191	60,000	60,224		(63)			2.800	2.702	MN	215	1,680	12/28/2015	05/15/2022
149123BX8	CATERPILLAR INC				1FE	48,902	97.5020	48,751	50,000	49,475		141			2.600	2.940	JD	18	1,300	09/30/2014	06/26/2022
124857AG8	CBS CORP NEW				2FE	59,791	99.1080	59,465	60,000	59,897		30			3.375	3.462	MS	675	2,025	12/22/2015	03/01/2022
151020AJ3	CELGENE CORP				2FE	26,183	100.4550	25,114	25,000	25,667		(131)			4.000	3.400	FA	378	1,000	11/14/2014	08/15/2023
808513AG0	CHARLES SCHWAB CORP				1FE	51,038	100.0480	50,024	50,000	50,516		(132)			3.225	2.947	MS	538	1,613	11/07/2014	09/01/2022
166764AH3	CHEVRON CORP				1FE	292,692	99.8430	284,553	285,000	289,388		(906)			3.191	2.843	JD	177	9,094	03/24/2016	06/24/2023
171232AE1	CHUBB CORPORATION				1FE	47,100	128.8530	45,099	35,000	44,855		(576)			6.800	4.023	MN	304	2,380	11/10/2014	11/15/2031
172967MD0	CITIGROUP INC			1	2FE	96,233	97.7320	92,845	95,000	96,224		(9)			4.650	4.622	JJ	1,939		07/18/2018	07/23/2048
172967EW7	CITIGROUP INC SR UNSECURED 07/39 8				2FE	86,378	138.7350	83,241	60,000	84,219		(667)			8.125	5.029	JJ	2,248	4,875	12/22/2015	07/15/2039
174610AK1	CITIZENS FINANCIAL GROUP SUBORDINA				2FE	10,988	98.6900	10,856	11,000	10,992		1			4.300	4.360	JD	37	473	11/30/2015	12/03/2025
18600TAA0	CLEVELAND CLINIC FOUND UNSECURED 0				1FE	90,396	102.5590	100,508	98,000	90,405		3			4.858	5.340	JJ	2,380	4,761	07/01/2015	01/01/2114
12572QAG0	CME GROUP INC				1FE	24,664	97.3710	24,343	25,000	24,776		32			3.000	3.185	MS	221	750	05/19/2015	03/15/2025
20030NAX9	COMCAST CORP				1FE	90,415	117.3130	84,465	72,000	88,891		(534)			6.400	4.615	MN	589	4,608	01/06/2016	05/15/2038
20030NCS8	COMCAST CORP NEW			1,2	1FE	54,932	101.1840	55,651	55,000	54,934		2			3.950	4.010	AO	519		10/02/2018	10/15/2025
20030NCG4	COMCAST CORP NEW 4.049%52				1FE	235,536	89.7490	214,500	239,000	235,590		46			4.049	4.170	MN	1,613	10,000	10/27/2017	11/01/2052
202795JN1	COMMONWEALTH EDISON CO			1	1FE	121,707	100.2970	122,362	122,000	121,717		10			3.700	3.764	FA	1,718		08/07/2018	08/15/2028
205887CD2	CONAGRA BRANDS INC			1	2FE	49,792	94.4940	47,247	50,000	49,793		1			5.300	5.405	MN	508		10/15/2018	11/01/2038
20826FAF3	CONOCOPHILLIPS CO			1	1FE	40,817	95.2280	38,091	40,000	40,764		(34)			4.150	4.026	MN	212	1,660	05/25/2017	11/15/2034
210518CL8	CONSUMERS ENERGY CO 1ST MORTGAGE 0				1FE	169,805	103.5660	155,349	150,000	156,450		(4,875)			5.650	2.261	AO	1,789	8,475	03/15/2016	04/15/2020
126650CW8	CVS HEALTH CORP			1,2	2FE	39,608	99.0020	39,601	40,000	39,648		40			4.100	4.308	MS	437	893	03/06/2018	03/25/2025
126650BY5	CVS HEALTH CORP AMZ 2011 144A 34			1	2FE	102,204	107.7010	96,048	89,180	101,609		(560)			5.930	4.740	MON	308	5,301	12/08/2017	01/10/2034
126650BQ2	CVS PASS THROUGH TRUST				2FE	243,914	111.0960	223,767	201,418	231,310		(3,834)			6.943	3.703	MON	2,667	14,050	11/19/2015	01/10/2030
233851CS1	DAIMLER FINANCE NORTH AMER LLC144A			1	1FE	175,805	97.6770	171,912	176,000	175,879		38			2.850	2.895	JJ	2,438	5,016	01/03/2017	01/06/2022
23745QAA2	DARTMOUTH-HITCHCOCK HEALTH			1	1FE	50,000	96.7870	48,394	50,000	50,000					4.178	4.222	FA	870	928	02/07/2018	08/01/2048
25389JAK2	DIGITAL RLTY TR LP			1	2FE	30,358	99.0520	29,716	30,000	30,238		(59)			3.625	3.427	AO	272	1,088	12/01/2016	10/01/2022
25389JAR7	DIGITAL RLTY TR LP			1	2FE	97,337	94.3820	94,382	100,000	97,539		202			3.700	4.082	FA	1,398	1,850	02/22/2018	08/15/2027
260543CQ4	DOW CHEM CO 144A			1	2FE	39,959	101.7470	40,699	40,000	39,959		0			4.800	4.871	MN	165		11/28/2018	11/30/2028
26078JAC4	DOWDUPONT INC			1	2FE	80,000	102.9580	82,366	80,000	80,000					4.493	4.543	MN	329		11/14/2018	11/15/2025
26442RAD3	DUKE ENERGY PROGRESS INC				1FE	248,031	97.0810	228,140	235,000	247,013		(268)			4.150	3.875	JD	813	9,753	12/29/2014	12/01/2044
26441YAY3	DUKE REALTY LP SR UNSECURED 12/24				2FE	29,589	99.2450	29,774	30,000	29,714		42			3.750	3.971	JD	94	1,125	12/22/2015	12/01/2024
278058DH2	EATON CORP				2FE	59,024	100.9620	50,481	50,000	50,478		(2,139)			6.950	2.582	MS	975	3,475	11/04/2014	03/20/2019
278642AE3	EBAY INC				2FE	61,251	96.6730	62,837	65,000	63,094		497			2.600	3.519	JJ	779	1,690	12/22/2015	07/15/2022
29273RAS8	ENERGY TRANSFER PARTNERS SR UNSECU				2FE	21,804	96.3430	21,195	22,000	21,893		24			3.600	3.765	FA	330	792	02/05/2015	02/01/2023
29336UAE7	ENLINK MIDSTREAM PARTNER SR UNSECU				3FE	22,279	90.1540	22,539	25,000	22,539	(471)	251			4.150	5.726	JD	86	1,038	12/01/2015	06/01/2025
29379VBB8	ENTERPRISE PRODUCTS OPER				2FE	57,341	100.8470	55,466	55,000	56,427		(251)			3.900	3.373	FA	810	2,145	03/10/2015	02/15/2024
294752AH3	EQUITY ONE			1	2FE	62,440	99.8410	59,905	60,000	61,789		(430)			3.750	2.952	MN	288	2,250	06/22/2017	11/15/2022
26884ABA0	ERP OPER LTD PARTNERSHIP			1	1FE	29,828	98.3610	29,508	30,000	29,877		27			3.000	3.127	AO	190	900	02/21/2017	04/15/2023
30219GAK4	EXPRESS SCRIPTS HOLDING COMPANY GU				2FE	54,591	97.1120	53,412	55,000	54,715		46			3.500	3.638	JD	86	1,925	03/23/2016	06/15/2024
30219GAL2	EXPRESS SCRIPTS HOLDING COMPANY GU				2FE	6,985	99.6330	6,974	7,000	6,993		3			3.300	3.374	FA	81	231	02/22/2016	02/25/2021
30219GAN8	EXPRESS SCRIPTS HOLDING COMPANY GU				2FE	131,946	92.7660	122,451	132,000	131,957		5			3.400	3.434	MS	1,496	4,488	06/29/2016	03/01/2027
30231GAT9	EXXON MOBIL CORPORATION SR UNSECUR				1FE	31,000	97.5570	30,243	31,000	31,000					3.043	3.066	MS	314	943	02/29/2016	03/01/2026
31428XBA3	FEDEX CORP				2FE	25,190	90.5360	22,634	25,000	25,163		(7)			3.900	3.882	FA	406	975	01/13/2015	02/01/2035
341081FF9	FLORIDA POWER + LIGHT CO 1ST MORTG				1FE	32,345	100.8360	30,251	30,000	32,187		(59)			4.125	3.688	FA	516	1,238	04/04/2016	02/01/2042
343412AF9	FLUOR CORP NEW SR GLBL NT 28			1	2FE	54,883	97.4170	53,579	55,000	54,886		3			4.250	4.322	MS	792		08/20/2018	09/15/2028
345370CA6	FORD MTR CO DEL				2FE	81,254	103.1020	67,016	65,000	79,694		(825)			7.450	5.064	JJ	2,219	4,843	01/25/2017	07/16/2031
369550BG2	GENERAL DYNAMICS CORP			1	1FE	59,264	99.5910	59,755	60,000	59,324		60			3.500	3.734	MN	268	1,073	05/08/2018	05/15/2025
36962G3P7	GENERAL ELEC CAP CORP MTN BE				2FE	191,572	95.6090	157,755	165,000	190,854		(717)			5.875	4.681	JJ	4,497	4,847	02/22/2018	01/14/2038
36962GXZ2	GENERAL ELEC CAP CORP MTN BE				2FE	198,478	104.2270	156,341	150,000	189,877		(2,235)			6.750	4.164	MS	2,981	10,125	12/28/2015	03/15/2032
37045XBK1	GENERAL MTRS FINL CO INC			1	2FE	96,210	95.1430	90,386	95,000	95,913		(191)			3.700	3.490	MN	508	3,515	06/06/2017	05/09/2023
37045XBS4	GENERAL MTRS FINL CO INC			1	2FE	142,266	96.9030	137,602	142,000	142,168		(52)			3.450	3.438	JJ	2,273	4,899	01/31/2017	01/14/2022
375558AW3	GILEAD SCIENCES INC				1FE	36,961	99.8330	34,942	35,000	36,430		(249)			3.700	2.877	AO	324	1,295	11/01/2016	04/01/2024
38141GCU6	GOLDMAN SACHS GROUP INC				1FE	149,745	113.9580	142,448	125,000	145,853		(1,036)			6.125	4.566	FA	2,892	7,656	12/22/2015	02/15/2033
38148LAC0	GOLDMAN SACHS GROUP INC				1FE	3,998	94.7910	3,792	4,000	3,999		0			3.500	3.536	JJ	61	140	01/20/2015	01/23/2025
40573LAQ9	HALFMOON PARENT INC 144A			1	2FE	24,979	99.8590	24,965	25,000	24,980		1			4.125	4.181	MN	298		09/06/2018	11/15/2025
406216BE0	HALLIBURTON CO				2FE	67,055	95.3600	61,984	65,000	66,876		(42)			4.750	4.611	FA	1,286	3,088	12/28/2015	08/01/2043
42217KAW6	HEALTH CARE REIT INC				2FE	55,159	103.9560	51,978	50,000	52,347		(718)			5.250	3.638	JJ	1,210	2,625	11/12/2014	01/15/2022
887315BN8	HISTORIC TW INC COMPANY GUAR 05/29				2FE	25,418	118.3290	24,849	21,000	24,692		(274)			6.625	4.537	MN	178	1,391	03/30/2016	05/15/2029
437076BX9	HOME DEPOT INC			1,2	1FE	78,642	103.2390	82,591	80,000	78,644		2			4.500	4.658	JD	250		11/27/2018	12/06/2048
44107HAC6	HOSPITAL FOR SPL SURGERY			1	1FE	50,000	100.7820	50,391	50,000	50,000					3.737	3.772	AO	467	924	03/23/2018	04/01/2028

SCHEDULE D - PART 1

Showing all Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	FOREIGN	Bond CHAR	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of Interest	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
44106MAS1	HOSPITALITY PPTYS TR			1	2FE	26,170	99.7030	24,926	25,000	25,919		(157)			4.650	3.901	MS	342	1,163	05/18/2017	03/15/2024
44107TAU0	HOST HOTELS & RESORTS LP			1	2FE	14,736	98.0850	14,713	15,000	14,808		36			3.750	4.088	AO	119	563	12/14/2016	10/15/2023
44409MAA4	HUDSON PAC PPTYS L P			1	2FE	44,917	92.9570	41,831	45,000	44,925		7			3.950	4.012	MN	296	1,921	09/25/2017	11/01/2027
446150AM6	HUNTINGTON BANCSHARES INC				2FE	94,702	100.5220	95,496	95,000	94,726		24			4.000	4.093	MN	486	1,900	05/08/2018	05/15/2025
45866FAG9	INTERCONTINENTAL EXCHANGE INC			1,2	1FE	319,853	100.3240	321,037	320,000	319,863		11			3.450	3.490	MS	4,232		08/06/2018	09/21/2023
459745GQ2	INTERNATIONAL LEASE FIN CORP				2FE	31,727	100.9530	30,286	30,000	30,990		(411)			4.625	3.144	AO	293	1,388	03/07/2017	04/15/2021
24422ERM3	JOHN DEERE CAPITAL CORP				1FE	49,471	98.4730	49,237	50,000	49,758		71			2.750	2.930	MS	405	1,375	09/30/2014	03/15/2022
478045AA5	JOHN SEVIER COMBINED CYCLE LLC				1FE	50,272	106.1670	48,098	45,304	49,773		(119)			4.626	3.837	JJ	966	2,114	11/14/2014	01/15/2042
46625HJD3	JPMORGAN CHASE + CO SR UNSECURED 0				1FE	271,255	103.0390	257,598	250,000	261,458		(3,524)			4.500	2.947	JJ	4,906	11,250	02/23/2016	01/24/2022
487836BW7	KELLOGG CO			1,2	2FE	99,646	99.7010	99,701	100,000	99,665		19			4.300	4.391	MN	549	2,162	05/07/2018	05/15/2028
49326EED1	KEYCORP MEDIUM TERM NTS BE				2FE	28,286	103.7150	25,929	25,000	26,212		(519)			5.100	2.862	MS	344	1,275	10/27/2014	03/24/2021
49456BAB7	KINDER MORGAN INC DEL 144A			1	2FE	89,920	105.7140	85,628	81,000	87,649		(1,221)			5.625	3.801	MN	582	4,556	02/24/2017	11/15/2023
48249DAA9	KKR GROUP FIN CO II COMPANY 144A				1FE	110,676	101.6680	104,718	103,000	110,157		(152)			5.500	5.065	FA	2,360	5,665	09/24/2015	02/01/2043
48248NAA8	KKR GROUP FINANCE CO 144A				1FE	315,044	104.5430	282,266	270,000	286,279		(8,978)			6.375	2.831	MS	4,399	17,213	02/24/2016	09/29/2020
50077LAL0	KRAFT HEINZ FOODS CO			1	2FE	31,656	93.8480	28,154	30,000	31,551		(62)			5.000	4.604	JJ	692	1,500	04/11/2017	07/15/2035
501044CN9	KROGER CO				2FE	56,724	101.6060	50,803	50,000	56,089		(165)			5.400	4.561	JJ	1,245	2,700	11/14/2014	07/15/2040
50540RAQ5	LABORATORY CORP OF AMER SR UNSECUR				2FE	24,770	96.2970	24,074	25,000	24,846		22			3.600	3.749	FA	375	900	05/29/2015	02/01/2025
52107QAJ4	LAZARD LLC SR GLBL NT4.5%28			1	1FE	89,171	100.0190	90,017	90,000	89,191		20			4.500	4.669	MS	1,148		09/12/2018	09/19/2028
524901AT2	LEGG MASON INC				2FE	60,409	98.5640	59,138	60,000	60,236		(38)			3.950	3.909	JJ	1,093	2,370	12/22/2015	07/15/2024
53079EBE3	LIBERTY MUTUAL GROUP INC 144A				2FE	25,945	100.8220	25,206	25,000	25,570		(116)			4.250	3.725	JD	47	1,063	08/13/2015	06/15/2023
53227JAA2	LIFE STORAGE LP			1	2FE	59,714	95.1650	57,099	60,000	59,740		24			3.875	3.972	JD	103	2,377	11/28/2017	12/15/2027
534187BD0	LINCOLN NATIONAL CORP SR UNSECURED				2FE	10,396	101.9420	10,194	10,000	10,268		(52)			4.000	3.403	MS	133	400	06/22/2016	09/01/2023
534187AY5	LINCOLN NATL CORP IND				2FE	58,730	103.2150	51,608	50,000	51,967		(1,704)			6.250	2.687	FA	1,181	3,125	11/12/2014	02/15/2020
539830AY5	LOCKHEED MARTIN CORP				2FE	51,924	100.6640	50,332	50,000	50,804		(282)			3.350	2.748	MS	493	1,675	11/12/2014	09/15/2021
548661DM6	LOWE S COS INC SR UNSECURED 04/26				2FE	64,711	88.8870	57,777	65,000	64,781		27			2.500	2.567	AO	343	1,625	05/13/2016	04/15/2026
565122AB4	MAPLE ESCROW SUBSIDIARY INC 144A			1	2FE	105,000	99.2460	104,208	105,000	105,000					4.597	4.650	MN	483	2,413	05/14/2018	05/25/2028
56585AAG7	MARATHON PETE CORP			1	2FE	29,753	97.3040	29,191	30,000	29,808		30			3.625	3.786	MS	320	1,088	02/24/2017	09/15/2024
571748BA9	MARSH + MCLENNAN COS INC SR UNSECU				1FE	46,118	98.8780	45,484	46,000	46,074		(16)			3.300	3.285	MS	451	1,518	03/15/2016	03/14/2023
573284AQ9	MARTIN MARIETTA MATLS INC			1	2FE	15,968	92.3660	14,779	16,000	15,972		3			3.450	3.504	JD	46	552	05/17/2017	06/01/2027
58942HAB7	MERCY HEALTH			1	1FE	160,000	96.7790	154,846	160,000	160,000					3.555	3.587	FA	2,370	3,476	12/12/2017	08/01/2027
59156RAM0	METLIFE INC				1FE	72,118	112.6520	67,591	60,000	70,459		(433)			5.700	4.265	JD	152	3,420	12/22/2015	06/15/2035
595017AL8	MICROCHIP TECHNOLOGY INC 144A			1	2FE	120,000	97.5420	117,050	120,000	120,000					4.333	4.380	JD	433	2,629	05/23/2018	06/01/2023
594918BZ6	MICROSOFT CORP			1	1FE	18,959	102.6160	19,497	19,000	18,961		1			4.100	4.158	FA	314	779	01/30/2017	02/06/2037
594918CA0	MICROSOFT CORP			1	1FE	131,645	104.9770	138,570	132,000	131,657		6			4.250	4.311	FA	2,260	5,610	01/30/2017	02/06/2047
61746BDJ2	MORGAN STANLEY			1	1FE	111,587	99.8240	108,808	109,000	110,801		(398)			3.750	3.348	FA	1,431	4,088	12/29/2016	02/25/2023
61747WAL3	MORGAN STANLEY				1FE	208,590	104.7990	193,878	185,000	195,267		(3,763)			5.500	3.263	JJ	4,324	10,175	12/22/2015	07/28/2021
61747YDY8	MORGAN STANLEY				1FE	113,880	93.5350	109,436	117,000	113,925		31			4.300	4.522	JJ	2,152	2,946	07/19/2018	01/27/2045
553794AC2	MUFG AMERICAS HLDGS CORP SR UNSECU				1FE	19,894	95.8990	19,180	20,000	19,931		10			3.000	3.085	FA	235	600	02/06/2015	02/10/2025
637417AG1	NATIONAL RETAIL PPTYS INC			1	2FE	30,940	100.0520	30,016	30,000	30,713		(117)			3.900	3.448	JD	52	1,170	01/12/2017	06/15/2024
64952WCE1	NEW YORK LIFE GLBL FDG SR SEC 144A				1FE	176,740	97.4400	172,469	177,000	176,878		52			2.000	2.041	AO	767	3,540	04/06/2016	04/13/2021
654740AT6	NISSAN MTR ACCEP CORP 144A			1	1FE	146,991	98.5700	144,898	147,000	146,997		3			2.250	2.265	JJ	1,544	3,308	01/10/2017	01/13/2020
655844BL1	NORFOLK SOUTHERN CORP				2FE	48,831	98.2790	49,140	50,000	49,378		139			2.903	3.254	FA	548	1,452	11/12/2014	02/15/2023
666807BG6	NORTHROP GRUMMAN CORP SR UNSECURED				2FE	24,423	98.4130	24,603	25,000	24,653		68			3.250	3.613	FA	339	813	06/25/2015	08/01/2023
670346AM7	NUCOR CORP SR UNSECURED 08/23 4				1FE	26,130	101.5350	25,384	25,000	25,656		(130)			4.000	3.406	FA	417	1,000	03/11/2015	08/01/2023
67103HAG2	O REILLY AUTOMOTIVE INC NEW			1	2FE	104,753	99.5750	104,554	105,000	104,765		13			4.350	4.427	JD	381	2,461	05/11/2018	06/01/2028
674599CG8	OCCIDENTAL PETE CORP DEL			1	1FE	15,150	98.9490	14,842	15,000	15,120		(16)			3.500	3.389	JD	23	525	02/16/2017	06/15/2025
674599CH6	OCCIDENTAL PETROLEUM COR SR UNSECU				1FE	15,964	97.8390	15,654	16,000	15,972		3			3.400	3.456	AO	115	544	03/28/2016	04/15/2026
68389XAM7	ORACLE CORP				1FE	56,799	110.4960	55,248	50,000	56,137		(167)			5.375	4.531	JJ	1,239	2,688	09/26/2014	07/15/2040
68389XBF1	ORACLE CORP SR UNSECURED 05/45 4.1				1FE	62,335	94.6210	61,504	65,000	62,480		50			4.125	4.422	MN	343	2,681	12/22/2015	05/15/2045
693475AP0	PNC FINANCIAL SERVICES SUBORDINATE				1FE	52,151	99.1450	49,573	50,000	51,328		(224)			3.900	3.380	AO	336	1,950	02/27/2015	04/29/2024
69352PAE3	PPL CAP FDG INC			1	2FE	25,659	98.3780	24,595	25,000	25,468		(111)			3.500	3.012	JD	73	875	04/07/2017	12/01/2022
740189AM7	PRECISION CASTPARTS CORP SR UNSECU				1FE	65,580	98.2250	63,846	65,000	65,406		(56)			3.250	3.167	JD	94	2,113	12/22/2015	06/15/2025
74251VAE2	PRINCIPAL FINANCIAL GROU				1FE	50,152	99.3300	49,665	50,000	50,076		(19)			3.300	3.283	MS	486	1,650	10/03/2014	09/15/2022
74251VAM4	PRINCIPAL FINL GROUP INC			1	1FE	32,952	93.3820	30,816	33,000	32,961		4			3.100	3.141	MN	131	1,023	11/03/2016	11/15/2026
743756AE8	PROVIDENCE HEALTH & SVCS OBLIG			1	1FE	155,000	95.2540	147,644	155,000	155,000					3.930	3.969	AO	1,523	3,976	01/30/2018	10/01/2048
74432QAC9	PRUDENTIAL FINL INC MTNS BOOK				1FE	23,274	113.5170	22,703	20,000	23,001		(145)			5.750	4.394	JJ	530	1,150	02/02/2017	07/15/2033
74432QBT1	PRUDENTIAL FINL INC MTNS BOOK				1FE	54,569	103.2080	51,604	50,000	51,965		(644)			4.500	3.085	MN	281	2,250	10/03/2014	11/16/2021
744448CA7	PUBLIC SERVICE CO COLO				1FE	81,220	129.3800	77,628	60,000	78,869		(615)			6.500	4.183	FA	1,625	3,900	12/22/2015	08/01/2038
747525AJ2	QUALCOMM INC			1	1FE	48,595	96.5350	43,441	45,000	48,366		(143)			4.650	4.063	MN	238	2,093	05/17/2017	05/20/2035
75886AAQ1	REGENCY ENERGY PARTNERS LP			1	2FE	5,426	102.0540	5,103	5,000	5,309		(76)			5.000	3.264	AO	63	250	06/13/2017	10/01/2022
760759AM2	REPUBLIC SVCS INC				2FE	65,683	104.6730	62,804	60,000	63,352		(700)			4.750	3.394	MN	364	2,850	12/22/2015	05/15/2023
771196BB7	ROCHE HOLDING INC 144A				1FE	202,600	99.4010	198,802	200,000	201,099		(381)			2.875	2.684	MS	1,469	5,750	11/24/2014	09/29/2021
78355HJZ3	RYDER SYS MTN BE				2FE	22,937	98.8220	22,729	23,000	22,982		13			2.500	2.575	MN	80	575	05/04/2015	05/11/2020
797440BN3	SAN DIEGO GAS & ELEC CO				1FE	255,918	99.5860	248,965	250,000	252,431		(884)			3.000	2.631	FA	2,833	7,500	11/24/2014	08/15/2021
828807DA2	SIMON PPTY GROUP LP			1	1FE	83,724	97.1180	81,579	84,000	83,833		52			2.350	2.432	JJ	828	1,974	11/15/2016	01/30/2022

SCHEDULE D - PART 1

Showing all Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	FOREIGN	Bond CHAR	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of Interest	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
828807CE5	SIMON PROPERTY GROUP LP				1FE	101,655	127.3460	95,510	75,000	99,040		(681)			6.750	4.450	FA	2,109	5,063	11/24/2014	02/01/2040
828807CF2	SIMON PROPERTY GROUP LP SR UNSECUR				1FE	164,385	102.1150	153,173	150,000	156,398		(2,845)			4.375	2.359	MS	2,188	6,563	02/18/2016	03/01/2021
842434CG5	SOUTHERN CALIF GAS CO				1FE	62,597	118.2240	59,112	50,000	60,871		(445)			5.750	4.009	MN	367	2,875	11/19/2014	11/15/2035
784710AB1	SSM HEALTH CARE CORP			2	1FE	49,688	100.9170	50,459	50,000	49,692		5			3.688	3.878	JD	154		12/04/2018	06/01/2023
85434VAA6	STANFORD HEALTH CARE			1	1FE	115,000	95.6960	110,050	115,000	115,000					3.795	3.831	MN	558	3,613	01/09/2018	11/15/2048
857477AM5	STATE STREET CORP				1FE	62,582	101.0100	60,606	60,000	61,593		(298)			3.700	3.134	MN	253	2,220	12/22/2015	11/20/2023
857477AL7	STATE STREET CORP SR SUB NT				1FE	24,840	98.2630	24,566	25,000	24,907		20			3.100	3.218	MN	99	775	06/19/2015	05/15/2023
86765BAL3	SUNOCO LOGISTICS PARTNER COMPANY G				2FE	66,073	96.7010	75,427	78,000	70,579		1,574			3.450	6.240	JJ	1,241	2,691	12/16/2015	01/15/2023
86765BAQ2	SUNOCO LOGITICS PARTNER				2FE	30,810	88.5140	30,980	35,000	30,955		51			5.350	6.434	MN	239	1,873	12/22/2015	05/15/2045
87612EBE5	TARGET CORP SR UNSECURED 04/26 2.5				1FE	94,991	93.3600	88,692	95,000	94,994		1			2.500	2.517	AO	501	2,375	04/04/2016	04/15/2026
87233QAC2	TC PIPELINES LP			1	2FE	18,000	95.4600	17,183	18,000	18,000					3.900	3.938	MN	70	702	05/22/2017	05/25/2027
87236YAA6	TD AMERITRADE HOLDING CO				1FE	58,580	102.1070	51,054	50,000	51,600		(1,711)			5.600	2.069	JD	233	2,800	10/14/2014	12/01/2019
623115AC6	THE MOUNT SINAI HOSPITAL			1	1FE	35,000	95.7910	33,527	35,000	35,000					3.831	3.868	JJ	670	708	12/14/2017	07/01/2035
889184AC1	TOLEDO HOSPITAL			1	2FE	95,000	101.4370	96,365	95,000	95,000					5.325	5.396	MN	927		10/18/2018	11/15/2028
89566EAK4	TRI-STATE GENERATION &TRANSMIS				1FE	32,736	93.2960	30,788	33,000	32,747		5			4.250	4.344	JD	117	1,403	07/01/2016	06/01/2046
90265EAL4	UDR INC MEDIUM TERM NTS BK ENT			1	2FE	34,741	92.1760	32,262	35,000	34,793		24			2.950	3.060	MS	344	1,033	10/04/2016	09/01/2026
91324PBT8	UNITEDHEALTH GROUP INC				1FE	52,212	100.6380	50,319	50,000	50,945		(312)			3.375	2.705	MN	216	1,688	10/08/2014	11/15/2021
91324PDM1	UNITEDHEALTH GROUP INC			1	1FE	131,671	100.6400	132,845	132,000	131,674		3			3.500	3.585	FA	180		12/13/2018	02/15/2024
91159JAA4	US BANCORP				1FE	61,665	98.6390	59,183	60,000	60,968		(259)			2.950	2.486	JJ	816	1,770	03/31/2016	07/15/2022
92276MAZ8	VENTAS REALTY LP/CAP CRP				2FE	24,665	98.8180	24,705	25,000	24,834		42			3.250	3.476	FA	307	813	10/08/2014	08/15/2022
92343VCX0	VERIZON COMMUNICATIONS INC				2FE	93,187	93.7250	94,662	101,000	93,493		106			4.522	5.075	MS	1,345	4,567	12/24/2015	09/15/2048
92343VER1	VERIZON COMMUNICATIONS INC			1	2FE	96,493	100.4110	96,395	96,000	96,473		(21)			4.329	4.313	MS	2,193		06/21/2018	09/21/2028
92553PAR3	VIACOM INC				2FE	24,193	96.2080	24,052	25,000	24,563		94			3.250	3.737	MS	239	813	11/10/2014	03/15/2023
927804FQ2	VIRGINIA ELEC + POWER CO				1FE	77,969	99.8880	74,916	75,000	76,732		(309)			3.450	2.983	FA	978	2,588	10/20/2014	02/15/2024
92826CAF9	VISA INC SR UNSECURED 12/45 4.3				1FE	49,917	103.3480	51,674	50,000	49,921		2			4.300	4.356	JD	102	2,150	12/09/2015	12/14/2045
929089AD2	VOYA FINL INC			1	2FE	228,624	94.2950	216,879	230,000	228,877		182			3.125	3.248	JJ	3,314	7,387	08/10/2017	07/15/2024
931142CH4	WAL MART STORES INC				1FE	62,213	116.5660	58,283	50,000	58,629		(888)			5.875	3.486	AO	702	2,938	09/26/2014	04/05/2027
931427AC2	WALGREENS BOOTS ALLIANCE INC				2FE	24,581	91.0470	22,762	25,000	24,606		7			4.800	4.968	MN	143	1,200	05/14/2015	11/18/2044
931142EK5	WALMART INC			1	1FE	190,948	101.0310	192,969	191,000	190,953		5			3.400	3.435	JD	90	3,229	06/20/2018	06/26/2023
942683AF0	WATSON PHARMACEUTICALS INC			1	2FE	65,165	97.7720	63,552	65,000	65,114		(28)			3.250	3.226	AO	528	2,113	03/09/2017	10/01/2022
94973VAW7	WELLPOINT INC				2FE	51,908	100.6720	50,336	50,000	50,789		(285)			3.700	3.092	FA	699	1,850	11/19/2014	08/15/2021
94974BFJ4	WELLS FARGO + COMPANY				1FE	149,496	97.9020	146,853	150,000	149,744		57			3.450	3.526	FA	1,984	5,175	12/22/2015	02/13/2023
94974BFY1	WELLS FARGO + COMPANY				1FE	25,296	97.6530	24,413	25,000	25,224		(25)			4.100	3.999	JD	80	1,025	01/27/2016	06/03/2026
949746RW3	WELLS FARGO + COMPANY SR UNSECURED				1FE	167,424	93.1840	156,549	168,000	167,563		53			3.000	3.063	AO	966	5,040	04/15/2016	04/22/2026
95040QAD6	WELLTOWER INC			1	2FE	24,990	98.9910	24,748	25,000	24,990		1			4.250	4.300	AO	224	546	04/03/2018	04/15/2028
959802AU3	WESTERN UN CO			1	2FE	64,908	99.6120	64,748	65,000	64,940		17			3.600	3.664	MS	689	2,340	03/08/2017	03/15/2022
960386AM2	WESTINGHOUSE AIR BRAKE CO NEW			1	2FE	109,878	93.7860	103,165	110,000	109,881		3			4.700	4.770	MS	1,537		09/12/2018	09/15/2028
960413AT9	WESTLAKE CHEM CORP				2FE	29,721	91.6890	27,507	30,000	29,764		26			3.600	3.754	FA	408	1,080	05/03/2017	08/15/2026
98978VAB9	ZOETIS INC				2FE	24,599	98.4890	24,622	25,000	24,774		51			3.250	3.520	FA	339	813	05/15/2015	02/01/2023
06367T4W7	BANK OF MONTREAL		C		1FE	63,925	99.9500	63,968	64,000	63,943		17			3.100	3.166	AO	430	992	04/10/2018	04/13/2021
13645RAX2	CANADIAN PACIFIC RR CO SR UNSECURE		A		2FE	71,000	116.3040	82,576	71,000	71,000					6.125	6.219	MS	1,280	4,349	09/08/2015	09/15/2115
3299999 Subtotal - Industrial & Miscellaneous (Unaffiliated) - Issuer Obligations						17,267,193	XXX	16,607,341	16,618,846	17,046,976	(439)	(65,688)			XXX	XXX	XXX	189,872	556,623	XXX	XXX
Industrial & Miscellaneous (Unaffiliated) - Residential Mortgage-Backed Securities																					
07384MWN8	BEAR STEARNS ARM TR 2003-5			4	1FM	35,518	99.9230	35,669	35,696	33,131		(42)			4.248	6.637	MON	126	1,436	10/21/2014	08/25/2033
46649CAQ6	JP MORGAN MTG TR 144A			4	1FM	77,288	99.2960	77,360	77,909	77,299		11			3.500	3.723	MON	227	452	10/19/2018	10/25/2048
46650JAD6	JP MORGAN MTG TR 144A			4	1FM	180,571	99.1830	180,322	181,808	180,637		66			3.500	3.691	MON	530	3,219	06/27/2018	12/25/2048
46646BAE8	JP MORGAN MTG TR 2016-1			4	1FM	110,077	98.9730	105,934	107,034	109,694		(246)			3.500	2.835	MON	312	3,807	06/09/2016	05/25/2046
46647JAE0	JP MORGAN MTG TR 2016-4			4	1FM	67,929	98.9130	65,873	66,597	67,699		(114)			3.500	3.124	MON	194	2,366	11/21/2016	10/25/2046
61748HFE6	MORGAN STANLEY CAP 2004-10AR			4	1FM	33,391	101.0090	33,686	33,350	33,385		(1)			4.333	4.389	MON	120	1,339	10/10/2014	11/25/2034
86358HTZ2	STRUCTURED ASSET MTG 2003-AR2			4	1FM	46,068	98.5340	46,083	46,769	46,137		16			4.062	4.582	MON	158	1,831	01/01/2016	12/19/2033
86359LEW5	STRUCTURED ASSET MTG 2004-AR6			4	1FM	37,178	98.1560	39,398	40,138	36,937		273			3.170	5.669	MON	42	1,075	12/23/2015	02/19/2035
92211MAC7	VANTAGE DATA CTR 144A			4	1FE	24,792	100.2000	24,842	24,792	24,792					4.072	4.149	MON	45	839	02/09/2018	02/16/2043
3399999 Subtotal - Industrial & Miscellaneous (Unaffiliated) - Residential Mortgage-Backed Securities						612,812	XXX	609,168	614,093	609,711		(37)			XXX	XXX	XXX	1,756	16,365	XXX	XXX
Industrial & Miscellaneous (Unaffiliated) - Commercial Mortgage-Backed Securities																					
056059AG3	BX COML MTG TR 144A			4	1FM	99,851	99.1880	99,040	99,851	99,851					3.180	3.274	MON	150	400	10/22/2018	11/15/2035
17291EAX9	CITIGROUP COML MTG TR 2016-P6			4	1FM	190,546	101.2180	187,253	185,000	189,385		(694)			3.512	3.048	MON	541	6,497	12/06/2016	12/10/2049
12624KAD8	COMM MTG TR 2012-CCRE2			4	1FM	442,479	99.6590	430,527	432,000	438,808		(1,890)			3.147	2.691	MON	1,133	13,595	01/07/2016	08/17/2045
12595VAD9	COMM MTG TR 2018-COR3 20510512 FLT			4	1FM	145,222	103.1810	145,486	141,000	145,040		(182)			4.228	3.947	MON	497	3,477	05/04/2018	05/12/2051
36249KAC4	GS MTG COML 2010-C1			4	1FM	386,648	101.9460	360,887	354,000	368,493		(12,113)			4.592	1.290	MON	1,355	16,256	10/13/2016	08/12/2043
36192KAT4	GS MTG SECS TR 2012-GCJ7			4	1FM	426,697	100.4220	411,460	409,731	421,427		(3,356)			3.377	1.472	MON	1,153	14,009	01/21/2016	05/12/2045
36254CAV2	GS MTG SECS TR 2017-GS7			4	1FM	154,495	97.6680	146,501	150,000	153,933		(403)			3.430	3.120	MON	429	5,145	08/11/2017	08/12/2050
46635TCG5	JP MORGAN CHASE CMBS 2011-C3			4	1FM	151,525	102.1680	141,761	138,752	145,649		(3,809)			4.717	0.010	MON	545	7,015	12/04/2015	02/16/2046

SCHEDULE D - PART 1

Showing all Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	FOREIGN	Bond CHAR	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of Interest	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
81746DAD2	SEQUOIA MTG TR 2017-5			4	1FM	192,473	98.7150	185,705	188,123	192,145		(240)			3.500	3.067	MON	549	6,637	07/12/2017	08/25/2047
84861CAC9	SPIRIT MASTER FDG LLC 2017-1 144A			4	1FE	100,148	101.1900	100,848	99,662	100,055		(93)			4.360	4.224	MON	362	4,027	01/23/2018	12/20/2047
86212VAD6	STORE MSTR FDG 144A			4	1FE	202,249	100.1560	202,617	202,301	202,249		1			3.960	4.036	MON	245	1,292	10/12/2018	10/20/2048
90269GAC5	UBS COML MTG TR 2012-C1			4	1FM	162,441	100.6150	156,578	155,620	160,708		(1,442)			3.400	1.272	MON	441	5,291	02/22/2017	05/12/2045
92935JBC8	WFRBS COML MTG TR 2011-C2			4	1FM	166,674	102.6530	152,032	148,103	158,941		(5,116)			4.869	(2.191)	MON	601	7,229	08/09/2016	02/18/2044
92890NAU3	WFRBS COML MTG TR 2012-C10			4	1FM	186,232	98.4540	178,202	181,000	184,839		(970)			2.875	2.308	MON	434	5,204	05/25/2016	12/15/2045
92938JAB8	WFRBS COML MTG TR 2013-UBS1			4	1FM	3,670	99.8740	3,541	3,546	3,604		(33)			2.927	1.141	MON	6	234	10/10/2014	03/16/2046
3499999 Subtotal - Industrial & Miscellaneous (Unaffiliated) - Commercial Mortgage-Backed Securities						3,011,350	XXX	2,902,439	2,888,689	2,965,126		(30,341)			XXX	XXX	XXX	8,440	96,306	XXX	XXX
Industrial & Miscellaneous (Unaffiliated) - Other Loan-Backed and Structured Securities																					
009090AA9	AIR CANADA 2015 1A PTT EQUIPMENT T			4	1FE	134,368	96.1210	128,687	133,880	134,281		(34)			3.600	3.595	MS	1,419	4,952	05/19/2016	09/15/2028
02007PAD5	ALLY AUTO RECV TR 2017-1			4	1FE	220,953	98.6790	218,080	221,000	220,975		19			1.990	2.017	MON	195	4,398	01/24/2017	11/15/2021
02376WAA9	AMER AIRLINES PT TR 2016-1			4	1FE	138,366	99.4260	137,572	138,366	138,366					4.100	4.142	JJ	2,616	5,818	01/12/2016	07/15/2029
02377UAB0	AMERICAN AIRLINES 2013 2			4	1FE	177,937	101.5050	169,107	166,600	173,637		(1,114)			4.950	4.133	JJ	3,803	8,627	02/13/2015	07/15/2024
03065GAE0	AMERICREDIT AUTO RECV 2017-2			4	1FE	190,974	98.7570	188,625	191,000	190,988		9			2.400	2.431	MON	166	4,584	05/09/2017	05/18/2022
05605GAA0	B2R MTG TRUST 2015-2			4	1FE	51,787	99.5890	51,574	51,787	51,787		0			3.336	3.388	MON	144	2,361	11/10/2015	11/18/2048
14314JAE0	CARMAX AUTO OWNER TR 2017-1			4	1FE	52,991	98.8790	52,406	53,000	52,993		3			2.540	2.576	MON	60	1,346	01/25/2017	09/15/2022
165183BK9	CHESAPEAKE FDG II LLC 2018-1 144A			4	1FE	120,000	100.5560	120,668	120,000	120,000		0			3.450	3.505	MON	184	2,737	04/11/2018	04/15/2030
20268KAA8	COMMONBOND ST LN TR 2017-B-GS			4	1FE	74,659	96.7690	72,262	74,674	74,657		(2)			2.680	2.718	MON	33	2,045	10/19/2017	09/25/2042
247367BH7	DELTA AIRLINES PT 2007-1			4	1FE	54,273	107.3700	52,427	48,829	53,178		(1,095)			6.821	3.017	FA	1,304	1,749	03/27/2018	02/10/2024
23291FAC0	DLL SECUR TR 2017-A 20211215 2.14			4	1FE	187,985	99.0000	186,120	188,000	187,993		7			2.140	2.165	MON	179	4,023	11/08/2017	12/15/2021
262074AF4	DRIVE AUTO REC TR 2015-A			4	1FE	1,814	99.9930	1,811	1,811	1,812		(1)			3.060	2.887	MON	2	77	12/29/2015	05/17/2021
26208FAH4	DRIVE AUTO RECV TR 2017-2			4	1FE	26,457	99.9280	26,438	26,457	26,457		2			2.250	2.295	MON	26	687	07/25/2017	06/15/2021
23341LAE3	DT AUTO OWNER TRUST 2017-1 144A			4	1FE	36,374	99.7560	36,293	36,382	36,380		3			2.700	2.746	MON	44	995	02/06/2017	11/15/2022
23341TAC0	DT AUTO OWNER TRUST 2017-2 144A			4	1FE	19,935	99.9370	19,922	19,935	19,935		0			2.440	2.469	MON	22	552	05/09/2017	02/16/2021
289333AB2	ELM TR 2018-2 144A			4	1FE	29,999	101.6330	30,490	30,000	29,999		0			4.605	4.704	MON	42	265	10/03/2018	10/20/2027
33844HAC7	FLAGSHIP CREDIT AUTO TRUST			4	1FE	39,991	99.2840	39,714	40,000	39,995		4			2.570	2.596	MON	3	1,028	05/19/2017	05/31/2020
34528QFD1	FORD CREDIT FLRPLN TR A 2016-5			4	1FE	430,914	98.9340	426,404	431,000	430,974		23			1.950	1.972	MON	374	8,404	12/06/2016	11/15/2021
36254AAD6	GM FINL CON AUTO REC TR 2017-1			4	1FE	129,981	99.1040	128,836	130,000	130,034		(58)			1.780	1.751	MON	96	2,314	04/03/2017	10/18/2021
60700DAC2	MMAF EQUIP FIN LLC 144A			4	1FE	198,981	100.4640	199,923	199,000	198,986		5			3.200	3.251	MON	371	3,396	05/22/2018	09/12/2022
65341KBD7	NEXTGEAR FLRPLN OWN TR 144A			4	1FE	158,962	100.7990	160,271	159,000	158,967		5			3.690	3.767	MON	261	929	10/09/2018	10/16/2023
65341KAK2	NEXTGEAR FLRPLN OWN TR 2016-1			4	1FE	314,927	99.8840	314,636	315,000	314,983		19			2.740	2.780	MON	384	8,631	04/21/2016	04/15/2021
65479BAD2	NISSAN AUTO LEASE TR 2017-B			4	1FE	255,955	99.2650	254,118	256,000	255,985		24			2.050	2.078	MON	233	5,248	10/03/2017	09/15/2020
68268EAA1	ONEMAIN FINL ISSUE TR 2015-1			4	1FE	19,391	99.9190	19,423	19,439	19,304		(101)			3.190	3.646	MON	22	703	01/05/2016	03/18/2026
68267LAA6	ONEMAIN FINL ISSUE TR 2017-1			4	1FE	129,985	98.4500	127,985	130,000	129,990		4			2.370	2.399	MON	145	3,081	08/29/2017	09/14/2032
74332MAA3	PROGRESS RESI TR 2015-SFR2			4	1FE	100,259	98.7320	98,989	100,261	100,260		1			2.740	2.776	MON	229	2,749	06/01/2015	06/14/2032
74332NAA1	PROGRESS RESI TR 2015-SFR3			4	1FE	103,931	99.0890	102,989	103,935	103,933		1			3.067	3.113	MON	266	3,188	10/23/2015	11/15/2032
80284CAF9	SANTANDER DRIVE AUTO 2015-1			4	1FE	4,568	99.9750	4,556	4,558	4,558		(4)			2.570	2.417	MON	5	152	10/09/2015	04/15/2021
784012AA4	SCF EQUIP TR LLC 2017-2 20231220			4	1FE	64,124	99.8110	64,013	64,134	64,127		3			3.410	3.474	MON	67	2,262	11/16/2017	12/20/2023
84474YAA4	SOUTHWEST AIRLINES 2007-1			4	1FE	147,131	105.0800	134,003	127,524	138,503		(2,792)			6.150	1.154	FA	3,268	8,509	01/12/2015	02/01/2024
90932PAA6	UNITED AIR 2014 1 A PTT			4	1FE	279,548	99.6420	273,711	274,694	278,263		(335)			4.000	3.861	AO	2,442	10,650	05/03/2018	10/11/2027
92348NAA5	VERIZON OWNER TR 2017-1			4	1FE	229,958	99.2540	228,285	230,000	229,984		13			2.060	2.085	MON	145	4,738	03/07/2017	09/20/2021
3599999 Subtotal - Industrial & Miscellaneous (Unaffiliated) - Other Loan-Backed and Structured Securities						4,127,477	XXX	4,070,338	4,086,267	4,112,283		(5,394)			XXX	XXX	XXX	18,550	111,199	XXX	XXX
3899999 Subtotal - Industrial & Miscellaneous (Unaffiliated)						25,018,833	XXX	24,189,286	24,207,895	24,734,096	(439)	(101,460)			XXX	XXX	XXX	218,619	780,493	XXX	XXX
7799999 Subtotals - Issuer Obligations						30,192,004	XXX	29,349,958	29,135,878	29,973,897	8,665	(72,803)			XXX	XXX	XXX	286,678	841,141	XXX	XXX
7899999 Subtotals - Residential Mortgage-Backed Securities						17,114,745	XXX	16,687,148	16,185,962	17,005,195		(33,181)			XXX	XXX	XXX	52,831	586,992	XXX	XXX
7999999 Subtotals - Commercial Mortgage-Backed Securities						3,011,350	XXX	2,902,439	2,888,689	2,965,126		(30,341)			XXX	XXX	XXX	8,440	96,306	XXX	XXX
8099999 Subtotals - Other Loan-Backed and Structured Securities						4,127,477	XXX	4,070,338	4,086,267	4,112,283		(5,394)			XXX	XXX	XXX	18,550	111,199	XXX	XXX
8399999 Grand Total - Bonds						54,445,576	XXX	53,009,884	52,296,796	54,056,501	8,665	(141,719)			XXX	XXX	XXX	366,499	1,635,639	XXX	XXX

E11 Schedule D - Part 2 Sn 1 Prfrd Stocks Owned . . . . . NONE

E12 Schedule D - Part 2 Sn 2 Common Stocks Owned . . . . . NONE

SCHEDULE D - PART 3

Showing All Long-Term Bonds and Stocks ACQUIRED During Current Year

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends
Bonds - U.S. Governments								
36179RZV4	GNMA PASS-THRU M SINGLE FAMILY		11/01/2018	Income Research & Mgmt DQ	X X X	82,405	79,871	180
3622AAAE4	GNMA PASS-THRU X PLATINUM 30YR		11/01/2018	Income Research & Mgmt DQ	X X X	46,242	44,510	100
83162CYW7	SMALL BUS ADMIN GTD DEV PTC		08/01/2018	Income Research & Mgmt DQ	X X X	192,550	203,824	2,273
912810PX0	UNITED STATES TREAS BDS		11/29/2018	Income Research & Mgmt DQ	X X X	509,233	416,000	5,183
912810SA7	UNITED STATES TREAS BDS		05/03/2018	JP Morgan Asset Mgmt	X X X	83,214	85,000	549
912810SD1	UNITED STATES TREAS BDS		11/29/2018	Income Research & Mgmt DQ	X X X	109,521	117,000	784
9128283F5	UNITED STATES TREAS NTS		04/27/2018	Income Research & Mgmt DQ	X X X	389,649	410,000	3,096
9128283W8	UNITED STATES TREAS NTS		06/28/2018	Income Research & Mgmt DQ	X X X	52,574	53,000	552
9128284N7	UNITED STATES TREAS NTS		11/05/2018	JP Morgan Asset Mgmt	X X X	370,173	380,000	5,195
9128284S6	UNITED STATES TREAS NTS		08/30/2018	Income Research & Mgmt DQ	X X X	841,182	843,000	4,941
9128284V9	UNITED STATES TREAS NTS		10/11/2018	VARIOUS	X X X	659,100	670,000	2,534
9128285D8	UNITED STATES TREAS NTS		11/29/2018	Income Research & Mgmt DQ	X X X	355,763	357,000	848
912828N30	UNITED STATES TREAS NTS		01/23/2018	JP Morgan Asset Mgmt	X X X	320,493	325,000	458
9128283R9	UNITED STATES TREAS NTS TIPS		12/17/2018	JP Morgan Asset Mgmt	X X X	277,037	285,000	619
912828P87	UNITED STATES TREAS NTS - NV		01/19/2018	Merrill Lynch	X X X	243,248	250,000	2,148
912828P87	UNITED STATES TREAS NTS - NC		01/18/2018	Merrill Lynch	X X X	437,677	450,000	3,706
0599999 Subtotal - Bonds - U.S. Governments						4,970,061	4,969,206	33,165
Bonds - U.S. States, Territories and Possessions (Direct and Guaranteed)								
64966MQM4	NEW YORK N Y		01/19/2018	JP Morgan Asset Mgmt	X X X	145,286	150,000	1,352
1799999 Subtotal - Bonds - U.S. States, Territories and Possessions (Direct and Guaranteed)						145,286	150,000	1,352
Bonds - U.S. Political Subdivisions of States (Direct and Guaranteed)								
4423313C6	HOUSTON TEX TAXABLE PENSION OBLG		01/31/2018	JP Morgan Asset Mgmt	X X X	149,601	150,000	571
467107CL0	JACKSON CNTY MICH		01/30/2018	JP Morgan Asset Mgmt	X X X	151,466	150,000	750
2499999 Subtotal - Bonds - U.S. Political Subdivisions of States (Direct and Guaranteed)						301,067	300,000	1,321
Bonds - U.S. Special Revenue, Special Assessment								
3132HRMV9	FHLMC PC GOLD PC 30YR		01/01/2018	Income Research & Mgmt DQ	X X X	180,081	178,133	148
3128MAEB1	FHLMC PC GOLD COMB 30		08/07/2018	Income Research & Mgmt DQ	X X X	189,858	194,601	195
31335BLX2	FHLMC PC GOLD COMB 30		02/01/2018	Income Research & Mgmt DQ	X X X	159,613	149,564	224
3132H7D84	FHLMC PC GOLD H LTV 30		05/09/2018	Income Research & Mgmt DQ	X X X	192,516	198,887	215
31335AWT1	FHLMC PCGOLD COMB 30		01/01/2018	Income Research & Mgmt DQ	X X X	212,824	206,560	201
3137FDER9	FHLMC REMIC SERIES K-1504		01/11/2018	JP Morgan Asset Mgmt	X X X	66,296	65,000	120
3138ET4W3	FNMA PASS-THRU LNG 30 YEAR		06/04/2018	Income Research & Mgmt DQ	X X X	106,571	101,799	153
3140J7UL7	FNMA PASS-THRU LNG 30 YEAR		04/09/2018	Income Research & Mgmt DQ	X X X	232,658	221,579	305
3138XYS96	FNMA PASS-THRU LNG 30 YEAR		10/04/2018	JP Morgan Asset Mgmt	X X X	955,043	945,076	840
3140H1V98	FNMA PASS-THRU LNG 30 YEAR		04/10/2018	JP Morgan Asset Mgmt	X X X	178,955	174,325	213
31410LTX0	FNMA PASS-THRU LNG 30 YEAR 4.000 2		10/01/2018	Income Research & Mgmt DQ	X X X	267,335	263,223	292
31418CXN9	FNMA PASS-THRU LNG 30 YEAR 4.000 2		07/25/2018	JP Morgan Asset Mgmt	X X X	397,613	391,074	1,130
7599113H1	REGIONAL TRANSN AUTH ILL		05/09/2018	JP Morgan Asset Mgmt	X X X	100,000	100,000	
882724ER4	TEXAS ST FOR PREVIOUS ISSUES S		02/08/2018	JP Morgan Asset Mgmt	X X X	137,933	150,000	638
3199999 Subtotal - Bonds - U.S. Special Revenue, Special Assessment						3,377,296	3,339,819	4,674
Bonds - Industrial and Miscellaneous (Unaffiliated)								
03522AAD2	ANHEUSER-BUSCH COS LLC ANHEU 144A		11/08/2018	JP Morgan Asset Mgmt	X X X	94,407	100,000	1,054
03522AAE0	ANHEUSER-BUSCH COS LLC ANHEU 144A		11/08/2018	JP Morgan Asset Mgmt	X X X	53,168	55,000	740
03522AAF7	ANHEUSER-BUSCH COS LLC ANHEU 144A		11/08/2018	Income Research & Mgmt DQ	X X X	209,257	219,000	3,100
03765HAA9	APOLLO MGMT HLDGS LP 144A		06/05/2018	Income Research & Mgmt DQ	X X X	111,486	112,000	87
04010LAV5	ARES CAP CORP		01/08/2018	JP Morgan Asset Mgmt	X X X	99,621	100,000	
00206RGD8	AT&T INC		12/14/2018	Income Research & Mgmt DQ	X X X	81,251	83,000	55

SCHEDULE D - PART 3

Showing All Long-Term Bonds and Stocks ACQUIRED During Current Year

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends
04686JAA9	ATHENE HOLDING LTD	C	01/09/2018	JP Morgan Asset Mgmt	X X X	99,846	100,000	
06051GFX2	BANK OF AMERICA CORP SR UNSECURED		02/23/2018	Income Research & Mgmt DQ	X X X	148,340	150,000	1,867
115637AS9	BROWN FORMAN CORP		03/22/2018	JP Morgan Asset Mgmt	X X X	19,911	20,000	
056059AG3	BX COML MTG TR 144A		10/22/2018	JP Morgan Asset Mgmt	X X X	100,000	100,000	
14040HBU8	CAPITAL ONE FINL CORP		01/25/2018	Income Research & Mgmt DQ	X X X	103,876	104,000	
165183BK9	CHESAPEAKE FDG II LLC 2018-1 144A		04/11/2018	JP Morgan Asset Mgmt	X X X	120,000	120,000	
172967MD0	CITIGROUP INC		07/18/2018	Income Research & Mgmt DQ	X X X	96,233	95,000	
20030NCS8	COMCAST CORP NEW		10/02/2018	JP Morgan Asset Mgmt	X X X	54,932	55,000	
12595VAD9	COMM MTG TR 2018-COR3 20510512 FLT		05/04/2018	Income Research & Mgmt DQ	X X X	167,880	163,000	402
202795JN1	COMMONWEALTH EDISON CO		08/07/2018	Income Research & Mgmt DQ	X X X	121,707	122,000	
205887CD2	CONAGRA BRANDS INC		10/15/2018	JP Morgan Asset Mgmt	X X X	49,792	50,000	
126650CW8	CVS HEALTH CORP		03/06/2018	JP Morgan Asset Mgmt	X X X	39,608	40,000	
23745QAA2	DARTMOUTH-HITCHCOCK HEALTH		02/07/2018	JP Morgan Asset Mgmt	X X X	50,000	50,000	
247367BH7	DELTA AIRLINES PT 2007-1		03/27/2018	JP Morgan Core Bond	X X X	57,012	51,293	476
25389JAR7	DIGITAL RLTY TR LP		02/22/2018	Income Research & Mgmt DQ	X X X	97,337	100,000	113
260543CQ4	DOW CHEM CO 144A		11/28/2018	JP Morgan Asset Mgmt	X X X	39,959	40,000	
26078JAC4	DOWDUPONT INC		11/14/2018	JP Morgan Asset Mgmt	X X X	80,000	80,000	
289333AB2	ELM TR 2018-2 144A		10/03/2018	JP Morgan Asset Mgmt	X X X	29,999	30,000	
343412AF9	FLUOR CORP NEW SR GLBL NT 28		08/20/2018	JP Morgan Asset Mgmt	X X X	54,883	55,000	
369550BG2	GENERAL DYNAMICS CORP		05/08/2018	JP Morgan Asset Mgmt	X X X	59,264	60,000	
36962G3P7	GENERAL ELEC CAP CORP MTN BE		02/22/2018	Income Research & Mgmt DQ	X X X	191,572	165,000	1,131
40573LAQ9	HALFMOON PARENT INC 144A		09/06/2018	JP Morgan Asset Mgmt	X X X	24,979	25,000	
437076BX9	HOME DEPOT INC		11/27/2018	Income Research & Mgmt DQ	X X X	78,642	80,000	
44107HAC6	HOSPITAL FOR SPL SURGERY		03/23/2018	JP Morgan Asset Mgmt	X X X	50,000	50,000	
446150AM6	HUNTINGTON BANCSHARES INC		05/08/2018	JP Morgan Asset Mgmt	X X X	94,702	95,000	
45866FAG9	INTERCONTINENTAL EXCHANGE INC		08/06/2018	Income Research & Mgmt DQ	X X X	319,853	320,000	
46649CAQ6	JP MORGAN MTG TR 144A		10/19/2018	Income Research & Mgmt DQ	X X X	80,506	81,153	174
46650JAD6	JP MORGAN MTG TR 144A		06/27/2018	Income Research & Mgmt DQ	X X X	193,673	195,000	531
487836BW7	KELLOGG CO		05/07/2018	JP Morgan Asset Mgmt	X X X	99,646	100,000	
52107QAJ4	LAZARD LLC SR GLBL NT4.5%28		09/12/2018	JP Morgan Asset Mgmt	X X X	89,171	90,000	
565122AB4	MAPLE ESCROW SUBSIDIARY INC 144A		05/14/2018	JP Morgan Asset Mgmt	X X X	105,000	105,000	
595017AL8	MICROCHIP TECHNOLOGY INC 144A		05/23/2018	JP Morgan Asset Mgmt	X X X	120,000	120,000	
60700DAC2	MMAF EQUIP FIN LLC 144A		05/22/2018	Income Research & Mgmt DQ	X X X	198,981	199,000	
61747YDY8	MORGAN STANLEY		07/19/2018	Income Research & Mgmt DQ	X X X	94,218	97,000	2,039
65341KBD7	NEXTGEAR FLRPLN OWN TR 144A		10/09/2018	Income Research & Mgmt DQ	X X X	158,962	159,000	
67103HAG2	O REILLY AUTOMOTIVE INC NEW		05/11/2018	JP Morgan Asset Mgmt	X X X	104,753	105,000	
743756AE8	PROVIDENCE HEALTH & SVCS OBLIG		01/30/2018	JP Morgan Asset Mgmt	X X X	155,000	155,000	
84861CAC9	SPIRIT MASTER FDG LLC 2017-1 144A		01/23/2018	JP Morgan Asset Mgmt	X X X	100,423	99,935	351
784710AB1	SSM HEALTH CARE CORP		12/04/2018	JP Morgan Asset Mgmt	X X X	49,688	50,000	51
85434VAA6	STANFORD HEALTH CARE		01/09/2018	JP Morgan Asset Mgmt	X X X	115,000	115,000	
86212VAD6	STORE MSTR FDG 144A		10/12/2018	Income Research & Mgmt DQ	X X X	202,947	203,000	
889184AC1	TOLEDO HOSPITAL		10/18/2018	JP Morgan Asset Mgmt	X X X	95,000	95,000	
90932PAA6	UNITED AIR 2014 1 A PTT		05/03/2018	Income Research & Mgmt DQ	X X X	34,192	34,149	99
91324PDM1	UNITEDHEALTH GROUP INC		12/13/2018	Income Research & Mgmt DQ	X X X	131,671	132,000	
92211MAC7	VANTAGE DATA CTR 144A		02/09/2018	JP Morgan Asset Mgmt	X X X	25,000	25,000	
92343VER1	VERIZON COMMUNICATIONS INC		06/21/2018	JP Morgan Asset Mgmt	X X X	96,660	96,169	
931142EK5	WALMART INC		06/20/2018	Income Research & Mgmt DQ	X X X	190,948	191,000	
95040QAD6	WELLTOWER INC		04/03/2018	JP Morgan Asset Mgmt	X X X	24,990	25,000	
960386AM2	WESTINGHOUSE AIR BRAKE CO NEW		09/12/2018	JP Morgan Asset Mgmt	X X X	109,878	110,000	
06367T4W7	BANK OF MONTREAL	C	04/10/2018	Income Research & Mgmt DQ	X X X	63,925	64,000	
3899999 Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						5,639,750	5,635,698	12,269
8399997 Subtotal - Bonds - Part 3						14,433,459	14,394,723	52,782
8399998 Summary item from Part 5 for Bonds						2,585,864	2,580,056	8,467

SCHEDULE D - PART 3

Showing All Long-Term Bonds and Stocks ACQUIRED During Current Year

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends
8399999 Subtotal - Bonds						17,019,323	16,974,779	61,248
9999999 Totals						17,019,323	X X X	61,248

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED, or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change in Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consideration	Par Value	Actual Cost	Prior Year Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in B./A.C.V. (Cols. 11+12-13)	Total Foreign Exchange Change in B./A.C.V.	Book/Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Contractual Maturity Date
Bonds - U.S. Governments																				
38374MU98	GNMA 2006 17 TW		12/01/2018	PRINCIPAL RECEIPT	XXX	6,563	6,563	7,602	7,348		(785)		(785)		6,563				277	04/20/2036
38374MWZ8	GNMA 2006 7 NC		12/01/2018	PRINCIPAL RECEIPT	XXX	13,862	13,862	14,750	14,672		(810)		(810)		13,862				371	08/20/2035
3617AGWQ0	GNMA PASS-THRU C SINGLE FAMILY		12/01/2018	PRINCIPAL RECEIPT	XXX	5,916	5,916	6,198	6,192		(276)		(276)		5,916				107	07/20/2047
36196JLD6	GNMA PASS-THRU C SINGLE FAMILY		12/01/2018	PRINCIPAL RECEIPT	XXX	6,041	6,041	6,309	6,309		(268)		(268)		6,041				73	05/20/2047
36179RZV4	GNMA PASS-THRU M SINGLE FAMILY		12/01/2018	PRINCIPAL RECEIPT	XXX	1,131	1,131	1,167			(36)		(36)		1,131					02/20/2046
36202EJZ3	GNMA PASS-THRU M SINGLE FAMILY		12/01/2018	PRINCIPAL RECEIPT	XXX	5,142	5,142	5,858	5,831		(689)		(689)		5,142				149	07/20/2036
3622AAAE4	GNMA PASS-THRU X PLATINUM 30YR		12/01/2018	PRINCIPAL RECEIPT	XXX	528	528	549			(21)		(21)		528					01/15/2042
36178DXU0	GNMA PASS-THRU X SINGLE FAMILY		12/01/2018	PRINCIPAL RECEIPT	XXX	32,813	32,813	33,571	33,571		0		0		33,571		(759)	(759)	440	02/15/2043
36200NTS0	GNMA PASS-THRU X SINGLE FAMILY		12/01/2018	PRINCIPAL RECEIPT	XXX	7,894	7,894	8,743	8,650		(756)		(756)		7,894				170	06/15/2034
36296Q2B4	GNMA PASS-THRU X SINGLE FAMILY		12/01/2018	PRINCIPAL RECEIPT	XXX	13,010	13,010	14,430	14,338		(1,328)		(1,328)		13,010				259	07/15/2039
38373V2C3	GNMA REMIC TRUST 2002-80		12/01/2018	PRINCIPAL RECEIPT	XXX	8,942	8,942	9,836	9,774		(832)		(832)		8,942				222	11/20/2032
38373S7F8	GNMA REMIC TRUST 2003-29		12/01/2018	PRINCIPAL RECEIPT	XXX	8,359	8,359	9,398	9,264		(906)		(906)		8,359				214	04/16/2033
38373YD92	GNMA REMIC TRUST 2003-4		12/01/2018	PRINCIPAL RECEIPT	XXX	12,580	12,580	13,815	13,794		(1,213)		(1,213)		12,580				315	01/20/2033
38374BDZ3	GNMA REMIC TRUST 2003-62		12/01/2018	PRINCIPAL RECEIPT	XXX	9,635	9,635	10,647	10,331		(695)		(695)		9,635				202	07/20/2033
38374GSA1	GNMA REMIC TRUST 2004-37		12/01/2018	PRINCIPAL RECEIPT	XXX	7,580	7,580	8,465	8,403		(823)		(823)		7,580				236	04/17/2034
38374JSK3	GNMA REMIC TRUST 2004-82		12/01/2018	PRINCIPAL RECEIPT	XXX	19,671	19,671	21,515	21,421		(1,750)		(1,750)		19,671				437	10/20/2034
38374JPX8	GNMA REMIC TRUST 2004-88		12/01/2018	PRINCIPAL RECEIPT	XXX	18,431	18,431	20,758	20,586		(2,155)		(2,155)		18,431				411	10/20/2034
38374J6G6	GNMA REMIC TRUST 2004-93		12/01/2018	PRINCIPAL RECEIPT	XXX	2,625	2,625	2,954	2,860		(235)		(235)		2,625				115	11/16/2034
38374KXC2	GNMA REMIC TRUST 2005-16		12/01/2018	PRINCIPAL RECEIPT	XXX	39,064	39,064	43,505	42,554		(3,490)		(3,490)		39,064				837	02/20/2035
38374K2D4	GNMA REMIC TRUST 2005-33		12/01/2018	PRINCIPAL RECEIPT	XXX	9,702	9,702	10,697	10,640		(938)		(938)		9,702				249	04/16/2035
38374KLR2	GNMA REMIC TRUST 2005-6		12/01/2018	PRINCIPAL RECEIPT	XXX	9,516	9,516	10,396	10,346		(831)		(831)		9,516				211	10/20/2034
38374LG88	GNMA REMIC TRUST 2005-63		12/01/2018	PRINCIPAL RECEIPT	XXX	5,824	5,824	6,377	6,319		(495)		(495)		5,824				127	08/20/2035
38374MAY5	GNMA REMIC TRUST 2005-77		12/01/2018	PRINCIPAL RECEIPT	XXX	15,404	15,404	16,540	16,428		(1,024)		(1,024)		15,404				409	02/17/2033
38374MSY6	GNMA REMIC TRUST 2005-98		12/01/2018	PRINCIPAL RECEIPT	XXX	13,114	13,114	15,016	14,565		(1,451)		(1,451)		13,114				319	12/20/2035
38375JCC7	GNMA REMIC TRUST 2006-69		12/01/2018	PRINCIPAL RECEIPT	XXX	19,239	19,239	21,308	21,289		(2,050)		(2,050)		19,239				479	12/20/2036
38375KEX6	GNMA REMIC TRUST 2007-33		12/01/2018	PRINCIPAL RECEIPT	XXX	22,247	22,247	25,334	24,750		(2,503)		(2,503)		22,247				534	06/20/2037
38375LEU0	GNMA REMIC TRUST 2007-53		09/01/2018	PRINCIPAL RECEIPT	XXX	33,673	33,673	36,745	35,596		(1,923)		(1,923)		33,673				751	10/20/2033
38375LPU8	GNMA REMIC TRUST 2007-59		12/20/2018	PRINCIPAL RECEIPT	XXX	15,874	15,874	15,715	15,748		126		126		15,874				162	10/20/2037
3837424J9	GNMA REMIC TRUST 2008-56		12/01/2018	PRINCIPAL RECEIPT	XXX	10,563	10,563	11,982	11,942		(1,380)		(1,380)		10,563				286	06/20/2038
38375XPA6	GNMA REMIC TRUST 2008-74		12/01/2018	PRINCIPAL RECEIPT	XXX	7,490	7,490	8,462	8,394		(904)		(904)		7,490				207	08/16/2038
38376TW99	GNMA REMIC TRUST 2010-4		12/01/2018	PRINCIPAL RECEIPT	XXX	18,878	18,878	20,105	20,044		(1,166)		(1,166)		18,878				343	01/16/2039
38375XZ72	GOVERNMENT NATIONAL MORTGAGE A		12/01/2018	PRINCIPAL RECEIPT	XXX	12,679	12,679	14,406	14,645		(1,966)		(1,966)		12,679				335	08/20/2038
83162CYW7	SMALL BUS ADMIN GTD DEV PTC		09/01/2018	VARIOUS	XXX	4,272	4,272	4,036			1		1		4,036		236	236		09/01/2037
83162CQX4	SMALL BUSINESS ADMINISTRATION		09/01/2018	PRINCIPAL RECEIPT	XXX	25,791	25,791	28,692	27,980		(2,190)		(2,190)		25,791				288	03/01/2027
83162CTN3	SMALL BUSINESS ADMINISTRATION		09/01/2018	PRINCIPAL RECEIPT	XXX	40,644	40,644	42,188	41,954		(1,309)		(1,309)		40,644				346	09/01/2030
83162CTU7	SMALL BUSINESS ADMINISTRATION		07/01/2018	PRINCIPAL RECEIPT	XXX	18,282	18,282	19,402	19,300		(1,018)		(1,018)		18,282				220	01/01/2031
83162CVR1	SMALL BUSINESS ADMINISTRATION		07/01/2018	PRINCIPAL RECEIPT	XXX	53,963	53,963	55,582	55,465		(1,502)		(1,502)		53,963				477	07/01/2033
83162CUG6	SMALL BUSINESS ADMINISTRATION SBAP		09/01/2018	PRINCIPAL RECEIPT	XXX	8,275	8,275	8,372	8,357		(82)		(82)		8,275				64	09/01/2031
83162CVY6	SMALL BUSINESS ADMINISTRATION SBAP		12/01/2018	PRINCIPAL RECEIPT	XXX	41,290	41,290	43,174	43,057		(1,767)		(1,767)		41,290				450	12/01/2033
9128334V9	U S TREAS SEC STRIPPED INT PMT		10/16/2018	JP Morgan Asset Mgmt	XXX	374,112	600,000	407,652	420,863		6,665		6,665		427,528		(53,416)	(53,416)		02/15/2033
9128334X5	U S TREAS SEC STRIPPED INT PMT		10/16/2018	JP Morgan Asset Mgmt	XXX	272,638	453,000	324,796	333,957		5,036		5,036		338,994		(66,356)	(66,356)		02/15/2034
912810RS9	UNITED STATES TREAS BDS		11/27/2018	Income Research & Mgmt DQ	XXX	852	1,000	925	927		2		2		928		(76)	(76)	26	05/15/2046
9128282B5	UNITED STATES TREAS NTS		04/27/2018	Income Research & Mgmt DQ	XXX	278,249	284,000	280,002	280,444		676		676		281,120		(2,870)	(2,870)	1,484	08/15/2019
9128282V1	UNITED STATES TREAS NTS		10/16/2018	JP Morgan Asset Mgmt	XXX	777,969	800,000	794,656	795,096		1,407		1,407		796,504		(18,535)	(18,535)	11,972	09/15/2020
9128283F5	UNITED STATES TREAS NTS		08/07/2018	Income Research & Mgmt DQ	XXX	171,412	182,000	179,792	179,805		110		110		179,915		(8,503)	(8,503)	2,786	11/15/2027
9128284S6	UNITED STATES TREAS NTS		12/13/2018	Income Research & Mgmt DQ	XXX	337,943	340,000	338,579			77		77		338,656		(713)	(713)	4,193	05/31/2023
9128284V9	UNITED STATES TREAS NTS		12/17/2018	JP Morgan Asset Mgmt	XXX	125,117	125,000	123,159			33		33		123,192		1,925	1,925	1,221	08/15/2028
912828RP7	UNITED STATES TREAS NTS		10/31/2018	VARIOUS	XXX	419,934	420,000	423,462	420,718		(682)		(682)		420,036		(101)	(101)	7,070	10/31/2018
912828SV3	UNITED STATES TREAS NTS		10/16/2018	JP Morgan Asset Mgmt	XXX	191,680	200,000	195,188	197,115		501		501		197,616		(5,937)	(5,937)	3,224	05/15/2022
912828V98	UNITED STATES TREAS NTS		10/17/2018	Income Research & Mgmt DQ	XXX	856,898	913,000	911,918	911,941		52		52		911,994		(55,096)	(55,096)	21,818	02/15/2027

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED, or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change in Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consideration	Par Value	Actual Cost	Prior Year Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year (Amortization/ Accretion)	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in B./A.C.V. (Cols. 11+12-13)	Total Foreign Exchange Change in B./A.C.V.	Book/Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Contractual Maturity Date
912828XR6	UNITED STATES TREAS NTS		06/20/2018	Income Research & Mgmt DQ	XXX	721,430	747,000	735,933	736,058		737		737		736,796		(15,366)	(15,366)	4,766	05/31/2022
912828D56	UNITED STATES TREAS NTS 2.375%		01/16/2018	JP Morgan Core Bond	XXX	154,243	155,000	155,938	155,835		(5)		(5)		155,831		(1,587)	(1,587)	1,551	08/15/2024
9128282L3	UNITED STATES TREAS NTS TIPS		01/29/2018	JP Morgan Asset Mgmt	XXX	311,994	317,640	316,879	319,507	(2,589)	8		(2,581)		316,926		(4,932)	(4,932)	650	07/15/2027
912810EW4	US TREASURY N/B		10/16/2018	JP Morgan Asset Mgmt	XXX	772,556	641,000	863,567	814,417		(12,287)		(12,287)		802,130		(29,574)	(29,574)	38,147	02/15/2026
912810FT0	US TREASURY N/B		10/17/2018	Income Research & Mgmt DQ	XXX	556,140	470,000	614,014	599,591		(3,030)		(3,030)		596,561		(40,421)	(40,421)	18,759	02/15/2036
912828TH3	US TREASURY N/B		10/16/2018	JP Morgan Asset Mgmt	XXX	493,359	500,000	479,492	493,120		3,421		3,421		496,540		(3,181)	(3,181)	5,302	07/31/2019
912828P46	US TREASURY N/B 02/26 1.625		09/24/2018	Income Research & Mgmt DQ	XXX	622,196	682,000	658,562	661,153		1,041		1,041		662,194		(39,998)	(39,998)	7,980	02/15/2026
912810RK6	US TREASURY N/B 02/45 2.5		07/18/2018	Income Research & Mgmt DQ	XXX	17,300	19,000	17,295	17,382		22		22		17,404		(104)	(104)	440	02/15/2045
912810RM2	US TREASURY N/B 05/45 3		11/27/2018	Income Research & Mgmt DQ	XXX	339,170	356,000	367,166	366,696		(227)		(227)		366,469		(27,299)	(27,299)	9,581	05/15/2045
912828G53	US TREASURY N/B 11/21 1.875		10/04/2018	JP Morgan Asset Mgmt	XXX	594,868	615,000	615,432	615,290		(55)		(55)		615,236		(20,367)	(20,367)	9,767	11/30/2021
0599999 Subtotal - Bonds - U.S. Governments						8,996,567	9,427,145	9,459,005	8,962,632	(2,589)	(37,936)		(40,525)		9,389,597		(393,031)	(393,031)	161,828	XXX
Bonds - U.S. Political Subdivisions of States (Direct and Guaranteed)																				
235218L28	DALLAS TEX		02/15/2018	MATURITY	XXX	130,000	130,000	122,775	129,725		275		275		130,000					02/15/2018
2499999 Subtotal - Bonds - U.S. Political Subdivisions of States (Direct and Guaranteed)						130,000	130,000	122,775	129,725		275		275		130,000					XXX
Bonds - U.S. Special Revenue, Special Assessment																				
29270CYP4	ENERGY NORTHWEST WASH ELEC REV		10/16/2018	Income Research & Mgmt DQ	XXX	73,895	75,000	76,699	75,980		(214)		(214)		75,766		(1,871)	(1,871)	2,727	07/01/2021
3133TSGY3	FEDERAL HOME LN MTG CORP		12/15/2018	PRINCIPAL RECEIPT	XXX	16,959	16,959	17,182	17,145		(186)		(186)		16,959				206	05/15/2029
313586RC5	FEDERAL NATL MTG ASSN		10/12/2018	JP Morgan Asset Mgmt	XXX	145,944	150,000	135,513	144,651		2,332		2,332		146,983		(1,039)	(1,039)		10/09/2019
3128MMF99	FHLMC PC GOLD COMB 15		12/01/2018	PRINCIPAL RECEIPT	XXX	14,444	14,444	15,843	15,366		(922)		(922)		14,444				387	06/01/2022
3132J4HV4	FHLMC PC GOLD COMB 20		12/01/2018	PRINCIPAL RECEIPT	XXX	15,055	15,055	15,330	15,325		(270)		(270)		15,055				226	09/01/2036
31296YJM6	FHLMC PC GOLD COMB 30		12/01/2018	PRINCIPAL RECEIPT	XXX	1,205	1,205	1,369	1,357		(152)		(152)		1,205				39	05/01/2034
31335BA22	FHLMC PC GOLD COMB 30		12/01/2018	PRINCIPAL RECEIPT	XXX	33,994	33,994	37,399	37,375		(3,380)		(3,380)		33,994				791	08/01/2044
31335BA89	FHLMC PC GOLD COMB 30		12/01/2018	PRINCIPAL RECEIPT	XXX	16,671	16,671	16,752	16,752		0		0		16,752		(81)	(81)	226	02/01/2047
3132HRMV9	FHLMC PC GOLD PC 30YR		12/01/2018	VARIOUS	XXX	203,235	201,259	203,460	182,639		(217)		(217)		203,235				409	01/01/2043
3132J94G0	FHLMC PC GOLD PC 30YR		10/16/2018	VARIOUS	XXX	137,115	139,208	147,713	147,599		(1,203)		(1,203)		146,396		(9,280)	(9,280)	4,011	05/01/2043
3132WHJY2	FHLMC PC GOLD PC 30YR		12/01/2018	PRINCIPAL RECEIPT	XXX	22,042	22,042	22,120	22,120		(78)		(78)		22,042				320	10/01/2046
3128MAEB1	FHLMC PC GOLD COMB 30		12/01/2018	PRINCIPAL RECEIPT	XXX	7,499	7,499	7,316			183		183		7,499				32	06/01/2043
31335BLX2	FHLMC PC GOLD COMB 30		12/01/2018	PRINCIPAL RECEIPT	XXX	17,240	17,240	18,398			(1,158)		(1,158)		17,240				267	12/01/2045
3132H7D84	FHLMC PC GOLD H LTV 30		12/01/2018	PRINCIPAL RECEIPT	XXX	17,253	17,253	16,701			553		553		17,253				112	11/01/2043
3132GSKA6	FHLMC PC GOLD PC 30YR		12/01/2018	PRINCIPAL RECEIPT	XXX	32,174	32,174	34,135	34,068		(1,894)		(1,894)		32,174				525	04/01/2042
3132XUZ40	FHLMC PC GOLD PC 30YR 3.500 20471		01/24/2018	VARIOUS	XXX	404,229	397,850	408,480	408,395		(103)		(103)		408,292		(4,064)	(4,064)	4,254	12/01/2047
31335AWT1	FHLMC PCGOLD COMB 30		12/01/2018	VARIOUS	XXX	237,185	230,855	237,857	215,007		(651)		(651)		237,185				533	07/01/2046
3133THM53	FHLMC REMIC SERIES 2112		12/01/2018	PRINCIPAL RECEIPT	XXX	16,324	16,324	18,492	18,294		(1,969)		(1,969)		16,324				511	01/15/2029
3133TRJM8	FHLMC REMIC SERIES 2283		12/01/2018	PRINCIPAL RECEIPT	XXX	19,774	19,774	22,110	21,590		(1,816)		(1,816)		19,774				572	12/15/2023
31394RLM9	FHLMC REMIC SERIES 2752		12/01/2018	PRINCIPAL RECEIPT	XXX	23,357	23,357	25,831	25,756		(2,399)		(2,399)		23,357				568	02/15/2034
31396AFT6	FHLMC REMIC SERIES 3028		12/01/2018	PRINCIPAL RECEIPT	XXX	15,090	15,090	17,005	16,921		(1,831)		(1,831)		15,090				378	09/15/2035
31396AGC2	FHLMC REMIC SERIES 3028		12/15/2018	PRINCIPAL RECEIPT	XXX		(1,192)	(1,288)	(1,392)		1,392		1,392						0	09/15/2035
31397JXC3	FHLMC REMIC SERIES 3344		12/15/2018	PRINCIPAL RECEIPT	XXX	15,993	15,993	15,958	15,777		216		216		15,993				157	07/15/2037
31398Q4F1	FHLMC REMIC SERIES 3664		12/01/2018	PRINCIPAL RECEIPT	XXX	11,954	11,954	12,623	12,589		(635)		(635)		11,954				267	11/15/2037
3137A7RM4	FHLMC REMIC SERIES 3817		12/01/2018	PRINCIPAL RECEIPT	XXX	28,283	28,283	30,563	30,411		(2,129)		(2,129)		28,283				620	10/15/2037
3137A7YA2	FHLMC REMIC SERIES 3827		12/01/2018	PRINCIPAL RECEIPT	XXX	10	10	11	11		0		0		10				0	11/15/2025
3137AHGR3	FHLMC REMIC SERIES 3959		12/01/2018	PRINCIPAL RECEIPT	XXX	15,698	15,698	16,973	16,934		(1,236)		(1,236)		15,698				319	11/15/2041
3137AN5X9	FHLMC REMIC SERIES 4016		10/16/2018	VARIOUS	XXX	121,056	127,978	127,058	127,090		186		186		127,276		(6,221)	(6,221)	2,039	07/15/2041
3137APGD6	FHLMC REMIC SERIES 4029		12/01/2018	PRINCIPAL RECEIPT	XXX	16,282	16,282	17,259	17,222		(940)		(940)		16,282				263	04/15/2041
3137B4UV6	FHLMC REMIC SERIES 4248		12/01/2018	PRINCIPAL RECEIPT	XXX	5,501	5,501	5,556	5,548		(47)		(47)		5,501				76	06/15/2030
3137B8CD7	FHLMC REMIC SERIES 4301		12/01/2018	PRINCIPAL RECEIPT	XXX	15,742	15,742	16,391	16,288		(546)		(546)		15,742				241	07/15/2032
3137B8JJ7	FHLMC REMIC SERIES 4315		12/01/2018	PRINCIPAL RECEIPT	XXX	13,367	13,367	14,854	14,670		(1,302)		(1,302)		13,367				297	08/15/2041
3137B95Z4	FHLMC REMIC SERIES 4316		12/01/2018	PRINCIPAL RECEIPT	XXX	15,186	15,186	16,975	16,476		(1,290)		(1,290)		15,186				319	04/15/2025

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED, or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change in Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consideration	Par Value	Actual Cost	Prior Year Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in B./A.C.V. (Cols. 11+12-13)	Total Foreign Exchange Change in B./A.C.V.	Book/Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Contractual Maturity Date
3137BCMT2	FHLMC REMIC SERIES 4363		12/01/2018	PRINCIPAL RECEIPT	XXX	22,069	22,069	23,586	23,286		(1,217)		(1,217)		22,069				426	05/15/2033
3137FDER9	FHLMC REMIC SERIES K-1504		12/01/2018	PRINCIPAL RECEIPT	XXX	1,444	1,444	1,473			(29)		(29)		1,444				19	11/25/2028
341271AB0	FLORIDA ST BRD ADMIN FIN CORP		10/16/2018	Income Research & Mgmt																
				DQ	XXX	73,654	75,000	75,000	75,000						75,000		(1,346)	(1,346)	2,567	07/01/2021
31381RKR4	FNMA PASS-THRU BLLN MULTI 7+		10/12/2018	VARIOUS	XXX	184,069	180,033	199,499	190,713		(2,526)		(2,526)		188,186		(4,117)	(4,117)	6,898	06/01/2021
31381U6P7	FNMA PASS-THRU BLLN MULTI 7+		10/12/2018	VARIOUS	XXX	183,257	188,834	192,227	191,557		(232)		(232)		191,326		(8,069)	(8,069)	5,414	06/01/2027
3138L3AM7	FNMA PASS-THRU BLLN MULTI 7+		12/01/2018	PRINCIPAL RECEIPT	XXX	3,677	3,677	3,648	3,658		20		20		3,677				44	03/01/2023
3138L4L43	FNMA PASS-THRU BLLN MULTI 7+		10/12/2018	VARIOUS	XXX	269,922	274,652	284,534	283,253		(664)		(664)		282,590		(12,668)	(12,668)	8,550	07/01/2028
3138L7QN9	FNMA PASS-THRU BLLN MULTI 7+		12/01/2018	PRINCIPAL RECEIPT	XXX	1,793	1,793	1,841	1,836		(44)		(44)		1,793				30	10/01/2029
31415CM53	FNMA PASS-THRU INT 15 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	15,786	15,786	17,502	17,024		(1,239)		(1,239)		15,786				405	05/01/2023
31417YSY4	FNMA PASS-THRU INT 20 YEAR		10/16/2018	VARIOUS	XXX	106,683	105,971	113,653	112,860		(1,299)		(1,299)		111,561		(4,878)	(4,878)	3,450	10/01/2030
31371LDG1	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	45,610	45,610	50,590	50,337		(4,727)		(4,727)		45,610				992	10/01/2033
3138AFFM7	FNMA PASS-THRU LNG 30 YEAR		10/17/2018	VARIOUS	XXX	64,382	60,500	67,117	67,000		(918)		(918)		66,082		(1,699)	(1,699)	2,487	05/01/2041
3138EKY74	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	25,599	25,599	27,283	27,254		(1,655)		(1,655)		25,599				376	10/01/2041
3138ELJT1	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	20,440	20,440	21,564	21,542		(1,102)		(1,102)		20,440				344	07/01/2043
3138ENNE5	FNMA PASS-THRU LNG 30 YEAR		10/17/2018	VARIOUS	XXX	39,174	36,866	40,985	40,874		(653)		(653)		40,220		(1,046)	(1,046)	1,497	05/01/2042
3138ENTM1	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	8,501	8,501	9,442	9,419		(918)		(918)		8,501				188	01/01/2042
3138EPAB0	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	18,262	18,262	19,890	19,844		(1,581)		(1,581)		18,262				362	06/01/2042
3138EPMM3	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	28,015	28,015	29,897	29,834		(1,819)		(1,819)		28,015				476	03/01/2039
3138EPS54	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	13,288	13,288	14,779	14,747		(1,458)		(1,458)		13,288				302	04/01/2042
3138ERCJ7	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	37,112	37,112	40,800	40,755		(3,643)		(3,643)		37,112				791	07/01/2044
3138ERD98	FNMA PASS-THRU LNG 30 YEAR		10/16/2018	VARIOUS	XXX	213,772	211,897	224,445	224,225		(1,798)		(1,798)		222,426		(8,655)	(8,655)	6,987	10/01/2044
3138ERE30	FNMA PASS-THRU LNG 30 YEAR		10/16/2018	VARIOUS	XXX	115,814	117,765	122,062	122,089		(540)		(540)		121,549		(5,735)	(5,735)	3,444	09/01/2046
3138ERZB9	FNMA PASS-THRU LNG 30 YEAR		10/16/2018	VARIOUS	XXX	82,775	80,452	86,410	86,293		(1,159)		(1,159)		85,134		(2,359)	(2,359)	2,909	08/01/2038
3138ET4W3	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	7,941	7,941	8,313			(372)		(372)		7,941				79	05/01/2046
3138ETC53	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	35,344	35,344	38,535	38,519		(3,176)		(3,176)		35,344				590	12/01/2045
3138LS2M1	FNMA PASS-THRU LNG 30 YEAR		10/16/2018	VARIOUS	XXX	149,200	151,382	161,104	160,931		(1,795)		(1,795)		159,136		(9,935)	(9,935)	4,190	05/01/2042
3138M3TE4	FNMA PASS-THRU LNG 30 YEAR		10/16/2018	VARIOUS	XXX	110,484	112,200	117,074	116,906		(523)		(523)		116,383		(5,900)	(5,900)	3,261	07/01/2042
3138W8AC6	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	9,650	9,650	9,911	9,899		(249)		(249)		9,650				190	04/01/2043
3138WDKQ3	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	18,942	18,942	19,726	19,700		(759)		(759)		18,942				313	11/01/2044
3138WFCF1	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	23,012	23,012	24,707	24,685		(1,673)		(1,673)		23,012				436	07/01/2045
3138X0AW8	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	39,301	39,301	41,104	41,045		(1,744)		(1,744)		39,301				580	07/01/2043
3138X3EZ1	FNMA PASS-THRU LNG 30 YEAR		10/16/2018	VARIOUS	XXX	84,496	83,763	89,365	89,274		(853)		(853)		88,421		(3,925)	(3,925)	2,749	08/01/2043
3140J5W62	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	23,169	23,169	24,013	24,020		(851)		(851)		23,169				383	07/01/2047
3140J5ZV4	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	45,899	45,899	50,697	50,674		(4,775)		(4,775)		45,899				974	11/01/2044
3140J7UL7	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	VARIOUS	XXX	151,679	148,421	155,842			(1,088)		(1,088)		154,754		(3,075)	(3,075)	2,999	11/01/2047
31410LR87	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	20,690	20,690	22,501	22,482		(1,792)		(1,792)		20,690				433	11/01/2045
31416XKD1	FNMA PASS-THRU LNG 30 YEAR		10/16/2018	VARIOUS	XXX	98,761	97,859	104,190	104,002		(695)		(695)		103,307		(4,545)	(4,545)	3,263	01/01/2041
31417LCN3	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	10,071	10,071	10,675	10,657		(587)		(587)		10,071				199	09/01/2039
31418MZ39	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	40,459	40,459	45,864	45,744		(5,285)		(5,285)		40,459				912	02/01/2040
31418UED2	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	17,009	17,009	18,609	18,570		(1,561)		(1,561)		17,009				325	06/01/2040
31419JRF7	FNMA PASS-THRU LNG 30 YEAR		10/16/2018	VARIOUS	XXX	33,314	33,057	35,237	35,165		(311)		(311)		34,855		(1,540)	(1,540)	1,096	10/01/2040
31418M5K4	FNMA PASS-THRU MEGA MULTI 7		12/01/2018	PRINCIPAL RECEIPT	XXX	19,242	19,242	21,287	20,099		(857)		(857)		19,242				474	02/01/2020
3138L7LE4	FNMA PASS-THRU 2ND LIEN MULT		10/25/2018	VARIOUS	XXX	198,188	200,000	203,875	202,470		(403)		(403)		202,066		(3,879)	(3,879)	5,476	07/01/2022
3138L4SP9	FNMA PASS-THRU BLLN MULTI 7+		10/25/2018	VARIOUS	XXX	234,097	230,000	246,064	240,892		(1,426)		(1,426)		239,466		(5,369)	(5,369)	7,622	08/01/2023
3138L77M2	FNMA PASS-THRU BLLN MULTI 7+		01/25/2018	VARIOUS	XXX	331,957	325,000	332,109	331,090		(93)		(93)		330,998		959	959	1,609	11/01/2026
3138L8NN0	FNMA PASS-THRU BLLN MULTI 7+		10/25/2018	VARIOUS	XXX	291,234	300,000	302,438	302,098		(158)		(158)		301,940		(10,706)	(10,706)	8,400	01/01/2027
3138WKPU3	FNMA PASS-THRU INT 20 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	22,328	22,328	23,319	23,319		(991)		(991)		22,328				325	04/01/2037
3138EP2K9	FNMA PASS-THRU INT 20 YEAR 4.000		12/01/2018	PRINCIPAL RECEIPT	XXX	31,885	31,885	33,952	33,946		(2,061)		(2,061)		31,885				526	07/01/2035
3138XYS96	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	21,788	21,788	22,017			(230)		(230)		21,788				31	07/01/2044
3140H1V98	FNMA PASS-THRU LNG 30 YEAR		12/01/2018	PRINCIPAL RECEIPT	XXX	8,606	8,606	8,835			(229)		(229)		8,606				111	03/01/2048
31410LTX0	FNMA PASS-THRU LNG 30 YEAR 4.000 2		12/01/2018	PRINCIPAL RECEIPT	XXX	8,937	8,937	9,076			(140)		(140)		8,937				5	08/01/2046
31418CXN9	FNMA PASS-THRU LNG 30 YEAR 4.000 2		12/01/2018	PRINCIPAL RECEIPT	XXX	10,502	10,502	10,677			(176)		(176)		10,502				70	06/01/2048
31374CQU3	FNMA PASS-THRU MEGA SF LT		12/01/2018	PRINCIPAL RECEIPT	XXX	30,697	30,697	33,714	33,660		(2,963)		(2,963)		30,697				581	02/01/2044
3138L3G41	FNMA POOL AM2918		10/12/2018	VARIOUS	XXX	177,822	183,451	182,993	183,141		48		48		183,188		(5,366)	(5,366)	4,045	04/01/2023
31393UXJ7	FNMA REMIC TRUST 2003-128		12/01/2018	PRINCIPAL RECEIPT	XXX	20,225	20,225	21,653	21,316		(1,091)		(1,091)		20,225				432	01/25/2024
31393XZV2	FNMA REMIC TRUST 2004-17		12/01/2018	PRINCIPAL RECEIPT	XXX	9,797	9,797	10,874	12,302		(2,506)		(2,506)		9,797				253	04/25/2034
31396LUS7	FNMA REMIC TRUST 2006-105		12/01/2018	PRINCIPAL RECEIPT	XXX	16,641	16,641	18,736	18,371		(1,730)		(1,730)		16,641				396	11/25/2036

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED, or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change in Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consideration	Par Value	Actual Cost	Prior Year Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year (Amortization/ Accretion)	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in B./A.C.V. (Cols. 11+12-13)	Total Foreign Exchange Change in B./A.C.V.	Book/Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Contractual Maturity Date
3136A9N61	FNMA REMIC TRUST 2012-120		12/01/2018	PRINCIPAL RECEIPT	XXX	17,348	17,348	18,031	17,993		(645)		(645)		17,348				269	10/25/2042
3136A35F4	FNMA REMIC TRUST 2012-28		12/01/2018	PRINCIPAL RECEIPT	XXX	13,418	13,418	15,007	14,963		(1,545)		(1,545)		13,418				384	06/25/2039
3136A54N3	FNMA REMIC TRUST 2012-51		12/01/2018	PRINCIPAL RECEIPT	XXX	11,279	11,279	12,798	12,772		(1,493)		(1,493)		11,279				339	05/25/2042
3136A7K76	FNMA REMIC TRUST 2012-92		12/01/2018	PRINCIPAL RECEIPT	XXX	21,106	21,106	21,885	21,777		(671)		(671)		21,106				315	04/25/2037
3136AGUU4	FNMA REMIC TRUST 2013-100		12/01/2018	PRINCIPAL RECEIPT	XXX	38,746	38,746	42,349	42,061		(3,316)		(3,316)		38,746				767	11/25/2041
3136AGNB4	FNMA REMIC TRUST 2013-103		12/01/2018	PRINCIPAL RECEIPT	XXX	15,405	15,405	16,734	16,616		(1,211)		(1,211)		15,405				326	03/25/2038
3136AGZ21	FNMA REMIC TRUST 2013-117		12/01/2018	PRINCIPAL RECEIPT	XXX	15,802	15,802	16,503	16,340		(538)		(538)		15,802				257	11/25/2026
3136ACJP7	FNMA REMIC TRUST 2013-17		12/01/2018	PRINCIPAL RECEIPT	XXX	17,840	17,840	18,804	18,705		(866)		(866)		17,840				355	03/25/2033
3136ACTJ0	FNMA REMIC TRUST 2013-20		12/01/2018	PRINCIPAL RECEIPT	XXX	21,039	21,039	22,321	22,184		(1,145)		(1,145)		21,039				418	03/25/2033
3136ACWD9	FNMA REMIC TRUST 2013-20		12/01/2018	PRINCIPAL RECEIPT	XXX	11,149	11,149	11,828	11,752		(603)		(603)		11,149				207	03/25/2033
3136ADFU8	FNMA REMIC TRUST 2013-31		12/01/2018	PRINCIPAL RECEIPT	XXX	16,915	16,915	17,816	17,723		(808)		(808)		16,915				315	04/25/2033
3136ADGY9	FNMA REMIC TRUST 2013-31		12/01/2018	PRINCIPAL RECEIPT	XXX	11,200	11,200	11,762	11,702		(502)		(502)		11,200				179	01/25/2033
3136ADY45	FNMA REMIC TRUST 2013-43		12/01/2018	PRINCIPAL RECEIPT	XXX	12,542	12,542	12,849	12,815		(273)		(273)		12,542				193	05/25/2033
3136AGJN3	FNMA REMIC TRUST 2013-94		12/01/2018	PRINCIPAL RECEIPT	XXX	25,479	25,479	27,183	27,017		(1,539)		(1,539)		25,479				481	01/25/2040
3136AJT97	FNMA REMIC TRUST 2014-29		12/01/2018	PRINCIPAL RECEIPT	XXX	18,700	18,700	19,589	19,499		(798)		(798)		18,700				337	01/25/2044
3136AV6R5	FNMA REMIC TRUST 2017-T1		12/01/2018	PRINCIPAL RECEIPT	XXX	124	124	124	124						124				2	06/25/2027
31358HM28	FNMA SERIES 91100		12/01/2018	PRINCIPAL RECEIPT	XXX	16,732	16,732	18,782	18,063		(1,330)		(1,330)		16,732				588	08/25/2021
491189FC5	KENTUCKY ASSET / LIABILITY COM		04/01/2018	Sink PMT @ 100.0000000	XXX	33,701	33,701	35,042	33,766		(65)		(65)		33,701				533	04/01/2018
880591CS9	TENN VALLEY AUTHORITY		10/12/2018	JP Morgan Asset Mgmt	XXX	125,938	100,000	133,768	130,257		(932)		(932)		129,325		(3,387)	(3,387)	6,125	04/01/2036
88059ENM2	TENNESSEE VALLEY AUTH FED BE		10/15/2018	JP Morgan Asset Mgmt	XXX	180,748	250,000	157,888	174,210		4,480		4,480		178,690		2,058	2,058		07/15/2027
3199999 Subtotal - Bonds - U.S. Special Revenue, Special Assessment						6,283,431	6,327,413	6,527,015	6,216,680		(107,801)		(107,801)		6,411,169		(127,738)	(127,738)	136,375	XXX
Bonds - Industrial and Miscellaneous (Unaffiliated)																				
00440EAK3	ACE INA HOLDINGS		03/15/2018	MATURITY	XXX	120,000	120,000	136,034	120,979		(979)		(979)		120,000				3,480	03/15/2018
00440EAT4	ACE INA HOLDINGS COMPANY GUAR 11/2		10/30/2018	Income Research & Mgmt DQ	XXX	220,787	225,000	227,945	226,816		(512)		(512)		226,304		(5,518)	(5,518)	5,079	11/03/2020
009090AA9	AIR CANADA 2015 1A PTT EQUIPMENT T		09/15/2018	Income Research & Mgmt DQ	XXX	7,479	7,479	7,479	7,479						7,479				70	09/15/2028
02376WAA9	AMER AIRLINES PT TR 2016-1		07/15/2018	PRINCIPAL RECEIPT	XXX	7,179	7,179	7,179	7,179						7,179				76	07/15/2029
02377UAB0	AMERICAN AIRLINES 2013 2		07/15/2018	Income Research & Mgmt DQ	XXX	15,770	15,770	16,933	16,607		(33)		(33)		16,574		(804)	(804)	204	07/15/2024
02377DAA0	AMERICAN AIRLS INC SER 2017-2B		10/15/2018	JP Morgan Asset Mgmt	XXX	5,055	5,055	5,055	5,055						5,055				99	04/15/2027
025816AY5	AMERICAN EXPRESS CO		03/19/2018	MATURITY	XXX	60,000	60,000	69,454	60,649		(649)		(649)		60,000				2,100	03/19/2018
03350WAC3	ANDEAVOR LOG LP & TESORO LOG F		10/16/2018	JP Morgan Asset Mgmt	XXX	48,380	50,000	49,911	49,912		6		6		49,918		(1,538)	(1,538)	1,889	12/01/2027
035242AN6	ANHEUSER BUSCH INBEV FIN COMPANY G		11/08/2018	Income Research & Mgmt DQ	XXX	163,563	171,000	184,577	184,357		(210)		(210)		184,147		(20,584)	(20,584)	10,800	02/01/2046
035242AP1	ANHEUSER BUSCH INBEV FIN COMPANY G		11/08/2018	JP Morgan Asset Mgmt	XXX	94,507	100,000	99,844	99,870		12		12		99,882		(5,375)	(5,375)	4,704	02/01/2026
035242AM8	ANHEUSER BUSCH INBEV FIN INC		11/08/2018	JP Morgan Asset Mgmt	XXX	53,223	55,000	58,026	57,927		(94)		(94)		57,833		(4,610)	(4,610)	3,325	02/01/2036
037411AX3	APACHE CORP		08/22/2018	JP Morgan Asset Mgmt	XXX	23,245	23,000	23,940	23,479		(96)		(96)		23,383		(137)	(137)	887	02/01/2021
04364UAB1	ASCENTIUM EQUIP RECV 2016-2		08/10/2018	PRINCIPAL RECEIPT	XXX	81,286	81,286	81,284	81,288		(1)		(1)		81,286				416	04/10/2019
00206RAJ1	AT&T INC		02/01/2018	MATURITY	XXX	50,000	50,000	55,974	50,154		(154)		(154)		50,000				1,375	02/01/2018
00206RER9	AT&T INC SR GLBL 144A 28		10/16/2018	JP Morgan Asset Mgmt	XXX	66,947	70,000	70,350	70,348		(22)		(22)		70,326		(3,379)	(3,379)	2,527	02/15/2028
05605GAA0	B2R MTG TRUST 2015-2		12/01/2018	PRINCIPAL RECEIPT	XXX	39,582	39,582	39,582	39,582		0		0		39,582				784	11/18/2048
05523UAK6	BAE SYSTEMS HLDGS INC 144A		10/15/2018	Income Research & Mgmt DQ	XXX	141,731	144,000	146,222	145,707		(179)		(179)		145,528		(3,797)	(3,797)	5,624	10/07/2024
06051GFX2	BANK OF AMERICA CORP SR UNSECURED		10/11/2018	Income Research & Mgmt DQ	XXX	211,600	221,000	219,667	101,987		90		90		219,759		(8,159)	(8,159)	8,012	04/19/2026
06406HBP3	BANK OF NEW YORK MELLON		09/27/2018	Income Research & Mgmt DQ	XXX	203,984	200,000	222,942	209,416		(3,361)		(3,361)		206,055		(2,071)	(2,071)	11,066	01/15/2020
05547WAG3	BBCMS MTG TR 2017-GLKS		12/17/2018	JP Morgan Asset Mgmt	XXX	125,000	125,000	125,000	125,000						125,000				3,969	11/15/2034
07384MWN8	BEAR STEARNS ARM TR 2003-5		12/01/2018	PRINCIPAL RECEIPT	XXX	17,849	17,849	17,760	16,588		1,261		1,261		17,849				288	08/25/2033
10112RAU8	BOSTON PROPERTIES LP		10/03/2018	Income Research & Mgmt DQ	XXX	125,210	125,000	129,494	128,045		(421)		(421)		127,624		(2,414)	(2,414)	5,668	02/01/2023
120568AT7	BUNGE LTD FIN CORP		09/10/2018	JP Morgan Asset Mgmt	XXX	26,039	25,000	30,931	26,967		(923)		(923)		26,044		(5)	(5)	1,570	06/15/2019
12189LAS0	BURLINGTN NORTH SANTA FE		10/15/2018	Income Research & Mgmt DQ	XXX	80,054	75,000	81,647	81,273		(103)		(103)		81,170		(1,115)	(1,115)	3,838	04/01/2044
056059AG3	BX COML MTG TR 144A		12/15/2018	PRINCIPAL RECEIPT	XXX	149	149	149							149				0	11/15/2035

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Showing All Long-Term Bonds and Stocks SOLD, REDEEMED, or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change in Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consideration	Par Value	Actual Cost	Prior Year Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in B./A.C.V. (Cols. 11+12-13)	Total Foreign Exchange Change in B./A.C.V.	Book/Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Contractual Maturity Date
14912L4E8	CATERPILLAR FINL SVCS MTNS BE		10/17/2018	Income Research & Mgmt DQ	XXX	131,841	130,000	150,118	137,624		(5,378)		(5,378)		132,246		(405)	(405)	10,922	02/15/2019
17325FAA6	CITIBANK NA N Y		07/18/2018	Income Research & Mgmt DQ	XXX	373,448	375,000	374,693	374,813		83		83		374,896		(1,449)	(1,449)	6,250	03/20/2019
17326CAZ7	CITIGROUP COML MTG TR 2017-B1		10/22/2018	JP Morgan Asset Mgmt	XXX	143,432	150,000	154,495	154,472		(330)		(330)		154,142		(10,711)	(10,711)	4,654	08/17/2050
172967ES6	CITIGROUP INC SR UNSECURED 05/18 6		05/15/2018	MATURITY	XXX	50,000	50,000	55,673	50,751		(751)		(751)		50,000				1,531	05/15/2018
18600TAA0	CLEVELAND CLINIC FOUND UNSECURED 0		10/17/2018	Income Research & Mgmt DQ	XXX	38,475	38,000	35,426	35,429		1		1		35,429		3,046	3,046	2,400	01/01/2114
19624MAA5	COLONY AMERICAN HOMES 2014-2		02/17/2018	PRINCIPAL RECEIPT	XXX	66,150	66,150	65,556	65,806		345		345		66,150				281	07/17/2031
20030NCG4	COMCAST CORP NEW 4.049%52		10/15/2018	Income Research & Mgmt DQ	XXX	86,924	100,000	98,551	98,554		15		15		98,569		(11,645)	(11,645)	4,027	11/01/2052
12623SAE0	COMM MTG TR 2012-CCRE5		10/17/2018	Income Research & Mgmt DQ	XXX	244,117	251,000	251,065	251,057		(9)		(9)		251,048		(6,931)	(6,931)	6,121	12/12/2045
12625UAZ6	COMM MTG TR 2013-CCRE9		06/12/2018	PRINCIPAL RECEIPT	XXX	129,754	129,754	134,539	133,243		(3,489)		(3,489)		129,754				1,018	07/12/2045
12593YBE2	COMM MTG TR 2016-CCRE28		02/07/2018	JP Morgan Asset Mgmt	XXX	153,727	150,000	159,961	159,664		(110)		(110)		159,555		(5,828)	(5,828)	1,066	02/12/2049
12595VAD9	COMM MTG TR 2018-COR3 20510512 FLT		09/26/2018	Income Research & Mgmt DQ	XXX	22,651	22,000	22,659			(18)		(18)		22,641		10	10	380	05/12/2051
20268KAA8	COMMONBOND ST LN TR 2017-B-GS		12/25/2018	PRINCIPAL RECEIPT	XXX	23,861	23,861	23,856	23,856		5		5		23,861				303	09/25/2042
12632DAB8	CPS AUTO RECV TR 2014-B		06/15/2018	PRINCIPAL RECEIPT	XXX	46,989	46,989	46,563	46,775		214		214		46,989				296	05/15/2020
12593XAB1	CPS AUTO TRUST CPS 2016 A B 144A		12/15/2018	PRINCIPAL RECEIPT	XXX	100,000	100,000	99,982	99,994		6		6		100,000				2,245	05/15/2020
126650BY5	CVS HEALTH CORP AMZ 2011 144A 34		12/10/2018	Income Research & Mgmt DQ	XXX	3,561	3,561	4,081	4,080		(11)		(11)		4,069		(508)	(508)	100	01/10/2034
126650BQ2	CVS PASS THROUGH TRUST		12/10/2018	Sink PMT @ 100.0000000	XXX	11,691	11,691	14,158	13,649		(1,958)		(1,958)		11,691				378	01/10/2030
12669GDJ7	CWMBS INC 2004-J8		08/25/2018	PRINCIPAL RECEIPT	XXX	12,666	12,666	12,730	12,697		(30)		(30)		12,666				278	11/25/2019
233851CF9	DAIMLER FINANCE NORTH AM LLC 144A		10/15/2018	Income Research & Mgmt DQ	XXX	148,449	150,000	149,777	149,887		59		59		149,945		(1,496)	(1,496)	2,888	07/05/2019
23317HAC6	DDR CORP		02/12/2018	JP Morgan Asset Mgmt	XXX	30,802	30,000	30,513	30,402		(14)		(14)		30,387		415	415	615	01/15/2021
247367BH7	DELTA AIRLINES PT 2007-1		08/10/2018	PRINCIPAL RECEIPT	XXX	2,464	2,464	2,739			(275)		(275)		2,464					02/10/2024
262074AF4	DRIVE AUTO REC TR 2015-A		12/15/2018	PRINCIPAL RECEIPT	XXX	48,951	48,951	49,012	48,993		(42)		(42)		48,951				747	05/17/2021
26207YAE1	DRIVE AUTO RECV TR 2016-A		01/15/2018	PRINCIPAL RECEIPT	XXX	5,598	5,583	5,583	5,582		16		16		5,598					05/15/2020
26208AAE2	DRIVE AUTO RECV TR 2016-B		04/15/2018	PRINCIPAL RECEIPT	XXX	14,613	14,613	14,613	14,613		0		0		14,613				75	06/15/2020
26208FAH4	DRIVE AUTO RECV TR 2017-2		12/15/2018	PRINCIPAL RECEIPT	XXX	96,543	96,543	96,539	96,534		9		9		96,543				1,709	06/15/2021
23340EAC4	DT AUTO OWNER TR 2015-1		02/15/2018	PRINCIPAL RECEIPT	XXX	2,941	2,939	2,910	2,901		39		39		2,941				7	11/16/2020
23341LAE3	DT AUTO OWNER TRUST 2017-1 144A		12/15/2018	PRINCIPAL RECEIPT	XXX	5,618	5,618	5,617	5,617		1		1		5,618				137	11/15/2022
23341TAC0	DT AUTO OWNER TRUST 2017-2 144A		12/15/2018	PRINCIPAL RECEIPT	XXX	56,065	56,065	56,065	56,065		0		0		56,065				1,130	02/16/2021
30161NAS0	EXELON CORP		10/15/2018	Income Research & Mgmt DQ	XXX	97,869	94,000	93,684	93,692		4		4		93,696		4,173	4,173	4,022	06/15/2045
38141GGS7	GOLDMAN SACHS GROUP INC		10/15/2018	Income Research & Mgmt DQ	XXX	113,311	107,000	124,853	120,689		(2,552)		(2,552)		118,137		(4,826)	(4,826)	7,571	01/24/2022
38141GWC4	GOLDMAN SACHS GROUP INC		10/03/2018	Income Research & Mgmt DQ	XXX	56,676	58,000	57,832	57,859		23		23		57,882		(1,207)	(1,207)	1,639	04/26/2022
38141EA25	GOLDMAN SACHS GRP INC MTN BE		09/24/2018	JP Morgan Asset Mgmt	XXX	76,481	75,000	90,231	79,084		(2,644)		(2,644)		76,440		41	41	6,281	02/15/2019
36192KAT4	GS MTG SECS TR 2012-GCJ7		12/12/2018	PRINCIPAL RECEIPT	XXX	14,307	14,307	14,899	14,832		(526)		(526)		14,307				313	05/12/2045
40414LAD1	HCP INC		07/16/2018	JP Morgan Asset Mgmt	XXX	8,472	8,000	8,947	8,493		(83)		(83)		8,410		62	62	412	02/01/2021
43814PAC4	HONDA AUTO RECV 2017-3		10/17/2018	Income Research & Mgmt DQ	XXX	225,565	229,000	228,975	228,978		10		10		228,988		(3,423)	(3,423)	3,416	09/20/2021
44857TAA6	HYATT HOTEL PORT TR 2017-HYT2		12/16/2018	PRINCIPAL RECEIPT	XXX	100,000	100,000	99,467	99,540		460		460		100,000				2,626	08/16/2032
45866FAB0	INTERCONTINENTALEXCHANGE GROUP		05/30/2018	Income Research & Mgmt DQ	XXX	124,984	125,000	127,540	125,537		(280)		(280)		125,256		(273)	(273)	1,962	10/15/2018
46186YAA2	INVITATION HOMES TR 2015-SFR3		07/19/2018	VARIOUS	XXX	362,821	362,821	363,778	363,536		(660)		(660)		362,876		(55)	(55)	6,480	08/19/2032
478045AA5	JOHN SEVIER COMBINED CYCLE LLC		07/15/2018	Sink PMT @ 100.0000000	XXX	814	814	903	897		(82)		(82)		814				10	01/15/2042
46625HGY0	JP MORGAN CHASE & CO		01/15/2018	MATURITY	XXX	110,000	110,000	124,124	110,171		(171)		(171)		110,000				3,300	01/15/2018
46635TCG5	JP MORGAN CHASE CMBS 2011-C3		12/01/2018	PRINCIPAL RECEIPT	XXX	15,248	15,248	16,651	16,424		(1,176)		(1,176)		15,248				540	02/16/2046
46649CAQ6	JP MORGAN MTG TR 144A		12/25/2018	PRINCIPAL RECEIPT	XXX	3,238	3,244	3,218			20		20		3,238				12	10/25/2048
46650JAD6	JP MORGAN MTG TR 144A		12/01/2018	PRINCIPAL RECEIPT	XXX	13,192	13,192	13,102			90		90		13,192				99	12/25/2048
46646BAE8	JP MORGAN MTG TR 2016-1		12/01/2018	PRINCIPAL RECEIPT	XXX	23,910	23,910	24,590	24,559		(649)		(649)		23,910				365	05/25/2046
46647JAE0	JP MORGAN MTG TR 2016-4		12/01/2018	PRINCIPAL RECEIPT	XXX	13,037	13,037	13,298	13,275		(238)		(238)		13,037				191	10/25/2046

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Showing All Long-Term Bonds and Stocks SOLD, REDEEMED, or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change in Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consideration	Par Value	Actual Cost	Prior Year Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year (Amortization/ Accretion)	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in B./A.C.V. (Cols. 11+12-13)	Total Foreign Exchange Change in B./A.C.V.	Book/Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Contractual Maturity Date
46649HAE2	JP MORGAN MTG TR 2017-6		11/25/2018	VARIOUS	XXX	91,208	93,000	94,235	94,381		(230)		(230)		94,151		(2,943)	(2,943)	2,715	12/25/2048
494550BS4	KINDER MORGAN ENER PART DQ		10/15/2018	Income Research & Mgmt	XXX	124,648	125,000	125,526	125,370		(43)		(43)		125,327		(680)	(680)	6,283	02/01/2024
50116WAB1	KUBOTA CR OWNER TR 2016-1		06/15/2018	PRINCIPAL RECEIPT	XXX	101,963	101,963	101,956	101,960		3		3		101,963				338	04/15/2019
565849AB2	MARATHON OIL CORP		10/16/2018	JP Morgan Asset Mgmt	XXX	75,952	65,000	76,759	75,251		(413)		(413)		74,838		1,114	1,114	4,825	03/15/2032
61748HFE6	MORGAN STANLEY CAP 2004-10AR		12/01/2018	PRINCIPAL RECEIPT	XXX	13,335	13,335	13,351	13,349		(14)		(14)		13,335				200	11/25/2034
55336VAG5	MPLX LP		10/17/2018	JP Morgan Asset Mgmt	XXX	31,006	30,000	31,923	31,730		(176)		(176)		31,554		(549)	(549)	1,292	12/01/2024
553794AC2	MUFG AMERICAS HLDGS CORP SR UNSECU		11/08/2018	JP Morgan Asset Mgmt	XXX	5,000	5,000	4,973	4,980		2		2		4,982		18	18	187	02/10/2025
637432LR4	NATIONAL RURAL UTILS COOP FIN		11/01/2018	VARIOUS	XXX	50,355	50,000	65,893	53,428		(3,051)		(3,051)		50,376		(21)	(21)	4,716	11/01/2018
670346AK1	NUCOR CORP SR UNSECURED 06/18 5.85		06/01/2018	MATURITY	XXX	35,000	35,000	37,470	35,441		(441)		(441)		35,000				1,024	06/01/2018
68267AAA0	ONEMAIN DIRECT AUTO RCV 2016-1		07/15/2018	PRINCIPAL RECEIPT	XXX	15,139	15,139	15,138	15,137		2		2		15,139				89	01/15/2021
68268BAA7	ONEMAIN FINL ISSUE TR 2014-2		01/18/2018	PRINCIPAL RECEIPT	XXX	1,208	1,208	1,209	1,242		(34)		(34)		1,208				2	09/18/2024
68268EAA1	ONEMAIN FINL ISSUE TR 2015-1		12/18/2018	PRINCIPAL RECEIPT	XXX	80,561	80,561	80,363	80,424		138		138		80,561				1,266	03/18/2026
68267JAA1	ONEMAIN FINL ISSUE TR 2015-2		11/18/2018	PRINCIPAL RECEIPT	XXX	44,546	44,546	44,024	44,022		524		524		44,546				445	07/18/2025
74332MAA3	PROGRESS RESI TR 2015-SFR2		12/15/2018	PRINCIPAL RECEIPT	XXX	220	220	220	220						220				1	06/14/2032
74332NAA1	PROGRESS RESI TR 2015-SFR3		12/14/2018	PRINCIPAL RECEIPT	XXX	57	57	57	57						57				1	11/15/2032
756109AS3	REALTY INCOME CORP		10/17/2018	JP Morgan Asset Mgmt	XXX	27,513	30,000	28,032	28,166		137		137		28,303		(790)	(790)	1,135	01/15/2027
80284CAF9	SANTANDER DRIVE AUTO 2015-1		12/15/2018	PRINCIPAL RECEIPT	XXX	79,303	79,303	79,477	79,378		(74)		(74)		79,303				1,001	04/15/2021
784012AA4	SCF EQUIP TR LLC 2017-2 20231220		12/20/2018	PRINCIPAL RECEIPT	XXX	33,001	33,001	32,995	32,996		5		5		33,001				569	12/20/2023
81746DAD2	SEQUOIA MTG TR 2017-5		12/01/2018	PRINCIPAL RECEIPT	XXX	18,724	18,724	19,157	19,149		(424)		(424)		18,724				269	08/25/2047
81746FAD7	SEQUOIA MTG TR 2017-6		11/25/2018	VARIOUS	XXX	107,201	109,396	112,489	112,606		(454)		(454)		112,152		(4,951)	(4,951)	3,175	09/25/2047
84474YAA4	SOUTHWEST AIRLINES 2007-1		08/01/2018	PRINCIPAL RECEIPT	XXX	22,591	22,591	26,065	25,031		(2,440)		(2,440)		22,591				395	02/01/2024
84755TAE7	SPECTRA ENERGY CAPITAL COMPANY GUA		03/27/2018	JP Morgan Asset Mgmt	XXX	30,584	30,000	28,267	28,804		50		50		28,854		1,730	1,730	528	03/15/2023
84861CAC9	SPIRIT MASTER FDG LLC 2017-1 144A		12/01/2018	PRINCIPAL RECEIPT	XXX	588	274	275			313		313		588				(6)	12/20/2047
86212VAD6	STORE MSTR FDG 144A		12/20/2018	PRINCIPAL RECEIPT	XXX	699	699	699			0		0		699				2	10/20/2048
86358HTZ2	STRUCTURED ASSET MTG 2003-AR2		12/01/2018	PRINCIPAL RECEIPT	XXX	45,748	45,748	45,062	45,115		633		633		45,748				772	12/19/2033
86359LEW5	STRUCTURED ASSET MTG 2004-AR6		12/19/2018	PRINCIPAL RECEIPT	XXX	7,314	7,314	6,774	6,681		633		633		7,314				102	02/19/2035
90269GAC5	UBS COML MTG TR 2012-C1		12/12/2018	VARIOUS	XXX	290,511	291,788	304,576	304,032		(2,290)		(2,290)		301,743		(11,232)	(11,232)	8,736	05/12/2045
90276GAS1	UBS COML MTG TR 2017-C3		10/22/2018	JP Morgan Asset Mgmt	XXX	143,303	150,000	154,496	154,532		(335)		(335)		154,197		(10,894)	(10,894)	4,611	08/17/2050
90932PAA6	UNITED AIR 2014 1 A PTT DQ		10/11/2018	Income Research & Mgmt	XXX	17,545	17,545	17,896	17,827		(13)		(13)		17,814		(269)	(269)	193	10/11/2027
91913YAN0	VALERO ENERGY CORP NEW DQ		06/18/2018	Income Research & Mgmt	XXX	104,930	100,000	126,778	107,825		(2,978)		(2,978)		104,847		83	83	7,109	03/15/2019
92211MAC7	VANTAGE DATA CTR 144A		12/15/2018	PRINCIPAL RECEIPT	XXX	208	208	208							208				3	02/16/2043
92343VBC7	VERIZON COMMUNICATIONS INC		06/15/2018	JP Morgan Asset Mgmt	XXX	96,660	95,000	97,894	96,942		(220)		(220)		96,722		(62)	(62)	2,124	11/01/2021
92343VCX0	VERIZON COMMUNICATIONS INC DQ		10/04/2018	Income Research & Mgmt	XXX	54,119	58,000	57,520	57,536		5		5		57,541		(3,423)	(3,423)	2,798	09/15/2048
92343VER1	VERIZON COMMUNICATIONS INC		06/15/2018	JP Morgan Asset Mgmt	XXX	169	169	167							167		2	2		09/21/2028
931427AH1	WALGREENS BOOTS ALLIANCE SR UNSECU		10/17/2018	JP Morgan Asset Mgmt	XXX	24,414	25,000	25,881	25,657		(68)		(68)		25,589		(1,175)	(1,175)	873	11/18/2024
95000XAF4	WELLS FARGO CO MTG TR 2017-C39		10/22/2018	JP Morgan Asset Mgmt	XXX	143,080	150,000	156,047	155,874		(441)		(441)		155,434		(12,354)	(12,354)	4,600	09/16/2050
92935JBC8	WFRBS COML MTG TR 2011-C2		12/01/2018	PRINCIPAL RECEIPT	XXX	4,370	4,370	4,918	4,840		(471)		(471)		4,370				98	02/18/2044
92938JAB8	WFRBS COML MTG TR 2013-UBS1		12/01/2018	VARIOUS	XXX	146,454	146,454	151,603	150,212		(3,734)		(3,734)		146,478		(24)	(24)	3,267	03/16/2046
96221TAE7	WFRBS COML MTG TR 2014-LC14		10/22/2018	JP Morgan Asset Mgmt	XXX	151,998	150,000	160,025	158,005		(998)		(998)		157,007		(5,009)	(5,009)	5,444	03/15/2047
06367TYL8	BANK OF MONTREAL	A	10/15/2018	Income Research & Mgmt DQ	XXX	95,397	97,000	96,991	96,993		2		2		96,995		(1,599)	(1,599)	1,709	06/15/2020
3899999 Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						7,716,494	7,761,983	8,058,335	7,752,477		(43,341)		(43,341)		7,870,034		(153,540)	(153,540)	239,536	XXX
8399997 Subtotal - Bonds - Part 4						23,126,491	23,646,541	24,167,130	23,061,514	(2,589)	(188,803)		(191,391)		23,800,800		(674,309)	(674,309)	537,739	XXX
8399998 Summary Item from Part 5 for Bonds						2,351,955	2,580,056	2,585,864			1,276		1,276		2,587,141		(235,185)	(235,185)	25,232	XXX
8399999 Subtotal - Bonds						25,478,447	26,226,597	26,752,995	23,061,514	(2,589)	(187,526)		(190,115)		26,387,941		(909,494)	(909,494)	562,971	XXX
9999999 Totals						25,478,447	XXX	26,752,995	23,061,514	(2,589)	(187,526)		(190,115)		26,387,941		(909,494)	(909,494)	562,971	XXX

SCHEDULE D - PART 5

Showing All Long-Term Bonds and Stocks ACQUIRED During Year and Fully DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	11	Change in Book/Adjusted Carrying Value					17	18	19	20	21
											12	13	14	15	16					
CUSIP Identification	Description	FOREIGN	Date Acquired	Name of Vendor	Disposal Date	Name of Purchaser	Par Value (Bonds) or Number of Shares (Stock)	Actual Cost	Consideration	Book/ Adjusted Carrying Value at Disposal	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in B./A.C.V. (Col. 12+ 13-14)	Total Foreign Exchange Change in B./A.C.V.	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Interest and Dividends Received During Year	Paid for Accrued Interest and Dividends
Bonds - U.S. Governments																				
36179RZV4	GNMA PASS-THRU M SINGLE FAMILY		10/17/2018	Income Research & Mgmt DQ	11/01/2018	Income Research & Mgmt DQ	81,487	84,071	84,071	84,071									183	183
3622AAAE4	GNMA PASS-THRU X PLATINUM 30YR		10/24/2018	Income Research & Mgmt DQ	11/01/2018	Income Research & Mgmt DQ	45,000	46,751	46,751	46,751									101	101
83162CZL0	SMALL BUSINESS ADMINISTRATION		05/10/2018	Income Research & Mgmt DQ	10/17/2018	Income Research & Mgmt DQ	152,000	152,000	149,851	152,000							(2,149)	(2,149)	2,246	
912810SA7	UNITED STATES TREAS BDS		06/28/2018	Income Research & Mgmt DQ	10/17/2018	Income Research & Mgmt DQ	66,000	66,284	61,723	66,282		(2)		(2)			(4,559)	(4,559)	1,334	749
9128283F5	UNITED STATES TREAS NTS		01/29/2018	JP Morgan Asset Mgmt	10/04/2018	JP Morgan Asset Mgmt	335,000	321,901	310,464	322,702		801		801			(12,238)	(12,238)	6,698	1,582
9128283U2	UNITED STATES TREAS NTS		04/27/2018	Income Research & Mgmt DQ	10/12/2018	Income Research & Mgmt DQ	615,000	606,874	604,070	607,450		576		576			(3,380)	(3,380)	7,682	2,312
9128284P2	UNITED STATES TREAS NTS		09/14/2018	Income Research & Mgmt DQ	10/17/2018	Income Research & Mgmt DQ	225,000	223,805	223,181	223,844		39		39			(663)	(663)	2,504	2,006
9128284S6	UNITED STATES TREAS NTS		05/30/2018	Income Research & Mgmt DQ	10/12/2018	Income Research & Mgmt DQ	234,000	234,795	232,856	234,766		(29)		(29)			(1,910)	(1,910)	1,279	18
9128284V9	UNITED STATES TREAS NTS		09/20/2018	JP Morgan Asset Mgmt	12/17/2018	JP Morgan Asset Mgmt	160,000	157,213	160,150	157,270		58		58			2,880	2,880	1,563	463
0599999 Subtotal - Bonds - U.S. Governments							1,913,487	1,893,693	1,873,116	1,895,135		1,442		1,442			(22,019)	(22,019)	23,590	7,415
Bonds - U.S. Special Revenue, Special Assessment																				
31335BLX2	FHLMC PC GOLD COMB 30		01/17/2018	Income Research & Mgmt DQ	02/13/2018	Income Research & Mgmt DQ	151,805	162,004	162,004	162,004									228	228
31396AGC2	FHLMC REMIC SERIES 3028		10/15/2018	JP Morgan Asset Mgmt	11/15/2018	VARIOUS	595	595	595	595									(3)	
31410LTX0	FNMA PASS-THRU LNG 30 YEAR 4.000 2		09/24/2018	Income Research & Mgmt DQ	11/25/2018	VARIOUS	266,169	270,328	270,328	270,328									737	296
3199999 Subtotal - Bonds - U.S. Special Revenue, Special Assessment							418,569	432,927	432,927	432,927									962	523
Bonds - Industrial and Miscellaneous (Unaffiliated)																				
035242AN6	ANHEUSER BUSCH INBEV FIN COMPANY G		10/04/2018	Income Research & Mgmt DQ	11/08/2018	Income Research & Mgmt DQ	48,000	47,056	45,912	47,057		2		2			(1,145)	(1,145)	679	444
694308GE1	PACIFIC GAS & ELEC CO		09/04/2018	JP Morgan Asset Mgmt	12/31/2018	JP Morgan Core Bond	100,000	112,472	0	112,295		(177)		(177)			(112,295)	(112,295)		84
694308JA6	PACIFIC GAS & ELEC CO 144A		08/02/2018	JP Morgan Asset Mgmt	12/31/2018	JP Morgan Asset Mgmt	100,000	99,716		99,725		9		9			(99,725)	(99,725)		
3899999 Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)							248,000	259,244	45,912	259,078		(166)		(166)			(213,166)	(213,166)	679	528
8399998 Subtotal - Bonds							2,580,056	2,585,864	2,351,955	2,587,141		1,276		1,276			(235,185)	(235,185)	25,232	8,467
9999999 Totals								2,585,864	2,351,955	2,587,141		1,276		1,276			(235,185)	(235,185)	25,232	8,467

SCHEDULE D - PART 6 - SECTION 1

Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

1	2	3	4	5	6	7	8	9	10	Stock of Such Company Owned by Insurer on Statement Date	
										11	12
CUSIP Identification	Description Name of Subsidiary, Controlled or Affiliated Company	Foreign	NAIC Company Code	ID Number	NAIC Valuation Method	Do Insurer's Assets Include Intangible Assets connected with Holding of Such Company's Stock?	Total Amount of Such Intangible Assets	Book/Adjusted Carrying Value	Nonadmitted Amount	Number of Shares	% of Outstanding
Preferred Stocks - Parent											
						No					
0199999 Subtotal - Preferred Stocks - Parent										XXX	XXX
Preferred Stocks - Other Affiliates											
						No					
0899999 Subtotal - Preferred Stocks - Other Affiliates										XXX	XXX
0999999 Subtotal - Preferred Stocks										XXX	XXX
Common Stocks - U.S. Property & Casualty Insurer											
						No					
1199999 Subtotal - Common Stocks - U.S. Property & Casualty Insurer										XXX	XXX
Common Stocks - U.S. Life Insurer											
						No					
1299999 Subtotal - Common Stocks - U.S. Life Insurer										XXX	XXX
Common Stocks - U.S. Health Entity											
000000000	DSM USA Insurance Co, Inc		67636			Yes	3,009,260	9,163,401		1,208,599.000	100.000
1399999 Subtotal - Common Stocks - U.S. Health Entity							3,009,260	9,163,401		XXX	XXX
Common Stocks - Other Affiliates											
						No					
1799999 Subtotal - Common Stocks - Other Affiliates										XXX	XXX
1899999 Subtotal - Common Stocks							3,009,260	9,163,401		XXX	XXX
1999999 Total - Preferred and Common Stocks							3,009,260	9,163,401		XXX	XXX

1. Amount of insurer's capital and surplus from the prior period's statutory statement reduced by any admitted EDP, goodwill and net deferred tax assets included therein: $.....0.
2. Total amount of intangible assets nonadmitted $.....0.

SCHEDULE D - PART 6 - SECTION 2

1	2	3	4	Stock in Lower-Tier Company Owned Indirectly by Insurer on Statement Date	
				5	6
CUSIP Identification	Name of Lower-Tier Company	Name of Company Listed in Section 1 Which Controls Lower-Tier Company	Total Amount of Intangible Assets Included in Amount Shown in Column 8, Section 1	Number of Shares	% of Outstanding
0399999 Total - Preferred and Common Stocks				XXX	XXX

SCHEDULE DA - PART 1

Showing all SHORT-TERM INVESTMENTS Owned December 31 of Current Year

1	Codes		4	5	6	7	Change in Book/Adjusted Carrying Value				12	13	Interest						20
	2	3					8	9	10	11			14	15	16	17	18	19	
Description	Code	For-eign	Date Acquired	Name of Vendor	Maturity Date	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Par Value	Actual Cost	Amount Due and Accrued Dec. 31 of Current Year on Bond Not in Default	Non-Admitted Due and Accrued	Rate of	Effective Rate of	When Paid	Amount Received During Year	Paid For Accrued Interest
8399999 Total Bonds															XXX	XXX	XXX		
Other Short-Term Invested Assets																			
SSFA MMF			04/15/2010		12/31/2019	100,000													
STATE STR INSTL INVT TR			01/10/2012		12/31/2019	10,355													
9099999 Subtotal - Other Short-Term Invested Assets						110,355					XXX				XXX	XXX	XXX		
9199999 Total Short-Term Investments						110,355					XXX				XXX	XXX	XXX		

E18 Schedule DB - Part A Sn 1 Opt/Cap/Floors/Collars/Swaps/Forwards Open . . . . NONE

E19 Schedule DB - Part A Sn 2 Opt/Cap/Floors/Collars/Swaps/Forwards Term. . . . NONE

E20 Schedule DB - Part B Sn 1 Futures Contracts Open . . . . . NONE

E21 Schedule DB - Part B Sn 2 Futures Contracts Terminated . . . . . NONE

E22 Schedule DB - Part D Sn 1 Counterparty Exposure for Derivative Instruments . NONE

E23 Schedule DB - Part D Sn 2 - Collateral Pledged By Reporting Entity . . . . . NONE

E23 Schedule DB - Part D Sn 2 - Collateral Pledged To Reporting Entity . . . . . NONE

E24 Schedule DL - Part 1 - Securities Lending Collateral Assets . . . . . NONE

E25 Schedule DL - Part 2 - Securities Lending Collateral Assets . . . . . NONE

SCHEDULE E - PART 1 - CASH

1 Depository			2 Code	3 Rate of Interest	4 Amount of Interest Received During Year	5 Amount of Interest Accrued December 31 of Current Year	6 Balance	7 *
open depositories								
Bank of America	Account #004622846813						50,425,985	X X X
Bank of America	Account #002220017095						(7,601,357)	X X X
Wells Fargo	Account # 4123536294						633,216	X X X
Santander Savings	Account # 9997064291						11,319,166	X X X
Texas Treasury Safekeeping Trust Company	Account #693		SD				5,183,000	X X X
Dreyfus Cash Management	996085254		SD				101,000	X X X
0199998 Deposits in .....0 depositories that do not exceed the allowable limit in any one depository (See Instructions) - open depositories				X X X				X X X
0199999 Totals - Open Depositories				X X X			60,061,010	X X X
0299998 Deposits in .....0 depositories that do not exceed the allowable limit in any one depository (See Instructions) - suspended depositories				X X X				X X X
0299999 Totals - Suspended Depositories				X X X				X X X
0399999 Total Cash On Deposit				X X X			60,061,010	X X X
0499999 Cash in Company's Office				X X X	X X X	X X X		X X X
0599999 Total Cash				X X X			60,061,010	X X X

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR

1. January	77,373,029	4. April	30,381,581	7. July	59,794,768	10. October	39,541,932
2. February	78,763,853	5. May	65,961,231	8. August	50,402,875	11. November	61,134,971
3. March	63,694,445	6. June	73,923,863	9. September	61,416,574	12. December	60,061,010

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned December 31 of Current Year

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due & Accrued	9 Amount Received During Year
All Other Money Market Mutual Funds								
857492599	STATE STR INSTL INVT TR		12/31/2018	0.000	X X X	1,557,938	0	15,741
8699999 Subtotal - All Other Money Market Mutual Funds						1,557,938	0	15,741
8899999 Total Cash Equivalents						1,557,938	0	15,741

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

States, Etc.	1 Type of Deposit	2 Purpose of Deposit	Deposits For the Benefit of All Policyholders 3 Book/Adjusted Carrying Value	 4 Fair Value	All Other Special Deposits 5 Book/Adjusted Carrying Value	 6 Fair Value
1. Alabama (AL)						
2. Alaska (AK)						
3. Arizona (AZ)						
4. Arkansas (AR)						
5. California (CA)						
6. Colorado (CO)						
7. Connecticut (CT)						
8. Delaware (DE)						
9. District of Columbia (DC)						
10. Florida (FL)						
11. Georgia (GA)	ST	Security deposit to meet regulatory requirements	100,000	100,000		
12. Hawaii (HI)						
13. Idaho (ID)						
14. Illinois (IL)						
15. Indiana (IN)						
16. Iowa (IA)						
17. Kansas (KS)						
18. Kentucky (KY)						
19. Louisiana (LA)						
20. Maine (ME)						
21. Maryland (MD)						
22. Massachusetts (MA)	ST	Satisfy Surplus Requirement per State of MA	101,000	101,000		
23. Michigan (MI)						
24. Minnesota (MN)						
25. Mississippi (MS)						
26. Missouri (MO)						
27. Montana (MT)						
28. Nebraska (NE)						
29. Nevada (NV)	B	Satisfy Surplus Requirement per State of MA	243,245	243,245		
30. New Hampshire (NH)						
31. New Jersey (NJ)						
32. New Mexico (NM)						
33. New York (NY)						
34. North Carolina (NC)	B	Satisfy Surplus Requirement per State of NC	437,678	437,678		
35. North Dakota (ND)						
36. Ohio (OH)						
37. Oklahoma (OK)						
38. Oregon (OR)						
39. Pennsylvania (PA)						
40. Rhode Island (RI)						
41. South Carolina (SC)						
42. South Dakota (SD)						
43. Tennessee (TN)						
44. Texas (TX)	O	Satisfy Surplus Requirement per State of Texas; pledging arrangement	5,183,000	5,183,000		
45. Utah (UT)						
46. Vermont (VT)						
47. Virginia (VA)						
48. Washington (WA)						
49. West Virginia (WV)						
50. Wisconsin (WI)						
51. Wyoming (WY)						
52. American Samoa (AS)						
53. Guam (GU)						
54. Puerto Rico (PR)						
55. U.S. Virgin Islands (VI)						
56. Northern Mariana Islands (MP)						
57. Canada (CAN)						
58. Aggregate Alien and Other (OT)	XXX	XXX				
59. TOTAL	XXX	XXX	6,064,923	6,064,923		
DETAILS OF WRITE-INS						
5801.						
5802.						
5803.						
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX				
5899. TOTALS (Lines 5801 through 5803 plus 5898) (Line 58 above)	XXX	XXX				

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INDEX TO HEALTH ANNUAL STATEMENT

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

FORM 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2018
OR
☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from _____ to _____
Commission file number 001-38769

CIGNA CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**82-4991898**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
900 Cottage Grove Road, Bloomfield, Connecticut	**06002**
(Address of principal executive offices)	*(Zip Code)*

(860) 226-6000
Registrant's telephone number, including area code
(860) 226-6741 or 215-761-5511
Registrant's facsimile number, including area code

SECURITIES REGISTERED PURSUANT TO SECTION 12(B) OF THE ACT:	
Title of each class	Name of each exchange on which registered
Common Stock, Par Value $0.01	**New York Stock Exchange, Inc.**

SECURITIES REGISTERED PURSUANT TO SECTION 12(G) OF THE ACT:
NONE

Indicate by check mark	**Yes**	**No**
• if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.	☑	☐
• if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act	☐	☑
• whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days	☑	☐
• whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files)	☑	☐
• if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K	☐	

• whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

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

• If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.	☐	
• whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).	☐	☑

The aggregate market value of the voting stock held by non-affiliates of the registrant as of June 30, 2018 was approximately $41.2 billion. As of January 31, 2019, 380,058,967 shares of the registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Form 10-K incorporates by reference information from the registrant's definitive proxy statement related to the 2019 annual meeting of shareholders.

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FREQUENTLY REQUESTED 10-K INFORMATION

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PART III

PART IV

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements are based on Cigna's current expectations and projections about future trends, events and uncertainties. These statements are not historical facts. Forward-looking statements may include, among others, statements concerning future financial or operating performance, including our ability to deliver affordable, personalized and innovative solutions for our customers and clients; future growth, business strategy, strategic or operational initiatives; economic, regulatory or competitive environments, particularly with respect to the pace and extent of change in these areas; financing or capital deployment plans and amounts available for future deployment; our prospects for growth in the coming years; the merger ("Merger") with Express Scripts Holding Company; and other statements regarding Cigna's future beliefs, expectations, plans, intentions, financial condition or performance. You may identify forward-looking statements by the use of words such as "believe," "expect," "plan," "intend," "anticipate," "estimate," "predict," "potential," "may," "should," "will" or other words or expressions of similar meaning, although not all forward-looking statements contain such terms.

Forward-looking statements are subject to risks and uncertainties, both known and unknown, that could cause actual results to differ materially from those expressed or implied in forward-looking statements. Such risks and uncertainties include, but are not limited to: our ability to achieve our financial, strategic and operational plans or initiatives; our ability to predict and manage medical and pharmacy costs and price effectively; our ability to adapt to changes or trends in an evolving and rapidly changing industry; our ability to effectively differentiate our products and services from those of our competitors and maintain or increase market share; our ability to develop and maintain good relationships with physicians, hospitals, other health care providers and pharmaceutical manufacturers; changes in drug pricing; the impact of modifications to our operations and processes; our ability to identify potential strategic acquisitions or transactions and realize the expected benefits (including anticipated synergies) of such transactions in full or within the anticipated time frame, including with respect to the Merger, as well as our ability to integrate operations, resources and systems; the substantial level of government regulation over our business and the potential effects of new laws or regulations or changes in existing laws or regulations; the outcome of litigation, regulatory audits, investigations, actions and/or guaranty fund assessments; uncertainties surrounding participation in government-sponsored programs such as Medicare; the effectiveness and security of our information technology and other business systems; the impact of our debt service obligations on the availability to funds for other business purposes; unfavorable industry, economic or political conditions, including foreign currency movements; acts of war, terrorism, natural disasters or pandemics; as well as more specific risks and uncertainties discussed in Part I, Item 1A—Risk Factors and Part II, Item 7—Management's Discussion and Analysis of Financial Condition and Results of Operations of this Form 10-K and as described from time to time in our future reports filed with the Securities and Exchange Commission (the "SEC").

You should not place undue reliance on forward-looking statements that speak only as of the date they are made, are not guarantees of future performance or results, and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Cigna undertakes no obligation to update or revise any forward-looking statement, whether as a result of new information, future events or otherwise, except as may be required by law.

PART I

ITEM 1. Business

Overview

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us") is a global health service organization.

Our revenues are derived principally from premiums on insured products, fees for products and services provided to self-insured plans, pharmacy sales, and investment income. In 2018, our revenues were $48.7 billion and shareholders' net income was $2.6 billion. As described more fully in Note 3 to the Consolidated Financial Statements on page 80 of this Annual Report on Form 10-K ("Form 10-K"), on March 8, 2018, we entered into a merger agreement with Express Scripts Holding Company ("Express Scripts"). The results of Express Scripts have been included in the Company's Consolidated Financial Statements from the date of acquisition. As of December 31, 2018, total assets were $153.2 billion and shareholders' equity was $41.0 billion.

Our combination with Express Scripts creates an enterprise uniquely capable of transforming health care. We now have broader and deeper capabilities, along with meaningful synergies, that accelerate our "Go" strategy to achieve our mission of improving the health, well-being and peace of mind of those we serve. Cigna's employees are champions of the people we serve and over the past decade, our focus has shifted to helping people thrive by offering solutions to prevent and better manage health challenges. When sickness or disability do occur, we support our customers' ability to have broad choices in how they best access high quality, affordable care. We maximize use of evidence-based care,

while delivering best-in-class quality of care for our customers with acute and chronic conditions through enhanced real time data across an expanded platform with industry-leading solutions to support care decisions.

Cigna offers a differentiated set of medical, pharmacy, behavioral, dental, disability, life and accident insurance and related products and services. By combining with Express Scripts, Cigna's expanded capabilities now include: 1) a broader portfolio of specialty services, some of which can be offered on a stand-alone basis; 2) integrated behavioral, medical and pharmacy management services; 3) leading specialty pharmacy expertise; and 4) advanced analytics that help us engage more meaningfully with individuals, plan sponsors we serve, and our provider partners. These capabilities accelerate Cigna's ability to drive improved cost affordability, quality of care and predictability.

Following entry into the merger agreement and throughout the pendency of the transaction, Cigna and Express Scripts designed integration plans to implement a new management and business reporting structure for the combined company upon closing. On December 20, 2018, Cigna completed the acquisition of Express Scripts. As a result, effective in the fourth quarter of 2018 our segments have changed to the following: 1) Integrated Medical, consisting of both a Commercial operating segment that includes our employer-sponsored medical coverage and a Government operating segment that includes Medicare offerings for seniors and individual insurance offerings to non-seniors both on and off the public health insurance exchanges; 2) Health Services, consisting primarily of Cigna's legacy home delivery pharmacy business and Express Scripts' pharmacy benefit management ("PBM") business beginning December 21, 2018; and 3) International Markets, that offers global supplemental benefits and global medical solutions. The remainder of our business is reported in Group Disability and Other, consisting of our group disability and life business together with our corporate owned life insurance ("COLI") business and run-off operations. See Note 1 to the Consolidated Financial Statements on page 72 of this Form 10-K for additional description of our segments. Among our segments, Cigna has four core growth platforms: Commercial, Government, Health Services and International Markets.

As individuals become increasingly involved in their health care purchasing decisions, Cigna continues to focus on delivering **affordable** and **personalized** products and services to customers through employer-based, government-sponsored, health plan client and individual coverage arrangements. In our Integrated Medical business, we collaborate with health care providers to accelerate the transition from volume-based, fee-for-service reimbursement arrangements to a value-based reimbursement model that delivers higher quality of care, lower costs and better health outcomes. We have worked toward achieving better health, affordability, localization and an improved patient experience through increased collaborative care and delivery arrangements with health care providers across the care delivery spectrum, including physician groups of all sizes, specialist groups and hospitals. We have also developed innovative tools and flexible provider arrangements that provide a truly personalized customer experience. These arrangements and tools are discussed in more detail in the "Integrated Medical" section of this Form 10-K that begins on page 3.

Our Health Services business puts medicine within reach for patients, and helps providers improve access to prescription drugs by making them more affordable. We improve patient outcomes and better manage the cost of the pharmacy benefit by:

- Delivering the best care available for those taking prescription medicines;
- Assessing drugs based on efficacy, value and price to assist clients in selecting the most cost-effective formulary;
- Offering cost-effective home delivery pharmacy and specialty services that result in cost savings for plan sponsors and better care for customers;
- Leveraging purchasing volume to deliver discounts to employers and other groups, resulting in leading prescription drug cost trend; and
- Promoting the use of generic and lower-cost brands.

We also work with key stakeholders across the health care system to improve health outcomes and patient satisfaction, increase efficiency in drug distribution and manage costs of the pharmacy benefit. We believe plan sponsors and participants can achieve the best health and financial outcomes when they use our comprehensive set of solutions to manage drug spend.

The ACA and Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively referred to throughout this Form 10-K as the "ACA" or "PPACA") continues to have a significant impact on our business operations. The future of the ACA is uncertain due to recent court decisions, congressional efforts to repeal and replace the ACA, various executive actions of the current administration, and repeal of the individual mandate as part of H.R.1, An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (referred to throughout this Form 10-K as the "Tax Cuts and Jobs Act" or "U.S. tax reform legislation"). The effects of the ACA, and efforts to repeal and replace it, are discussed throughout this Form 10-K where appropriate, including in the Integrated Medical business description, Regulation, Risk Factors, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), and the Notes to the Consolidated Financial Statements.

Other Information

The financial information included in this Form 10-K for the fiscal year ended December 31, 2018 is in conformity with accounting principles generally accepted in the United States of America ("GAAP") unless otherwise indicated. In the segment discussions that follow, we use the terms "adjusted revenues" and "pre-tax adjusted income from operations" to describe segment results. See the introduction to the MD&A on page 42 of this Form 10-K for definitions of those terms. Industry rankings and percentages set forth herein are for the year ended December 31, 2018 unless otherwise indicated. In addition, statements set forth in this document concerning our rank or position in an industry or particular line of business have been developed internally based on publicly available information unless otherwise noted.

Cigna Holding Company (formerly Cigna Corporation) was incorporated in Delaware in 1981. Halfmoon Parent, Inc. was incorporated in Delaware in March 2018. Halfmoon Parent, Inc. was renamed Cigna Corporation concurrently with the consummation of the combination with Express Scripts. Our annual, quarterly and current reports, proxy statements and other filings, and any amendments to these filings, are made available free of charge on our website (http://www.cigna.com, under the "Investors – Quarterly Reports and SEC Filings" captions) as soon as

reasonably practicable after we electronically file these materials with, or furnish them to, the Securities and Exchange Commission (the "SEC"). We use our website as a channel of distribution for material company information. Important information, including news releases, analyst presentations and financial information regarding Cigna is routinely posted on and accessible at http://www.cigna.com. See "Code of Ethics and Other Corporate Governance Disclosures" in Part III, Item 10 beginning on page 131 of this Form 10-K for additional information available on our website.

Integrated Medical

Integrated Medical consists of a Commercial operating segment that includes our employer-sponsored medical coverage and a Government operating segment that includes Medicare offerings for seniors and individual insurance offerings to non-seniors both on and off the public health insurance exchanges. In 2018, Integrated Medical reported adjusted revenues of $32.8 billion and pre-tax adjusted income from operations of $3.5 billion.

How We Win
• **Broad and deep portfolio of solutions** across Commercial and Government operating segments
• **Commitment** to highest quality health outcomes and customer experiences
• **Collaborative** physician engagement models emphasizing value over volume of services
• **Integrated benefit solutions** that deliver value for our customers, clients and partners
• **Technology and data analytics** powering actionable insights and affordable, personalized solutions
• **Talented and caring people** embracing change and putting customers at the center of all we do

We differentiate ourselves by providing innovative, personalized, and affordable health care benefit solutions based on the unique needs of the individuals and clients we serve. We increase value through our integrated approach and use of technology and data analytics to enhance patient engagement and health care outcomes, underscoring our strategic focus on delivering an industry-leading customer experience. We continue to strengthen our partnerships with providers as we accelerate our transition to a value-based reimbursement system.

We offer a mix of core health insurance products and services to employers, other groups and individuals along with specialty products and services designed to improve the quality of care, lower cost and help customers achieve better health outcomes. Many of these products are available on a standalone basis, but we believe they are most valuable when integrated with a Cigna-administered health plan. Our products are available through several distribution channels including brokers, direct sales, and public and private exchanges. Our three funding solutions (i.e., insured – experience-rated, insured – guaranteed cost, and administrative services only ("ASO") arrangements) enable us to customize the amount of risk taken by, and lower costs for, our customers and clients.

The following chart depicts a high level summary of our principal products and services in this segment as of year-end, with definitions on subsequent pages.

Principal Products & Services	*Major Brand(s)*	*Geography*	*Funding Solution(s)*	*Market Segment(s)*	*Primary Distribution Channel(s)*	*Primary Competitors*
Commercial Medical						
Managed Care	Cigna HealthCare	Nationwide	Insured (experience-rated ("ER"), guaranteed cost ("GC")) and ASO	Commercial	Brokers, Private Exchanges, Direct	National Insurers, Local Healthplans, Third-Party Administrators ("TPAs")
Preferred Provider ("PPO")	Cigna	Nationwide				National Insurers, TPAs
Consumer-Driven	Cigna	Nationwide				National Insurers, Local Health Maintenance Organizations ("HMOs")
Government Medical						
Individual and Family Plans	Cigna Connect	10 states	GC	Individual	Public and Private Exchanges	Local Healthplans, Start-ups, National Insurers
Medicare Advantage	Cigna-HealthSpring	17 states	GC	Government	Direct, Brokers	National Insurers, Local Healthplans
Medicare Part D	Cigna-HealthSpring, Express Scripts	Nationwide	GC	Government	Direct, Brokers	National Insurers
Medicaid	Cigna-HealthSpring	Texas	GC	Government	Direct, Brokers	National Insurers
Medicare Supplement	Cigna	48 states & District of Columbia	GC	Government	Brokers, Direct, Private Exchanges	National Insurers
Specialty Products and Services						
Stop-Loss	Cigna	Nationwide	GC	Commercial	Brokers, Direct	National Insurers, Specialty Companies
Cost-Containment	Cigna	Nationwide	GC, ER, ASO	Commercial	Direct	National Insurers, Specialty Companies
Consumer Health Engagement	Cigna	Nationwide	GC, ER, ASO	Commercial, Government	Brokers, Direct	National Insurers, Specialty Companies
Pharmacy Management	Cigna	Nationwide	GC, ER, ASO	Commercial, Government	Brokers, Direct	National PBMs
Behavioral Health	Cigna Behavioral Health	Nationwide	GC, ER, ASO	Commercial	Brokers, Direct	National Insurers, Specialty Companies
Dental	Cigna Dental HealthCare	Nationwide	GC, ER, ASO	Commercial, Individual	Brokers, Direct	Dental Insurers, National Insurers
Vision	Cigna Vision	Nationwide	GC, ER, ASO	Commercial, Individual	Brokers, Direct	National Insurers, Specialty Companies

Principal Products & Services

Commercial Medical

- ***Managed Care Plans*** These plans are offered through our insurance companies, HMOs and TPA companies. HMO, Network Open Access and Open Access Plus plans use meaningful cost-sharing incentives to encourage the use of "in-network" versus "out-of-network" health care providers. The national provider network for Managed Care Plans is somewhat smaller than the national network used with the preferred provider ("PPO") plan product line.
- ***PPO Plans*** feature a network with broader provider access than the Managed Care Plans.
- ***Consumer-Driven Products*** are typically paired with a high-deductible medical plan and offer customers a tax-advantaged way to pay for eligible health care expenses. These products, consisting of health savings accounts ("HSAs"), health reimbursement accounts ("HRAs") and flexible spending accounts ("FSAs"), encourage customers to play an active role in managing their health and health care costs. When integrated with a Cigna medical plan, we can deliver a seamless experience for our customers and clients. More than three million customers have one of these integrated product solutions.

Government Medical

- ***Individual and Family Plans*** feature an insurance policy coupled with a network of health care providers in a geographic area who have been selected with cost and quality in mind.
- ***Medicare Advantage Plans*** allow Medicare-eligible beneficiaries to receive health care benefits, including prescription drugs, through a managed care health plan such as our coordinated care plans. Our Medicare Advantage Plans are primarily HMO plans marketed to individuals. A significant portion of our Medicare Advantage customers receive medical care from our value-based models that focus on developing highly engaged physician networks, aligning payment incentives to improved health outcomes and using timely and transparent data sharing.
- ***Medicare Part D Plans*** provide a number of plan options, as well as service and information support, to Medicare and Medicaid eligible customers. Our plans offer the savings of Medicare combined with the flexibility to provide enhanced benefits and a drug list tailored to individuals' specific needs. Eligible beneficiaries benefit from broad network access and value-added services intended to promote wellness and affordability for our eligible beneficiaries.
- ***Medicaid Plans*** provide our low-income customers with the benefit of many of the coordinated care aspects of our Medicare Advantage programs. For customers eligible for both Medicare and Medicaid ("dual eligible") we receive revenue from both the state and the Center for Medicare and Medicaid Services ("CMS").
- ***Medicare Supplement Plans*** provide Medicare-eligible beneficiaries with federally standardized Medigap-style plans. Beneficiaries may select among the various plans with specific plan options to meet their unique needs and may visit, without the need for a referral, any health care professional or facility that accepts Medicare throughout the United States.

Specialty Solutions

- ***Stop-Loss*** insurance coverage is offered to self-insured clients whose group health plans are administered by Cigna. Stop-loss insurance provides reimbursement for claims in excess of a predetermined amount for individuals, the entire group, or both.
- ***Cost-Containment Programs*** are designed to contain the cost of covered health care services and supplies. These programs reduce out-of-network utilization and costs, protect members from balance billing, and educate customers regarding the availability of lower cost in-network services. In addition, under these programs, we negotiate discounts with out-of-network providers, review provider bills and recover overpayments. We charge fees for providing or arranging for these services. These programs may be administered by third-party vendors that have contracted with Cigna.
- ***Consumer Health Engagement*** services are offered to customers covered under plans administered by Cigna or by third-party administrators. These services consist of an array of medical management, disease management and wellness services. Our Medical Management programs include case, specialty and utilization management and a 24-hour nurse information line. Our Health Advocacy program services include early intervention in the treatment of chronic conditions and an array of health and wellness coaching. Additionally, we administer incentives programs designed to encourage customers to engage in health improvement activities.
- ***Pharmacy Management*** services and benefits can be combined with our medical offerings. The comprehensive suite of pharmacy management services available to clients and customers includes benefits management, specialty pharmacy services, clinical solutions, home delivery, and certain medical management services. Cigna's home delivery pharmacy operation along with the Express Scripts PBM, are reported in the Health Services segment and described further there.
- ***Behavioral Health*** services are offered to employers, government entities and other groups sponsoring health benefit plans. These services consist of behavioral health care case management, employee assistance programs ("EAP"), and work/life programs. We focus on integrating our programs and services with medical, pharmacy and disability programs to facilitate customized, holistic care.
- ***Dental*** solutions include dental health maintenance organization plans ("Dental HMO"), dental preferred provider organization ("Dental PPO") plans, exclusive dental provider organization plans, traditional dental indemnity plans and a dental discount program. Employers and other groups can purchase our products on either an insured or self-insured basis as standalone products or in conjunction with medical products. Additionally, individual customers can purchase insured Dental PPO plans as standalone products or in conjunction with individual medical policies.

- ***Vision*** offerings include flexible, cost-effective PPO coverage that includes a range of both in and out-of-network benefits for routine vision services offered in conjunction with our medical and dental product offerings. Our national vision care network includes private practice ophthalmologist and optometrist offices, as well as retail eye care centers.

Funding Solutions

- ***ASO.*** Plan sponsors (i.e., employers, unions and other groups) self-fund all claims, but may purchase stop-loss insurance to limit exposure. We collect fees from plan sponsors for providing access to our participating provider network and for other services and programs including: claims administration; behavioral health services; disease management; utilization management; cost containment; dental; and pharmacy benefit management. Approximately 86% of our commercial medical customers are in ASO arrangements.
- ***Experience-Rated Insurance.*** Premium rates are established at the beginning of a policy period and are typically based on prior claim experience of the policyholder. When claims and expenses are less than the premium charged (an "experience surplus" or "margin"), the policyholder may be credited for a portion of this experience surplus or margin. If claims and expenses exceed the premium charged (an "experience deficit"), we bear these costs. In certain cases, experience deficits incurred while the policy is in effect are accumulated and may be recovered through future policy year experience surpluses or margins. Approximately 6% of commercial medical customers are in experience-rated arrangements.
- ***Guaranteed Cost Insurance.*** Premium rates are established at the beginning of a policy period and, depending on group size, may be based in whole or in part on prior experience of the policyholder or on a pool of similar policyholders. We generally cannot subsequently adjust premiums to reflect actual claim experience until the next annual renewal. The policyholder does not participate, or share in, actual claim experience. We keep any experience surplus or margin if costs are less than the premium charged (subject to minimum medical loss ratio rebate requirements discussed below) and bear the risk for actual costs in excess of the premium charged. Approximately 8% of commercial medical customers are in guaranteed cost arrangements.

In most states, individual and group insurance premium rates must be approved by the applicable state regulatory agency (typically department of insurance) and state or federal laws may restrict or limit the use of rating methods. Premium rates for groups and individuals are subject to state review to determine whether they are adequate, not excessive and not unfairly discriminatory. In addition, the ACA subjects individual and small group policy rate increases above an identified threshold to review by the United States Department of Health and Human Services ("HHS") and requires payment of premium refunds on individual and group medical insurance products if minimum medical loss ratio ("MLR") requirements are not met. The MLR represents the percentage of premiums used to pay medical claims and expenses for activities that improve the quality of care. In our individual business, premiums may also be adjusted as a result of the government risk adjustment program that accounts for the relative health status of our customers. See the "Regulation" section of this Form 10-K for additional information about commercial MLR requirements and risk mitigation programs of the ACA.

Market Segments

- ***Commercial*** comprises employers from the National, Middle Market and Select market segments.
    - ***National.*** Multi-state employers with 5,000 or more U.S.-based, full-time employees. We offer primarily ASO funding solutions in this market segment.
    - ***Middle Market.*** Employers generally with 500 to 4,999 U.S.-based, full-time employees. This segment also includes single-site employers with more than 5,000 employees and Taft-Hartley plans and other groups. We offer ASO, experience-rated and guaranteed cost insured funding solutions in this market segment.
    - ***Select.*** Employers generally with 51-499 eligible employees. We usually offer ASO with stop loss insurance coverage and guaranteed cost insured funding solutions in this market segment.
- ***Individual.*** Consistent with the regulations for Individual ACA compliant plans, we offer these plans only on a guaranteed cost basis in this market segment.
- ***Government*** includes individuals who are Medicare-eligible beneficiaries, as well as employer group sponsored pre- and post-65 retirees. We also have dual-eligible members who receive both Medicare and Medicaid benefits.

Primary Distribution Channels

- ***Brokers.*** Sales representatives distribute our products and services to a broad group of insurance brokers and consultants across the United States.
- ***Direct.*** Cigna sales representatives distribute our products and services directly to employers, unions and other groups or individuals across the United States. Various products may also be sold directly to insurance companies, HMOs and third-party administrators. This may take the form of in-person contact, telephonic or group selling venues.
- ***Private Exchanges.*** We partner with select companies that have created private exchanges where individuals and organizations can acquire health insurance. We actively evaluate private exchange participation opportunities as they emerge in the market, and target our participation to those models that best align with our mission and value proposition.
- ***Public Exchanges.*** Many states have set up public health insurance exchanges for ACA compliant plans on which Cigna may offer individual policies.

Competition

The primary competitive factors affecting our business are quality and cost-effectiveness of service and provider networks; effectiveness of medical care management; products that meet the needs of employers and their employees; total cost management; technology; and effectiveness of marketing and sales. Financial strength, as indicated by ratings issued by nationally recognized rating agencies, is also a competitive factor. Our health advocacy capabilities, holistic approach to consumer engagement, breadth of product offerings, clinical care and medical management capabilities and array of product funding options are competitive advantages. We believe our focus on improving the health, well-being and peace of mind of the customers we serve will allow us to further differentiate ourselves from our competitors.

- ***National Insurers.*** UnitedHealth Group, Aetna (owned by CVS Health), Anthem and Humana compete with us in a variety of products and regions throughout the United States.
- ***Local Healthplans.*** Blue Cross Blue Shield plans, local affiliates of major insurance companies and hospitals, and regional stand-alone managed care and specialty companies compete with us in the states in which we offer managed care products. Additionally, plan sponsors may contract directly with providers.
- ***TPAs.*** Third-party administrators compete with us for ASO business.
- ***Start-ups.*** Recent market entrants Oscar, Bright Health and other health plans seek to disrupt competition primarily in the individual market, in part through technology. Alternative health service models, including consortiums, search for a new approach to obtaining health services.
- ***Dental Insurers.*** Various companies offering primarily dental insurance compete with us on these products.
- ***Specialty Companies.*** Specialty insurance or service companies that offer niche products and services compete with us.

Delivering the Health Care Promise

Cigna's Connected Care strategy engages customers in their health, collaborates with providers to help them improve their performance, and connects customers and providers through aligned health goals, incentives and actionable information to enable better decisions and outcomes. Cigna is committed to developing innovative solutions that span the health care delivery system and can be applied to different types of providers. Currently we have numerous collaborative arrangements with our participating health care providers that reach over 3.6 million customers and are actively developing new arrangements to support our Connected Care strategy.

- ***Accountable Care Program.*** We have over 240 collaborative care arrangements with primary care groups built on the patient-centered medical home and accountable care organization ("ACO") models. Our arrangements span more than 32 states and reach over 2.7 million customers. We are committed to increasing the number of groups over the next several years, with a goal of reaching 280 programs by the end of 2020.
- ***Hospital Quality Program.*** We have contracts with over 500 hospitals with reimbursements tied to quality metrics. We expect to grow this number to over 600 hospitals by the end of 2020.
- ***Specialist Programs.*** We have approximately 250 arrangements with specialist groups in value-based reimbursement arrangements. Our goal is to reach approximately 380 arrangements by the end of 2020. Programs include arrangements with several types of specialist groups around the country including orthopedics, obstetrics and gynecology, cardiology, gastroenterology, oncology, nephrology and neurology. Arrangements include care coordination and episodes of care reimbursements for meeting cost and quality goals.
- ***Independent Practice Associations.*** We have value-based physician engagement models in our Cigna-HealthSpring business that allow physician groups to share financial outcomes with us. The Cigna-HealthSpring clinical model also includes outreach to new and at-risk patients to ensure they are accessing their primary care physician.
- ***Participating Provider Network.*** We provide our customers with an extensive network of participating health care professionals, hospitals and other facilities, pharmacies and providers of health care services and supplies. In most instances, we contract with them directly; however, in some instances, we contract with third parties for access to their provider networks and care management services. In addition, we have entered into strategic alliances with several regional managed care organizations (e.g., Tufts Health Plan, HealthPartners, Inc., Health Alliance Plan and MVP Health Plan) to gain access to their provider networks and discounts.

Technology

Cigna Information Technology supports our ***Go Deeper, Go Local, Go Beyond*** strategy by focusing first and foremost on strong foundational technology services, delivery of a business aligned technology project portfolio and prioritized strategic innovation that creates solutions that differentiate us in the market. Our technology innovation continues to focus on three strategic areas: insights and analytics; digital health; and care delivery and management. Our technology strategy ultimately improves the customer experience, increases engagement and advances population health using data driven insights, utilizing artificial intelligence and machine learning to provide key areas of competitive advantage. Innovation is core to the way we do business and will be a critical factor to our success in the highly dynamic health care industry. Cigna's innovative technology solutions continue to improve affordability and increase personalization: for example the Cigna One Guide® program combines a state-of-the-art digital experience with a human concierge service, and the Cigna SureFit® network allows individual family members to choose their personal care networks consistent with their health needs and provider preferences.

Our business strategy is based upon providing customers with differentiated, easy-to-use, seamless and secure products and solutions that utilize insights from advanced analytics to meet their expectations. We anticipate needs and meet customers where they are, from predicting and preventing chronic diseases, to mining data to reduce payment and claims fraud, to using the data from wearable devices to optimize population health status. In 2018, Cigna advanced its strategic technology leadership position by expanding our digital portfolio with the integration of the Brighter acquisition. Brighter's digital platform for connecting patients with a dental provider, allowing them to review their experience, gain insights to costs and see a dentist's history demonstrates the leadership in the digital engagement of health care customers. We also began the roadmap of leveraging Express Scripts technology value creators. Each of these companies contributes to our business model and strengthens the Cigna portfolio. Further, Cigna will apply the Express Scripts technology toolkit to advance the 360 degree view of the patient through flexible, open and connected solutions. With the combined strengths and capabilities of Cigna and Express Scripts, we see greater opportunities to create novel, highly-tailored customer insights as we mine data and use sophisticated artificial intelligence and machine learning techniques to build better models that help us find solutions to complex questions and improve health care outcomes. We will continue to develop leading data driven solutions such as applying propriety algorithms and machine learning to predict customers that could overdose on prescription opioids.

Data Analytics

Cigna has transformed substantial investments in analytics talent, data infrastructure and machine learning capabilities over the past several years into a closed-loop, self-learning insights system that guides our decision-making and allows us to execute on our strategy. Our "Insights That Matter" analytics process helps our business leaders identify the questions that matter most to our customers and partners while our data science experts focus on answering those questions with innovative methodologies and transform our insights into targeted business actions. We apply advanced analytics across our business and will continue to invest in expanding and strengthening our capabilities to better anticipate, meet and exceed our customers' and partners' expectations.

Health Services

This segment consists of the Express Scripts PBM business beginning December 21, 2018 as well as Cigna's legacy home delivery operations that offer high quality, efficient, and cost-effective mail order, telephone, and on-line pharmaceutical fulfillment services. In 2018, Health Services reported adjusted revenues of $6.6 billion and pre-tax adjusted income from operations of $380 million, including 11 days of Express Scripts results.

How We Win
• **Identifying** products and offering solutions that focus on improving patient outcomes and assist in controlling costs • **Evaluating** medicines for efficacy, value and price to assist clients in selecting a cost-effective formulary • **Offering** home delivery and specialty services that save clients money and provide better care • **Leveraging** purchasing volume to deliver discounts • **Promoting** the use of generics and lower cost brands

The following chart depicts a high level summary of our principal products and services in this segment with definitions on subsequent pages.

Principal Products & Services	*Brands/ Subsidiaries*	*Key Customer(s)*	*Primary Competitors*
Clinical Solutions	RationalMed, ScreenRx, ExpressAlliance, Advanced Opioid Management	Clients, Customers	Independent PBMs, Managed Care PBMs
Value Programs	SafeGuardRx	Clients, Customers, Pharmacies	Independent PBMs, Managed Care PBMs
Specialized Pharmacy Care	Therapeutic Resource Center	Customers	Independent PBMs, Managed Care PBMs, Retail Pharmacies
Home Delivery Pharmacy Services	Tel-Drug, Express Scripts, Therapeutic Resource Centers	Customers	Independent PBMs, Managed Care PBMs, Retail Pharmacies
Specialty Pharmacy Services	Accredo, Freedom Fertility, Tel-Drug	Clients, Customers, Pharmacies	Independent PBMs, Managed Care PBMs, Retail Pharmacies
Retail Network Pharmacy Administration	Express Scripts	Clients, Customers	Independent PBMs, Managed Care PBMs
Benefit Design Consultation	Express Scripts	Clients	Independent PBMs, Managed Care PBMs, Third-Party Benefit Administrators
Drug Utilization Review	Express Scripts	Clients, Customers	Independent PBMs, Managed Care PBMs, Third-Party Benefit Administrators
Drug Formulary Management	Express Scripts	Clients	Independent PBMs, Managed Care PBMs
Drug Claim Adjudication	Express Scripts	Clients	Independent PBMs, Managed Care PBMs, Third-Party Benefit Administrators
Administration of Group Purchasing Organizations ("GPO")	Econdisc, ValoremRx	Clients, Pharmacies	Group Purchasing Organizations
Prescription Card	Inside Rx	Customers	Retail Pharmacies, Discount Programs

Principal Products & Services	*Brands/ Subsidiaries*	*Key Customer(s)*	*Primary Competitors*
Digital Consumer Health and Drug Information	Express Scripts	Customers	Independent PBMs, Managed Care PBMs, Retail Pharmacies
Provider Services	CuraScript Specialty Distribution	Healthcare Providers, Clinics, Hospitals	Specialty drug distributors
Medical Benefit Management Services	eviCore, CareContinuum	Health Plans, Commercial and Government Payors	Health Plans, Third-Party Benefits Administrators, Clinical Solutions and Health Care Data Analytics Companies

Principal Products & Services

Pharmacy Benefit Management Services. Our PBM services drive high quality, cost-effective pharmaceutical care through prescription drug utilization and cost management. We consult with clients to assist in selecting plan design features that balance their requirements for cost control with customer choice and convenience. We focus our solutions to enable better decisions in four important, interrelated areas: benefit choices, drug choices, pharmacy choices and health choices. As a result, we believe we deliver better outcomes, higher customer satisfaction and a more affordable prescription drug benefit. As of December 31, 2018, we operated four high-volume automated dispensing home delivery pharmacies, five non-dispensing prescription processing centers, five customer contact centers, seven specialty home delivery pharmacies, 20 specialty branch pharmacies and eight specialty nursing offices.

- ***Clinical Solutions.*** We offer innovative clinical programs to drive better health outcomes at a lower cost by identifying and addressing unsafe, ineffective and wasteful prescribing; dispensing and utilization of prescription drugs; and intervening with, or supporting interventions with, physicians, pharmacies and customers.
    - RationalMed® evaluates medical, pharmacy and laboratory data to detect critical customer health and safety risks that are addressed through timely notice to physicians, pharmacies, customers and case managers.
    - ScreenRx® uses proprietary predictive models to detect customers at risk for nonadherence and proactively address the problem through customized interventions for each individual customer.

- Express*Alliance*® offers customer care coordination services that enable customer-authorized health care professionals to share a common view of a customer's health record and coordinate customer outreach and counseling.
- Advanced Opioid Management℠ works comprehensively with customers, prescribers and pharmacies to minimize early exposure to opioids while helping prevent progression to overuse and abuse.

Other solutions include Total Performance Management, Concurrent Drug Utilization Review, Advanced Utilization Management, Medication Therapy Management, Digital Report Monitoring and Fraud, Waste and Abuse.

- ***Express Scripts SafeGuardRx®.*** We are the industry leader in offering a suite of solutions aimed at therapy classes that pose significant budgetary threats and clinical challenges to patients. Our solutions are designed to keep our clients ahead of the cost curve while providing customers the personalized care and access they need. These solutions are offered throughout our PBM services and include, but are not limited to: Pulmonary Care Value Program℠; Multiple Sclerosis Care Value Program℠; Inflammatory Conditions Care Value Program℠; Diabetes Care Value Program℠; Hepatitis Cure Value Program®; Cholesterol Care Value Program®; Oncology Care Value Program®; Market Events Protection Program®; and Inflation Protection Program℠. Innovative programs, such as Express Scripts SafeGuardRx, combine utilization management controls with formulary management, the specialized care model of our Therapeutic Resource Center® program (described below) and comprehensive guarantees, and help us to change the market in key specialty categories. Notably, our programs covering oncology and inflammatory conditions have introduced a value-based contracting approach, with payments now tied to a product's effectiveness.
- ***Specialized Pharmacy Care.*** At the center of Express Scripts' condition-specific approach to care are Therapeutic Resource Center services, which are pharmacy practices specializing in caring for customers with the most complex and costly chronic conditions including cardiovascular disease, diabetes, cancer, HIV, asthma, depression and other rare and specialty conditions. Our Therapeutic Resource Center services are designed to optimize the safe and appropriate dispensing of therapeutic agents, minimize waste, and improve clinical and financial outcomes. Through our Therapeutic Resource Center services, specialist pharmacists provide the expert, personalized care that customers increasingly demand.
- ***Home Delivery Pharmacy Services.*** In addition to the order processing that occurs at these home delivery pharmacies, we operate several non-dispensing prescription processing facilities and customer contact centers. Our pharmacies provide greater safety and accuracy than retail pharmacies, convenient access to maintenance medications, and better management of our clients' drug costs through operating efficiencies. We are directly involved with the prescriber and customer through our home delivery pharmacies, and our research shows that we achieve a higher level of generic substitutions, therapeutic interventions and better adherence than is achieved through retail pharmacy networks.
- ***Specialty Pharmacy Services.*** Specialty medications are used primarily for the treatment of complex diseases. These medications are broadly characterized to include those with frequent dosing adjustments, intensive clinical monitoring, the need for customer training, specialized product administration requirements and/or medications limited to certain specialty pharmacy networks by manufacturers. Through a combination of assets and capabilities, we provide an enhanced level of personalized care and therapy management for customers taking specialty medications, increased visibility and improved outcomes for payors, as well as custom programs for biopharmaceutical manufacturers.
  - Accredo Health Group ("Accredo") is focused on dispensing injectable, infused, oral or inhaled drugs that require a higher level of clinical service and support than traditional pharmacies typically offer.
  - Accredo achieves better outcomes for customers and reduces waste for clients through specialty trained clinicians, a nationwide footprint, a network of in-home nursing services, reimbursement and customer assistance programs, and biopharmaceutical services.
  - Our subsidiary Freedom Fertility is a leading specialty pharmacy focused on the needs of fertility customers and providers. Through Freedom Fertility, we provide insurance assistance, customer education, and support.
  - Our subsidiary Care Continuum provides medical benefit drug management services that enable greater oversight of our clients' specialty spend billed through the medical benefit designed to ultimately make specialty drugs more affordable and accessible.
- ***Retail Network Pharmacy Administration.*** We contract with retail pharmacies to provide prescription drugs to customers of the pharmacy benefit plans we manage. In the United States, Puerto Rico and the Virgin Islands, we negotiate with pharmacies to discount drug prices provided to customers and manage national and regional networks responsive to client preferences related to cost containment, convenience of access for customers and network performance. We also manage networks of pharmacies customized for or under direct contract with specific clients and have contracted with pharmacy provider networks to comply with CMS access requirements for the federal Medicare Part D Prescription Drug Program ("Medicare Part D"). All retail pharmacies in our network communicate with us online and in real-time to process prescription drug claims. When a plan member presents their identification card at a network pharmacy, the network pharmacist sends specific member, prescriber and prescription information in an industry-standard format through our systems, which process the claim and respond to the pharmacy with relevant information to process the prescription.
- ***Benefit Design Consultation.*** We consult with our clients on how best to structure and leverage the pharmacy benefit to meet plan objectives for affordable access to the prescription medications people need to stay healthy, and ensure the safe and effective use of those medications.
- ***Drug Utilization Review.*** When prescriptions are presented to our pharmacies or submitted for coverage, we review them electronically and systematically in real-time for safety and effectiveness. We then alert the dispensing pharmacy to detected issues. Issues not adequately addressed at the time of dispensing may also be communicated to the prescriber retrospectively.
- ***Drug Formulary Management.*** Formularies are lists of drugs with designations that may be used to determine drug coverage, customer out-of-pocket costs, and communicate plan preferences in competitive drug categories. Our formulary management services support clients

in establishing formularies that assist customers and physicians in choosing clinically appropriate, cost-effective drugs and prioritize access, safety and affordability. We administer specific formularies on behalf of our clients, including standard formularies developed and offered by Express Scripts and custom formularies in which we play a more limited role. Most of our clients select standard formularies, governed by our National Pharmacy & Therapeutics Committee (the "P&T Committee") that comprises a panel of independent physicians and pharmacists in active clinical practice representing a variety of specialties and practice settings, typically with major academic affiliations. In making formulary recommendations, the P&T Committee considers only the drug's safety and efficacy and not the cost of the drug, including any negotiated manufacturer discount or rebate arrangement. This process is designed to ensure the clinical recommendation is not affected by our financial arrangements. We fully comply with the P&T Committee's clinical recommendations regarding drugs that must be included or excluded from the formulary based on their assessment of safety and efficacy.

- ***Drug Claim Adjudication.*** We process drug claims for home delivery or retail networks through integration of retail network pharmacy administration, benefit design consultation, drug utilization review, drug formulary management and pharmacy fulfillment services. We administer payments to retail networks and bill benefits costs to our clients through our end-to-end adjudication services.
- ***Inside Rx.*** The Inside Rx program delivers broad and affordable access to medication for the uninsured and those navigating the changing health care landscape. Inside Rx partners with participating retail pharmacies and major pharmaceutical companies to provide discounts, via a discount card for customers who would otherwise pay full list price for prescription medications. This program works collaboratively across the pharmacy supply chain with a shared focus to ensure customers have affordable access to medication they need. Inside Rx also provides access to pet prescriptions via our home delivery pharmacy services.
- ***Administration of a Group Purchasing Organization.*** We operate a group purchasing organization ("GPO") that negotiates pricing for the purchase of pharmaceuticals from pharmaceutical manufacturers and suppliers. We also provide various administrative services to GPO participants including negotiation and management of the GPO purchasing contracts. Express Scripts' GPO is a member of the GPO of Walgreens Boots Alliance Development GmbH.
- ***Digital Consumer Health and Drug Information.*** We empower customer decision-making through online and mobile tools that help customers make informed drug, pharmacy and health choices. Information included on our website and mobile application are not part of this annual report.
- ***Provider Services.*** CuraScript Specialty Distribution ("CSD") is a specialty distributor of pharmaceuticals and medical supplies (including injectable and infusible pharmaceuticals and medications to treat specialty and rare or orphan diseases) directly to health care providers, clinics and hospitals in the United States for office or clinic administration. Through our CSD business, we provide distribution services primarily to office and clinic-based physicians who treat customers with chronic diseases and regularly order costly specialty pharmaceuticals. CSD provides competitive pricing on pharmaceuticals and medical supplies, operates three distribution centers, and ships most products overnight within the United States; CSD also provides distribution capabilities to Puerto Rico and Guam. CSD is a contracted supplier with most major group purchasing organizations and leverages our distribution platform to operate as a third-party logistics provider for several pharmaceutical companies.
- ***Medical Benefit Management Services.*** eviCore is a leading provider of integrated medical benefit management solutions that focus on driving adherence to evidence-based guidelines, improving the quality of customer outcomes and reducing the cost of care for our clients. eviCore manages medical benefits in categories including radiology, cardiology, musculoskeletal disorders, sleep disorders, post-acute care, genetic lab, specialty pharmacy and medical oncology. eviCore contracts with health plans and other commercial and governmental payors to promote the appropriate use of health care services and contracts. In certain instances, this occurs through capitated risk arrangements, where we assume the financial obligation for the cost of health care services provided to eligible customers covered by eviCore's health care management programs.

Customers

- ***Clients.*** We provide services to managed care organizations, health insurers, third-party administrators, employers, union-sponsored benefit plans, workers' compensation plans, government health programs, providers, clinics, hospitals and others.
- ***Customers.*** Prescription drugs are dispensed to customers of the clients we serve primarily through networks of retail pharmacies under non-exclusive contracts with us and through our home delivery fulfillment pharmacies, specialty drug fulfillment pharmacies and fertility fulfillment pharmacies.

Our key customers include the United States Department of Defense ("DoD") and Anthem. The DoD's TRICARE Pharmacy Program is the military health care program serving active-duty service customers, National Guard and Reserve customers, and retirees, as well as their dependents. Under our DoD contract, we provide online claims adjudication, home delivery services, specialty pharmacy clinical services, claims processing and contact center support and other services critical to managing pharmacy trend.

On January 30, 2019, Anthem exercised its right to early terminate their pharmacy benefit management services agreement with us, effective March 1, 2019. There is a twelve-month transition period ending March 1, 2020. It is expected that the transition of Anthem's customers will occur at various dates, as informed by Anthem's technology platform migration schedule. Over the next twelve months, we will focus on an effective transition of this relationship and related services over Anthem's accelerated timeline. For further discussion of our Anthem relationship, see the "Executive Summary — Key Transactions and Developments" section of our MD&A located in Part II, Item 7 of the Form 10-K.

Competition

The health care industry has undergone periods of substantial consolidation and may continue to consolidate in the future. We believe the primary competitive factors in the industry include the ability to: negotiate with retail pharmacies to ensure our home delivery pharmacy and retail pharmacy networks meet the needs of our clients and customers; negotiate discounts and rebates on prescription drugs with drug manufacturers; navigate the complexities of government-reimbursed business including Medicare, Medicaid and the Public Exchanges; manage cost and quality of specialty drugs; use the information we obtain about drug utilization patterns and consumer behavior to reduce costs for our clients and customers; and the level of service we provide.

- ***Independent PBMs.*** MedImpact and Navitus Health Solutions compete with us on a variety of products and in various regions throughout the United States.
- ***Managed Care PBMs.*** Aetna Inc. (owned by CVS Health Corporation), Humana, OptumRx (owned by UnitedHealth Group) and Prime Therapeutics (owned by a collection of Blue Cross / Blue Shield Plans) compete with us on a variety of products and in various regions throughout the United States.
- ***Retail Pharmacies.*** CVS Caremark (owned by CVS Health) and Envision Rx (owned by Rite Aid). Wal-Mart Stores, Inc. engages in certain activities competitive with PBMs.
- ***Third-Party Benefits Administrators.*** Third parties that specialize in claim adjudication and benefit administration, such as Argus, are direct competitors. With the emergence of alternative benefit models through Private Exchanges, the competitive landscape also includes brokers, health plans and consultants. Some of these competitors may have greater financial, marketing and technological resources than we do and new market entrants, including strategic alliances aimed at modifying the current health care delivery models or entering the prescription drug sector from another sector of the health care industry, may increase competitiveness as barriers to entry are relatively low.
- ***Clinical Solutions and Health Care Data Analytics Companies.*** Optum (owned by UnitedHealth Group), Anthem, Inc., Magellan Health, HealthHelp, Cotiviti, and Inovalon are among the companies that compete with us in this market.

Quality

- ***Sales and Account Management.*** Our sales and account management teams market and sell PBM solutions and are supported by client service representatives, clinical pharmacy managers and benefit analysis consultants. These teams work with clients to develop innovative strategies that put medicine within reach of customers while helping health benefit providers improve access to and affordability of prescription drugs.
- ***Supply Chain.*** Our supply chain contracting and strategy teams negotiate and manage pharmacy network contracts, pharmaceutical and wholesaler purchasing contracts, and manufacturer rebate contracts. As our clients continue to experience increased cost trends, our supply chain teams develop innovative solutions such as Express Scripts SafeGuardRx and narrow networks to combat these price increases. In addition, our Formulary Consulting team, consisting of pharmacists and financial analysts, provides services to our clients to support formulary decisions, benefit design consultation and utilization management programs.
- ***Clinical Support.*** Our staff of highly trained health care professionals provides clinical support for our PBM and medical benefit management services, including more specialized care for customers with select chronic and complex conditions. We operate condition-specific Therapeutic Resource Center facilities staffed with specialist pharmacists, nurses and other clinicians who provide personal and specialized customer care. Our clinical solutions staff of pharmacists and physicians provides clinical development and operational support for our PBM services. These health care professionals conduct a wide range of activities including identifying emerging medication-related safety issues and alerting physicians, clients, and customers (as appropriate); providing drug information services; managing formulary; and developing utilization management, safety (drug utilization review) and other clinical interventions.
- ***Research and Analytics.*** Our research and analytics team conducts timely, rigorous and objective research that supports evidence-based pharmacy benefit management and evaluates the clinical, economic and individual impact of pharmacy benefits. They also use predictive modeling, machine learning and other analytical tools to develop and improve our products and services. The team also produces the Express Scripts Drug Trend Report, which examines trends in pharmaceutical utilization and cost, the factors triggering those trends and new solutions our clients can implement to control their pharmacy spend while improving the health of their customers.

Technology

Our technology team supports the various management information systems essential to our operations including the pharmacy and medical benefit claims processing systems and specialty pharmacy systems, while seeking opportunities to optimize our technology solutions by consolidating and upgrading our technology platforms.

Uninterrupted point-of-sale electronic retail pharmacy claims processing is a significant operational requirement for our business. Claims in the United States are processed through systems managed and operated domestically by internal resources and an outsourced vendor. We believe we have substantial capacity for growth in our United States claims processing facilities.

We leverage outsourced vendor services to provide certain disaster recovery services for systems located at our data centers. For systems not covered by a third-party vendor arrangement, such as our specialty pharmacy data centers, our corporate disaster recovery organization manages internal recovery services.

Express Scripts is proud of its commitment to innovation in the field of health care. Express Scripts innovations improve patient outcomes while eliminating waste in the health care system. Express Scripts Holding Company and its affiliated companies (individually and/or collectively "Express Scripts") hold more than 170 United States patents. We use these patents to protect our proprietary technological advances.

Our technology platform allows us to safely, rapidly, and accurately adjudicate 1.4 billion adjusted prescriptions annually. Our technology helps retail pharmacies focus on patient care, and our real-time safety checks help avoid hundreds of thousands of medication errors annually. Technology is the backbone to all of our solutions – from our provider-focused advances that improve e-prescribing and electronic prior authorization – to our patient-friendly app and website interfaces, and our continued investments provide an easier, more efficient experience with all of our partners.

Our formulary strategy and our SafeGuardRx program are also rooted in technology that applies our deep pharmacy expertise and data insights more rapidly and comprehensively to drive better clinical and financial outcomes for clients and patients.

Our Health Services business owns and has registered certain trade and service marks with the United States Patent and Trademark Office, including but not limited to the following marks: EXPRESS SCRIPTS®, MEDCO®, ACCREDO®, CURASCRIPTSD®, EVICORE HEALTHCARE®, FREEDOM FERTILITY PHARMACY®, RATIONALMED®, SCREENRX®, EXPRESSALLIANCE®, THERAPEUTIC RESOURCE CENTER®, ADVANCED OPIOID MANAGEMENT℠, SAFEGUARDRX®, CHOLESTEROL CARE VALUE℠, HEPATITIS CURE VALUE℠, MARKET EVENTS PROTECTION℠, ONCOLOGY CARE VALUES℠, DIABETES CARE VALUE℠, INFLAMMATORY CONDITIONS CARE VALUE℠, INFLATION PROTECTION℠, PULMONARY CARE VALUE℠, MULTIPLE SCLEROSIS CARE VALUE℠, and INSIDE RX®.

We also hold a portfolio of patents and pending patent applications. We are not substantially dependent on any single patent or group of related patents.

Suppliers

We maintain an inventory of brand name and generic pharmaceuticals in our home delivery and specialty pharmacies. Our specialty pharmacies also carry biopharmaceutical products to meet the needs of our customers, including pharmaceuticals for the treatment of rare or chronic diseases; if a drug is not in our inventory, we can generally obtain it from a supplier within one business day.

We purchase pharmaceuticals either directly from manufacturers or through authorized wholesalers. Express Scripts uses one wholesaler more than others in the industry, but holds contracts with other wholesalers if needs for an alternate source arise and believes alternative supply is readily available should it be needed. Generic pharmaceuticals are generally purchased directly from manufacturers.

Industry Developments

See the "Industry Developments" section of the MD&A in this Form 10-K beginning on page 47 for discussion of key industry developments impacting this segment.

International Markets

Cigna's International Markets segment has operations in over 30 countries or jurisdictions providing a full range of comprehensive medical and supplemental health, life, and accident benefits to individuals and employers. Products and services include comprehensive health coverage, hospitalization, dental, critical illness, personal accident, term life, and variable universal life. In 2018, International Markets reported adjusted revenues of $5.4 billion and pre-tax adjusted income from operations of $735 million.

How We Win

- Broad range of health and protection related solutions to meet the needs of the growing middle class and globally mobile
- Leveraging deep consumer insights to drive product and service innovation
- Leading innovative, direct to consumer distribution capabilities
- Access to quality, affordable care through one of the **largest global provider networks**
- Locally licensed and **compliant** solutions managed by **strong, locally developed talent**

Demand for our products and services is underpinned by the growing global middle class, aging populations, increasing prevalence of chronic conditions, and rising global health care costs. Our focus on product and service innovation means we continue to deliver solutions that meet the evolving needs of individual and group customers. Our distribution channels and funding sources range by product, customer, and geography.

International Markets is well-positioned to address the growing demand for access to quality, affordable care and supplemental health and life protection that fill gaps in public and private care. We distinguish ourselves through differentiated direct-to-consumer distribution, customer insights, product innovation, a leading provider network, and compliant solutions. We identify and pursue attractive market opportunities to bring health and protection solutions and tailor those solutions to the market and customer needs. Over the past several years, we have

extended our product offerings and geographic reach. The chart below provides a high-level summary of our Principal Products and Services in this segment as of year-end, with definitions on subsequent pages.

Principal Products & Services	*Major Brand(s)*	*Geography*	*Funding Solution(s)*	*Key Customer(s)*	*Primary Distribution Channel(s)*	*Primary Competitors*
Global Health Care	Cigna Global Health Benefits Cigna Global IPMI	Worldwide	Experience-rated, Guaranteed Cost, ASO	Multinational Companies, Inter-governmental and Non-governmental Organizations Globally mobile individuals	Brokers, Agents, Direct-to-Consumer	Global insurers
Local Health Care	Cigna CignaTTK CignaCMB	United Kingdom, Spain, Hong Kong, India, China	Experience-rated, Guaranteed Cost, ASO	Employer Groups Individuals	Brokers, Agents, Direct-to-Consumer	Global insurers
Supplemental Health, Life, & Accident	Cigna LINA Korea CignaCMB CignaTTK CignaFinans	Asia Pacific, India, Turkey	Guaranteed Cost	Individuals	Affinity, Bancassurance, Brokers, Agents, Direct-to-Consumer	Global and local foreign insurers

Principal Products & Services

Global Health Care products and services include insurance and administrative services for medical, dental, pharmacy, vision, and life, accidental death and dismemberment, and disability risks. We are leading providers of products and services that meet the needs of multi-national employers, intergovernmental and non-governmental organizations and globally mobile individuals with a focus on keeping employees healthy and productive. The employer benefits products and services are offered through guaranteed cost, experience-rated, and administrative services only funding solutions, while individuals purchase guaranteed cost (insured) coverage. For definitions of funding solutions, see "Funding Solutions" in the "Integrated Medical" description of business section on page 6 of this Form 10-K.

Local Health Care products and services include medical, dental, pharmacy, and vision as well as life coverage. The customers of local health care businesses are employers and individuals located in specific countries where the products and services are purchased. These employer services can similarly be funded through a range of options and individuals purchase on a guaranteed cost basis.

Supplemental Health, Life and Accident Insurance products and services generally provide simple, affordable coverage of risks for the health and financial security of individuals. Supplemental health products provide specified payments for a variety of health risks and include personal accident, accidental death, critical illness, hospitalization, travel, dental, cancer and other dread disease coverages. We also offer customers term and variable universal life insurance and certain savings products in select markets.

Competition

We anticipate that the competitive environment will intensify as insurance and financial services providers more aggressively pursue expansion opportunities across geographies, particularly Asia. We believe competitive factors will include speed-to-market, customer insights, branding, product, distribution and service innovation, underwriting and pricing, efficient management of marketing and operating processes, commission levels paid to distribution partners, the quality of claims, network coverage and medical cost management, and talent acquisition and retention. Additionally, in most overseas markets, perception of commitment to the market and financial strength will likely be an important competitive factor.

Pricing and Reinsurance

Premium rates and fees for our global and local health care products reflect assumptions about future claims, expenses, customer demographics, investment returns, and profit margins. For products using networks of contracted health care professionals and facilities, premiums reflect assumptions about the impact of these contracts and utilization management on future claims. Most contracts permit rate changes at least annually.

The profitability of health care products is dependent upon the accuracy of projections for health care inflation (unit cost, location of delivery of care, currency of incurral and utilization), customer demographics, the adequacy of fees charged for administration and effective medical cost management.

Premium rates for our supplemental benefits products are based on assumptions about mortality, morbidity, customer acquisition and retention, customer demographics, expenses and capital requirements, as well as interest rates. Variable universal life insurance products fees consist of mortality, administrative, asset management and surrender charges assessed against the contract holder's fund balance. Mortality charges on variable universal life may be adjusted prospectively to reflect expected mortality experience. Most contracts permit premium rate changes at least annually.

A global approach to underwriting risk management allows each local business to underwrite and accept risk within specified limits. Retentions are centrally managed through cost effective use of external reinsurance to limit our liability on per life, per risk and per event (catastrophe) bases.

Industry Developments and Other Items Affecting International Markets

South Korea represents our single largest geographic market for International Markets. For information on this concentration of risk for the International Markets segment's business in South Korea. see "Other Items Affecting Results of International Markets" in the International Markets section of the MD&A beginning on page 59 of this Form 10-K.

Pressure on social health care systems, a rapidly aging population and increased wealth and education in developing insurance markets are leading to higher demand for health insurance and financial security products. In the supplemental health, life and accident business, direct marketing channels continue to grow and attract new competitors with industry consolidation among financial institutions and other affinity partners.

Data privacy regulation has tightened in all markets in the wake of data privacy news scandals, impacting affinity partner and customer attitudes toward direct marketing of insurance and other financial services.

Group Disability and Other

As explained further in the introduction to this Form 10-K, Group Disability and Other consists of our Group Disability and Life operating segment, along with COLI and certain run-off businesses reported together in Other Operations. In 2018, Group Disability and Other reported adjusted revenues of $5.1 billion and pre-tax adjusted income from operations of $529 million.

How We Win

- **Disability absence management model** that reduces overall costs to employers
- **Integration** of disability products **with medical and specialty offerings,** promoting health and wellness and optimizing employee productivity
- **Complementary portfolio** of group disability, life and accident offerings
- **Disciplined underwriting, pricing and investment strategies** supporting profitable long-term growth

Group Disability and Life

Our Group Disability and Life operating segment includes our commercial long- and short-term disability products, and our term life and universal life group insurance products. We also offer personal accident insurance and voluntary products and services. These products and services are distributed through brokers and direct sales and are available in fully-insured, experience-rated and ASO arrangements. The following chart depicts a high-level summary of our Principal Products and Services in this segment as of year-end, with definitions on subsequent pages.

Principal Products & Services	Payee	Premium Rates	Funding Solution(s)	Market Segment(s)	Primary Distribution Channel(s)	Primary Competitors
			Group Disability			
Long-term Disability	Employer, Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured, ASO	Commercial	Brokers, Direct	National Insurers, Regional Insurers
Short-term Disability	Employer, Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured, ASO	Commercial	Brokers, Direct	National Insurers, Regional Insurers
			Group Life			
Term Life	Employer, Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured	Commercial	Brokers, Direct	National Insurers, Regional Insurers
Universal Life	Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured	Commercial	Brokers, Direct	National Insurers, Regional Insurers
			Group Accident and Voluntary			
Personal Accident Insurance	Employer, Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured	Commercial	Brokers, Direct	National Insurers, Regional Insurers
Voluntary Products and Services	Employee	Preset, guaranteed	Guaranteed Cost Insured	Commercial	Brokers, Direct	National Insurers, Regional Insurers

Principal Products & Services

Group Disability

- ***Group Long-term and Short-term Disability*** insurance products generally provide a fixed level of income to replace a portion of wages lost due to disability. As part of our group disability insurance products, we also assist employees in returning to work and employers with

resources to manage the cost of employee disability. We are an industry leader in helping employees return to work quickly, enabling higher productivity and lower cost for employers and a better quality of life for employees. While we offer this coverage in all three funding arrangements, most of our coverages are guaranteed cost.

- ***Leave Administration*** solutions help customers effectively manage workforce absence and provide coverage for paid leave. We integrate the administration of our disability insurance products with other disability benefit programs, behavioral programs, medical programs, social security advocacy and administration of the federal Family and Medical Leave Act ("FMLA"), State Leave laws and other leave-of-absence programs. We believe this integration supports greater efficiency and effectiveness in disability claims management, enhances productivity and reduces overall costs to employers. Integration also provides early insight into employees at risk for future disability claims. Coordinating the administration of these disability programs with programs offered by our medical business provides enhanced opportunities to influence outcomes, reduce the cost of both medical and disability events and improve the return-to-work rate.

Group Life Insurance

- ***Group Term Life*** insurance may be employer-paid basic life insurance, employee-paid supplemental life insurance or a combination thereof.
- ***Group Universal Life*** insurance is a voluntary life insurance product in which the owner may accumulate a cash value. The cash value earns interest at rates declared from time to time, subject to a minimum guaranteed contracted rate, and may be borrowed, withdrawn, or, within certain limits, used to fund future life insurance coverage.

Other Products and Services

- ***Personal Accident Insurance*** coverage consists primarily of accidental death and dismemberment and travel accident insurance to employers.
- ***Specialty Insurance Services*** consist of disability and life, accident and hospital indemnity products to professional or trade associations and financial institutions.
- ***Voluntary Products and Services*** include plans that provide employers with administrative solutions designed to provide a complete and simple way to manage their benefits program. These voluntary offerings include accidental injury insurance, critical illness coverage and hospital care coverage, and provide additional dollar payouts to employees for unexpected accidents, hospitalization or more serious illnesses.

Pricing and Reinsurance

Premiums charged for disability and term life insurance products are usually established in advance of the policy period, are generally guaranteed for one to three years, but selectively guaranteed for up to five years. Policies are generally subject to termination by the policyholder or by the insurance company annually. Premium rates reflect assumptions about future claims, expenses, credit risk, investment returns and profit margins. These assumptions may be based in whole or in part on prior experience of the account or on a pool of accounts, depending on the group size and the statistical credibility of the experience that varies by product.

Premiums for group universal life insurance products consist of mortality and administrative charges assessed against the policyholder's fund balance. Interest credited and mortality charges for group universal life may be adjusted prospectively to reflect expected interest and mortality experience. Mortality charges are subject to maximum guaranteed rates and interest credited on cash values is subject to minimum guaranteed rates as stated in the policy.

The premiums for these products are typically collected within the coverage year and then invested in assets that match the duration of the expected benefit payments that occur over many future years (primarily for disability benefits). With significant investments in longer-duration securities, net investment income is a critical element of profitability for this segment.

The effectiveness of return-to-work programs and morbidity levels will impact the profitability of disability insurance products. Our claim experience and industry data indicate a correlation between disability claim incidence levels and economic conditions, with submitted claims rising under adverse economic conditions, although the extent of this impact is unclear. For life insurance products, the degree to which future experience deviates from mortality and expense assumptions also affects profitability.

To reduce our exposure to large individual and catastrophic losses under group life, disability and accidental death policies, as well as our more recent accidental injury and critical illness policies, we purchase reinsurance from a diverse group of unaffiliated reinsurers. Our comprehensive reinsurance program consists of excess of loss treaties and catastrophe coverage designed to mitigate earnings volatility and provide surplus protection.

Market Segments

- ***Commercial.*** Commercial Market Segments are comprised of National, Middle Market and Select.
    - ***National.*** Multi-state employers with 5,000 or more U.S.-based, full-time employees.
    - ***Middle Market.*** Employers generally with 250 to 4,999 U.S.-based, full-time employees.
    - ***Select.*** Employers generally with up to 249 eligible employees.

Primary Distribution Channels

- ***Insurance Broker and Consultants.*** Sales representatives distribute our products and services to a broad group of insurance brokers and consultants across the United States.

- ***Direct.*** Sales representatives distribute our products and services directly to employers, unions and other groups or individuals across the United States. This may take the form of in-person contact, telephonic or group selling venues.

Competition

The principal competitive factors that affect the Group Disability and Life segment are underwriting and pricing, the quality and effectiveness of claims management, relative operating efficiency, investment and risk management, distribution methodologies and producer relations, the breadth and variety of products and services offered, the quality of customer service and, more importantly, the state of the tools and technology available for customers, clients, consultants and producers. For certain products with longer-term liabilities, such as group long-term disability insurance, the financial strength of the insurer, as indicated by ratings issued by nationally recognized rating agencies, is also a competitive factor.

- ***National Insurers.*** Unum, The Hartford, Prudential, Lincoln and MetLife compete with us on a variety of products and regions throughout the United States.

Industry Developments

Employers have expressed a growing interest in employee wellness, absence management and productivity, and recognize a strong link between employee health productivity and profitability. As this interest grows, we believe our healthy lifestyle and return-to-work programs and integrated family medical leave, disability and health care programs position us to deliver integrated solutions for employers and employees. Our strong disability management portfolio and fully integrated programs also provide tools for employers and employees to improve health status. Our focus on managing employees' total absence enables us to increase the number and effectiveness of interventions and minimize disabling events.

The group insurance market remains highly competitive as the rising cost of medical coverage has forced companies to re-evaluate their overall employee benefit spending, resulting in lower volumes of group disability and life insurance business and more competitive pricing. Demographic shifts have further driven demand for products and services that are sufficiently flexible to meet the evolving needs of employers and employees who want innovative, cost-effective insurance solutions, and employers continue to move towards greater employee participatory coverage and voluntary purchases. As the market becomes more retail-focused, our broad suite of voluntary offerings and continued focus on developing additional voluntary products and service capabilities positions us well to meet the needs of both employers and employees.

Over the past few years, there has been heightened review by state regulators of the claims handling practices within the disability and life insurance industry. This has resulted in an increase in coordinated, multi-state examinations that target specific market practices in addition to regularly recurring examinations of an insurer's overall operations conducted by an individual state's regulators. We have been subject to such an examination over the past several years. See Note 19D. to our Consolidated Financial Statements for additional information.

The lower level of interest rates in the United States over the last several years has constrained earnings growth in this segment due to lower yields on our fixed-income investments and higher benefit expenses resulting from the discounting of future claim payments at lower interest rates.

Other Operations

Other Operations includes the following:

Corporate-owned Life Insurance

The principal products of the COLI business are permanent insurance contracts sold to corporations to provide coverage on the lives of certain employees for the purpose of financing employer-paid future benefit obligations. Permanent life insurance provides coverage that, when adequately funded, does not expire after a term of years. The contracts are primarily non-participating universal life policies. Fees for universal life insurance products consist primarily of mortality and administrative charges assessed against the policyholder's fund balance. Interest credited and mortality charges for universal life and mortality charges on variable universal life may be adjusted prospectively to reflect expected interest and mortality experience. To reduce our exposure to large individual and catastrophe losses, we purchase reinsurance from unaffiliated reinsurers.

Run-off Settlement Annuity Business

Our settlement annuity business is a closed, run-off block of single premium annuity contracts. These contracts are primarily liability settlements with approximately 20% of the liabilities associated with guaranteed payments not contingent on survivorship. Non-guaranteed payments are contingent on the survival of one or more parties involved in the settlement.

Run-off Reinsurance

Our reinsurance operations are an inactive business in run-off.

In February 2013, we effectively exited the guaranteed minimum death benefit ("GMDB") and guaranteed minimum income benefit ("GMIB") business by reinsuring 100% of our future exposures, net of retrocessional arrangements in place at that time, up to a specified limit. For additional information regarding this reinsurance transaction and the arrangements that secure our reinsurance recoverables, see Note 8 to our Consolidated Financial Statements.

Individual Life Insurance and Annuity and Retirement Benefits Businesses

This business includes deferred gains recognized from the 1998 sale of the individual life insurance and annuity business and the 2004 sale of the retirement benefits business. For more information regarding the arrangements that secure our reinsurance recoverables for the retirement benefits business, see Note 8 to our Consolidated Financial Statements.

Certain International Run-off Businesses

Certain European, Middle Eastern and Canadian operations are in run-off and included in Other Operations.

Investment Management

General Accounts

Our investment operations provide investment management and related services for our corporate invested assets and the insurance-related invested assets in our General Account ("General Account Invested Assets"). We acquire or originate, directly or through intermediaries, a broad range of investments including private placement and public securities, commercial mortgage loans, real estate, mezzanine, private equity partnerships and short-term investments. Invested assets also include policy loans that are fully collateralized by insurance policy cash values. Invested assets are managed primarily by our subsidiaries and, to a lesser extent, external managers with whom our subsidiaries contract. Net investment income is included as a component of adjusted income from operations for each of our segments and Corporate. Realized investment gains (losses) are reported by segment but excluded from adjusted income from operations. For additional information about invested assets, see the "Investment Assets" section of the MD&A beginning on page 61 and Notes 9 and 10 of our Consolidated Financial Statements.

We manage our investment portfolios to reflect the underlying characteristics of related insurance and contractholder liabilities and capital requirements, as well as regulatory and tax considerations pertaining to those liabilities and state investment laws. Insurance and contractholder liabilities range from short duration health care products to longer term obligations associated with disability and life insurance products and the run-off settlement annuity business. Assets supporting these liabilities are managed in segregated investment portfolios to facilitate matching of asset durations and cash flows to those of corresponding liabilities. Investment strategy and results are affected by the amount and timing of cash available for investment, competition for investments, economic conditions, interest rates and asset allocation decisions. We routinely monitor and evaluate the status of our investments, obtaining and analyzing relevant investment-specific information and assessing current economic conditions, trends in capital markets and other factors such as industry sector, geographic and property-specific information.

Separate Accounts

Our subsidiaries or external advisors manage invested assets of Separate Accounts on behalf of contractholders, including the Cigna Pension Plan, variable universal life products sold through our corporate-owned life insurance business, and other disability and life products. These assets are legally segregated from our other businesses and are not included in General Account Invested Assets. Income, gains and losses generally accrue directly to the contractholders.

Investing in Innovation

In addition to the portfolio investments in our general and separate accounts discussed above that support our insurance operations, in 2018, we began targeted investing within the health care industry specifically. Our recently-formed Cigna Ventures unit has been allotted $250 million to invest in promising startups and growth-stage companies that create new growth possibilities in health care. These targeted investments bring improved care quality, affordability, choice and greater simplicity to customers, patients and clients by harnessing transformative ideas in: 1) insights and analytics; 2) digital health and retail; and 3) care delivery and management.

Regulation

The laws and regulations governing our business continue to increase each year and are subject to frequent change. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. These regulations can vary significantly from jurisdiction to jurisdiction, and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact the health care system.

Many aspects of our business are directly regulated by federal and state laws and administrative agencies, such as HHS, CMS, the Internal Revenue Service ("IRS"), the Departments of Labor ("DOL"), Treasury and Justice ("DOJ"), the Securities and Exchange Commission ("SEC"), state departments of insurance and state boards of pharmacy. Our business practices may also be shaped by judicial decisions.

In addition, aspects of our business are subject to indirect regulation. The self-funded benefit plans sponsored by our employer clients are regulated under federal law. These self-funded clients expect us to assure that our administration of their plans complies with the regulatory requirements applicable to them.

Our business operations and the books and records of our regulated businesses are routinely subject to examination at regular intervals by state insurance and HMO regulatory agencies, state boards of pharmacy, CMS, DOL, IRS and comparable international regulators to assess compliance with applicable laws and regulations. Our operations are also subject to non-routine examinations and investigations by various state and federal regulatory agencies, generally as the result of a complaint. In addition, we may be implicated in investigations of our clients whose group benefit plans we administer on their behalf. As a result, we routinely receive subpoenas and other demands or requests for information from various state insurance and HMO regulatory agencies, state attorneys general, the Office of Inspector General ("OIG"), the DOJ, the DOL and other state, federal and international authorities. We may also be called upon to provide information by members of the U.S. Congress, including testifying before congressional committees and subcommittees regarding certain of our business practices. If Cigna is determined to have failed to comply with applicable laws or regulations, these examinations, investigations, reviews, subpoenas and demands may:

- result in fines, penalties, injunctions, consent orders or loss of licensure;
- require changes in business practices;
- damage relationships with the agencies that regulate us and affect our ability to secure regulatory approvals necessary for the operation of our business; or
- damage our brand and reputation.

Our international subsidiaries are subject to regulations in international jurisdictions where foreign insurers may face more rigorous regulations than their domestic competitors.

The laws and regulations governing our business, as well as the related interpretations, are subject to frequent change and can be inconsistent or in conflict with each other. For a discussion of the risks related to our compliance with these laws and regulations see the Risk Factors section located in Part 1, Item 1A of the Form 10-K. Management continues to be actively engaged with regulators and policymakers with respect to legislation and rule-making. See the "Executive Overview – Health Care Industry Developments and Other Matters Affecting our Integrated Medical and Health Services Segments" section of our MD&A located in Part II, Item 7 of the Form 10-K for a discussion of the anticipated impact of certain recent industry developments.

Patient Protection and the Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (ACA) mandated broad changes affecting many aspects of the health care system. The ACA affects many aspects of health care, including insured and self-insured health benefit plans and pharmacy benefit managers. Our business model is impacted by the ACA, including our relationships with current and future producers and health care providers, products, service providers and technologies. Key provisions of the ACA include the imposition of a non-tax deductible health insurance industry fee and other assessments on health insurers, the creation of health insurance exchanges for individuals and small group employers to purchase insurance coverage and minimum loss ratios for our commercial and Medicare Part D business. Other provisions of the ACA in effect include reduced Medicare Advantage premium rates, the requirement to cover preventive services with no enrollee cost-sharing, banning the use of lifetime and annual limits on the dollar amount of essential health benefits, increasing restrictions on rescinding coverage, extending coverage of dependents up to age 26, enforcement mechanisms and rules related to healthcare fraud and abuse enforcement activities and certain pharmacy benefit transparency requirements. The employer mandate requires employers with 50 or more full-time employees to offer affordable health insurance that provides minimum value (each as defined under the ACA) to full-time employees and their dependents, including children up to age 26, or be subject to penalties based on employer size. The ACA also changed certain tax laws to effectively limit tax deductions for certain employee compensation paid by health insurers.

Since its adoption, there have been several attempts to repeal or limit the utility of the ACA. The current administration has issued several executive orders and approved legislative changes that affect the ACA, the impacts of which are not yet fully known. Among other things, these actions restricted agencies from taking certain actions that would impose a fiscal burden on any state, individual, provider, insurer, recipient of health care services, purchaser of health insurance or maker of medical devices, products or medications; and stopped payment of cost-sharing reduction subsidies to insurers. In December 2017, U.S. tax reform legislation was signed into law that, among other things, reduced the "individual mandate" penalty for individuals without health insurance to zero dollars, effective January 1, 2019. As a result of this change, a federal district court has ruled that the "individual mandate" is unconstitutional thereby leaving in doubt whether the entire ACA is unconstitutional until there is a final judicial determination on appeal.

Additionally, in 2017, the current administration issued an executive order asking the DOL to revise the Employee Retirement Income Security Act of 1974, as amended ("ERISA") regulations to make it easier for employers, particularly small employers, to associate for the purpose of sponsoring large group health plans and thereby avoid the ACA's small group market reform (e.g., community-rating and mandated coverage of essential health benefits) that impaired the affordability of providing health coverage to their employees. In the spring of 2018, the DOL issued final rules that revised the definition of "employer" in the ERISA rules to make it easier for employers, including self-employed individuals, to form bona fide employer groups, all of whose employees would be counted in determining whether they were small or large groups for purposes of the ACA. While the regulation of these groupings by state insurance departments is not affected by the DOL's final association health plan rules, the final rules have resulted in an increase in interest among employers, associations, producers and benefit consultants in forming new groupings for purposes of offering insured or self-funded group health plans.

Medicare and Medicaid Regulations

Through our subsidiaries, we offer individual and group Medicare Advantage, Medicare Pharmacy (Part D) and Medicare Supplement products. We also provide Medicare Part D-related products and services to other Medicare Part D sponsors, Medicare Advantage Prescription Drug Plans and other employers and clients offering Medicare Part D benefits to Medicare Part D eligible beneficiaries. As part of our Medicare Advantage and Medicare Part D business, we contract with CMS to provide services to Medicare beneficiaries. As a result, our ability to obtain payment (and the determination of the amount of such payments), market to, enroll and retain members and expand into new service areas is subject to compliance with CMS' numerous and complex regulations and requirements that are frequently modified and subject to

administrative discretion. Our Medicaid and dual-eligible products are regulated by CMS. State Medicaid agencies audit our performance to determine compliance with contracts and regulations.

CMS evaluates Medicare Advantage plans and Part D plans under its "Star Rating" system. The Star Rating system considers various measures adopted by CMS, including, for example, quality of care, preventative services, chronic illness management, coverage determinations and appeals and customer satisfaction. A plan's Star Rating affects its image in the market and plans that perform very well are able to market more effectively and for longer periods of time than other plans. Medicare Advantage plans' quality-bonus payments are determined by the Star Rating, with plans receiving a rating of four or more stars eligible for such payments. The Star Rating system is subject to change annually by CMS, which may make it more difficult to achieve four stars or greater.

CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage plans according to customers' health status. The risk-adjustment model generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to Medicare Advantage plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to the plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program.

On November 1, 2018, CMS released a proposed rule titled "Proposed Rule on Changes to MA and Part D Programs for CY 2020 and 2021" (the "MAPD Proposed Rule") that would revise its Risk Adjustment Data Validation ("RADV") methodology by, among other things, excluding an adjustment for underlying fee-for-service data errors (FFS Adjuster) and extrapolating RADV results at the contract level. On November 30, 2018, CMS released proposed rules titled "Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses" (the "Proposed Part D Rule") that focused on drug pricing, including a proposal to amend the definition of "negotiated price" in Part D to require Part D plans to apply pharmacy price concessions at the point of sale when calculating a Part D beneficiary's copayment. The Proposed MAPD Rule and the Proposed Part D Rule are subject to revision through the comment process.

In February 2019, CMS proposed rules to support the seamless and secure access, exchange and use of electronic health information. In the proposed rules, CMS proposes requirements that Medicaid, the Children's Health Insurance Program, Medicare Advantage plans and qualified health plans in the federally-facilitated exchanges provide enrollees with immediate electronic access to medical claims and other health information electronically by 2020. This proposed rule is subject to revision through a comment process.

Non-compliance with these laws and regulations may result in significant consequences, including fines and penalties, enrollment sanctions, exclusion from the Medicare and Medicaid programs, limitations on expansion, and criminal penalties.

False Claims Act and Anti-Kickback Laws

Our products and services are subject to numerous laws and regulations, including the federal False Claims Act (the "False Claims Act") and federal and state anti-kickback laws. Additionally, the federal government has made investigating and prosecuting health care fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks in return for customer referrals, billing for unnecessary medical services, upcoding and improper marketing. The regulations and contractual requirements in this area are complex, are frequently modified, and are subject to administrative discretion and judicial interpretation.

False Claims Act and Related Criminal Provisions. The False Claims Act imposes civil penalties for knowingly making or causing to be made false claims or false records or statements with respect to governmental programs, such as Medicare and Medicaid, to obtain reimbursement or for failure to return overpayments. Private individuals may bring qui tam or "whistleblower" suits against providers under the False Claims Act, which authorizes the payment of a portion of any recovery to the individual bringing suit. The ACA amended the federal anti-kickback laws to state any claim submitted to a federal or state healthcare program which violates the anti-kickback laws is also a false claim under the False Claims Act. The False Claims Act generally provides for the imposition of civil penalties and for treble damages, resulting in the possibility of substantial financial liabilities. Criminal statutes similar to the False Claims Act provide that if a corporation is convicted of presenting a claim or making a statement it knows to be false, fictitious or fraudulent to any federal agency, the corporation may be fined. Conviction under these statutes may also result in exclusion from participation in federal and state healthcare programs. Many states have also enacted laws similar to the False Claims Act, some of which may include criminal penalties, substantial fines and treble damages.

Anti-Kickback and Referral Laws. Subject to certain exceptions and "safe harbors," the federal anti-kickback statute generally prohibits, among other things, knowingly and willfully paying, receiving or offering any payment or other remuneration to induce a person to purchase, lease, order or arrange for items (including prescription drugs) or services reimbursable in whole or in part under Medicare, Medicaid or another federal healthcare program. Many states have similar laws, some of which apply similar anti-kickback prohibitions to items or services reimbursable by non-governmental payors. Sanctions for violating these federal and state anti-kickback laws may include criminal and civil fines and exclusion from participation in the federal and state healthcare programs.

Anti-kickback laws have been cited as a partial basis, along with state consumer protection laws described below, for investigations and multi-state settlements relating to financial incentives provided by drug manufacturers to pharmacies and/or payors in connection with "product conversion" or promotion programs. Other anti-kickback laws may be applicable to arrangements with pharmaceutical manufacturers, such as the Public Contracts Anti-Kickback Act, the ERISA Health Plan Anti-Kickback Statute, the federal "Stark Law" and various state anti-kickback restrictions.

In February 2019, HHS proposed changes to the federal anti-kickback safe harbor to exclude regulatory protection for rebates between drug manufacturers and Medicare Part D plans, Medicaid managed care organizations and pharmacy benefit managers in the context of these government programs. The proposed regulations in their current form apply solely to Medicare Part D and Medicaid programs, which include our Government business in the Integrated Medical segment. The proposed regulations also seek to create new safe harbor protections for fixed fee services arrangements between drug manufacturers and pharmacy benefit managers, as well as protections for discounts offered at

the point of sale. HHS has stated that it does not intend for the proposal to have an effect on existing protections for value-based arrangements between manufacturers and plan sponsors under Medicare Part D and Medicaid MCOs. While legislative and regulatory discussions on the other issues raised in the blueprint continue to be the subject of legislative and regulatory activity, they have yet to be implemented in any form.

Federal Civil Monetary Penalties Law. The federal civil monetary penalty statute provides for civil monetary penalties against any person who gives something of value to a Medicare or Medicaid program beneficiary which the person knows or should know is likely to influence the beneficiary's selection of a particular provider for Medicare or Medicaid items or services. Under this law, our wholly-owned home delivery pharmacies, specialty pharmacies and home health providers are restricted from offering certain items of value to influence a Medicare or Medicaid patient's use of services. The ACA also includes several civil monetary provisions, such as penalties for the failure to report and return a known overpayment and failure to grant timely access to the OIG under certain circumstances.

Federal and State Oversight of Government-Sponsored Health Care Programs

Participation in government-sponsored health care programs subjects us to a variety of federal and state laws and regulations and risks associated with audits conducted under these programs. These audits may occur years after the provision of services. Risks include potential fines and penalties, restrictions on our ability to participate or expand our presence in certain programs and restrictions on marketing our plans. For example, with respect to our Medicare Advantage business, CMS and the OIG perform audits to determine a health plan's compliance with federal regulations and contractual obligations, including program audits and compliance with proper coding practices (sometimes referred to as "Risk Adjustment Data Validation Audits" or "RADV audits").

Separately, the DOJ is currently conducting an industry review of the risk adjustment data submission practices and business processes, including review of medical charts, of Cigna and a number of other Medicare Advantage organizations under Medicare Parts C and D.

For our Medicare Part D business, compliance with fraud and abuse enforcement practices is monitored through Recovery Audit Contractor audits in which third-party contractors conduct post-payment reviews on a contingency fee basis to detect and correct improper payments.

Government Procurement Regulations

We have a contract with the DoD, which subjects us to all of the applicable Federal Acquisition Regulations ("FAR") and the DoD FAR Supplement, which govern federal government contracts. Further, there are other federal and state laws applicable to our DoD arrangement and our arrangements with other clients that may be subject to government procurement regulations. In addition, certain of our clients participate as contracting carriers in the Federal Employees Health Benefits Program administered by the Office of Personnel Management, which includes various pharmacy benefit management standards.

Employee Retirement Income Security Act

Our domestic subsidiaries sell most of their products and services to sponsors of employee benefit plans that are governed by ERISA. ERISA is a complex set of federal laws and regulations enforced by the IRS and the DOL, as well as the courts. ERISA regulates certain aspects of the relationship between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Certain of our domestic subsidiaries are also subject to requirements imposed by ERISA affecting claim payment and appeals procedures for individual health insurance and insured and self-insured group health plans and for the insured dental, disability, life and accident plans we administer. Certain of our domestic subsidiaries also may contractually agree to comply with these requirements on behalf of the self-insured dental, disability, life and accident plans they administer. We believe the conduct of our pharmacy benefit management business is not generally subject to the fiduciary obligations of ERISA. However, there can be no assurances that the DOL may not assert that pharmacy benefit managers are fiduciaries. From time to time, states have considered legislation to declare a pharmacy benefit manager or medical benefit manager a fiduciary with respect to its clients.

Plans subject to ERISA can also be subject to state laws and the legal question of whether and to what extent ERISA preempts a state law will continue to be subject to court interpretation.

Privacy, Security and Data Standards Regulations

Many of our activities involve the receipt or use of confidential health and other personal information. In addition, we use aggregated and de-identified data for our own research and analysis purposes and, in some cases, provide access to such data to pharmaceutical manufacturers and third-party data aggregators.

The federal Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") impose minimum standards on health insurers, pharmacy benefit managers, HMOs, health plans, health care providers and clearinghouses for the privacy and security of protected health information. HIPAA also established rules that standardize the format and content of certain electronic transactions, including, but not limited to, eligibility and claims.

The Health Information Technology for Economic and Clinical Health Act ("HITECH") imposes additional contracting requirements for covered entities, the extension of privacy and security provisions to business associates, the requirement to provide notification to various parties in the event of a data breach of protected health information, and enhanced financial penalties for HIPAA violations, including potential criminal penalties for individuals. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law.

A number of states have adopted data security laws and regulations regulating data security and requiring security breach notification that may apply to us in certain circumstances and are increasingly focused on protecting individuals from identity theft. Neither HIPAA nor the Gramm-Leach-Bliley privacy regulations preempt more stringent state laws and regulations. In addition, international laws, rules and regulations governing the use and disclosure of personal information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction.

The Cybersecurity Information Sharing Act of 2015 ("CISA") encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. States have also begun to issue regulations specifically related to cybersecurity. In October 2017, the National Association of Insurance Commissioners ("NAIC"), an organization of state insurance regulators, adopted the Insurance Data Security Model Law that creates rules for insurers and other covered entities addressing data security, investigation and notification of breaches. This includes maintaining an information security program based on ongoing risk assessment, overseeing third-party service providers, investigating data breaches and notifying regulators of a cybersecurity event. As the model law is intended to serve as model legislation only, states will need to enact legislation for the model law to become mandatory and enforceable. We will continue to monitor states' activity regarding cybersecurity regulation.

The European Union's General Data Protection Regulation ("GDPR"), which became enforceable in May 2018, introduced a number of new obligations regarding the handling of personal data of European customers. GDPR provides certain individual privacy rights to certain persons whose data we may store and provides for greater penalties for non-compliance than previous European data protection laws. In addition, many countries outside of Europe where we conduct business are considering data protection laws and regulations that include requirements modeled after those in the GDPR.

Consumer Protection Laws

We engage in direct-to-consumer activities and are increasingly offering mobile and web-based solutions to our customers. We are therefore subject to federal and state regulations applicable to electronic communications and other consumer protection laws and regulations, such as the Telephone Consumer Protection Act and the CAN-SPAM Act. In particular, the Federal Trade Commission is increasingly exercising its enforcement authority in the areas of consumer privacy and data security, with a focus on web-based, mobile data and "big data." Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

Most states have consumer protection laws that have been the basis for investigations and multi-state settlements relating to financial incentives provided by drug manufacturers to retail pharmacies in connection with product conversion programs. Such statutes have also been cited as the basis for claims or investigations by state attorneys general relative to privacy and data security.

Office of Foreign Assets Control Sanctions and Anti-Money Laundering

We are also subject to regulation by the Office of Foreign Assets Control of the Department of the Treasury that administers and enforces economic and trade sanctions against targeted foreign countries and regimes based on U.S. foreign policy and national security goals.

Certain of our products are subject to the Department of the Treasury anti-money laundering regulations under the Bank Secrecy Act.

In addition, we may be subject to similar regulations in non-U.S. jurisdictions in which we operate.

Corporate Practice of Medicine and Other Laws

Many states in which our subsidiaries operate limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed health care providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes could subject us to penalties or restructuring or reorganization of our business.

Network Access Legislation

A majority of states now have some form of legislation affecting our ability, or our clients' ability, to limit access to a pharmacy provider network or remove a provider from a network. Such legislation may require us or our clients to admit any retail pharmacy or provider willing to meet the plan's terms and conditions for network participation ("any willing provider" legislation) or may direct that a provider may not be removed from a network except in compliance with certain procedures ("due process" legislation).

Certain states have enacted legislation prohibiting certain pharmacy benefit management clients from imposing additional co-payments, deductibles, limitations on benefits, or other conditions ("Conditions") on covered individuals utilizing a retail pharmacy when the same Conditions are not otherwise imposed on covered individuals utilizing home delivery pharmacies. However, the legislation requires the retail pharmacy to agree to the same reimbursement amounts and terms and conditions as are imposed on the home delivery pharmacies. An increase in the number of prescriptions filled at retail pharmacies may have a negative impact on the number of prescriptions filled through home delivery. We anticipate additional states will consider similar legislation.

Legislation Affecting Plan Design

Some states have enacted legislation that prohibits managed care plan sponsors from implementing certain restrictive benefit plan design features, and many states have introduced legislation to regulate various aspects of managed care plans, including provisions relating to the

pharmacy benefit. For example, some states, under so-called "freedom of choice" legislation, provide members of the plan may not be required to use network providers, but must instead be provided with benefits even if they choose to use non-network providers. Some states have also enacted legislation, which, as described above, can negatively impact the use of cost-saving network configurations for plan sponsors. Other states have enacted legislation purporting to prohibit health plans from offering members financial incentives for use of home delivery pharmacies. Medicare and some states have issued guidance and regulations which limit our ability to fill or refill prescriptions electronically submitted by a physician to our home delivery pharmacy without first obtaining consent from the patient. Such restrictions generate additional costs and limit our ability to maximize efficiencies which could otherwise be gained through the electronic prescription and automatic refill processes. Legislation has been introduced in some states to prohibit or restrict therapeutic intervention, or to require coverage of all Food and Drug Administration approved drugs. Other states mandate coverage of certain benefits or conditions, and require health plan coverage of specific drugs if deemed medically necessary by the prescribing physician. States are also standardizing the process for, and restricting the use of, utilization management rules and shortening the time frames within which prescription drug prior authorization determinations must be made. Even where states do not regulate pharmacy benefit or utilization management companies directly, these laws will apply to many of our clients, including managed care organizations and health insurers.

Pharmacy Benefit Management and Drug Pricing Regulation

Our pharmacy benefit management services are subject to numerous laws and regulations. These laws and regulations govern, and proposed legislation and regulations may govern, critical practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; the receipt and retention of transmission fees from contracted pharmacies; use of, administration of, and/or changes to drug formularies, maximum allowable cost list pricing, and/or clinical programs; disclosure of data to third parties; drug utilization management practices; the level of duty a pharmacy benefit manager owes its clients or customers; configuration of pharmacy networks; the operations of our subsidiary pharmacies; disclosure of negotiated provider reimbursement rates; disclosure of negotiated drug rebates, calculation of customer cost share for prescription drug claims; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to customers' drug utilization; and registration or licensing of pharmacy benefit managers. Some states have adopted so-called "most favored nation" legislation which provides that a pharmacy participating in the state Medicaid program must give the state the best price the pharmacy makes available to any third-party plan.

Prescription drug pricing and the role of pharmacy benefit managers have been a focus of the current administration. In May 2018, the current administration announced a blueprint, titled "American Patients First," which considers a series of drug pricing proposals including, among other things, removal of the anti-kickback safe harbor protection for rebates between drug manufacturers and insurers and pharmacy benefit managers and improvements to pricing transparency. In October 2018, Congress enacted laws that prohibited pharmacy benefit managers and insurers from restricting pharmacies from providing drug pricing information to a plan enrollee when there is a difference between the cost of the drug under insurance and the cost of the drug when purchased without insurance. See also, "False Claims Act and Anti-Kickback Laws" for a discussion of HHS' proposed rule changes to the federal anti-kickback safe harbor to exclude regulatory protection for rebates between drug manufacturers and Medicare Part D plans, Medicaid managed care organizations and pharmacy benefit managers in the context of these government programs.

Some states have enacted statutes regulating the use of maximum allowable cost ("MAC") pricing. These statutes, referred to as "MAC Transparency Laws," generally require pharmacy benefit managers to disclose specific information related to MAC pricing to pharmacies and provide certain appeal rights for pharmacies. MAC Transparency Laws also restrict the application of MAC and may require operational changes to maintain compliance with the law. Some states have also enacted laws regulating pharmacy pricing and protecting the profitability of pharmacies for dispensing certain MAC-priced drugs. Some states have enacted laws requiring that the customer cost share for a prescription drug claim not exceed certain price points, such as the pharmacy's usual and customary charge or its contracted reimbursement for the drug.

In March 2018, the NAIC adopted changes to the Health Carrier Prescription Drug Benefit Management Model Act. The changes address issues relating to (i) transparency, accuracy and disclosure regarding prescription drug formularies and formulary changes during a policy year; (ii) accessibility of prescription drug benefits using a variety of pharmacy options; and (iii) tiered prescription drug formularies and discriminatory benefit design. While the actions of the NAIC do not have the force of law, they may influence states to adopt laws based on the model legislation.

The federal Medicaid rebate program requires participating drug manufacturers to provide rebates on all drugs reimbursed through state Medicaid programs, including through Medicaid managed care organizations. Manufacturers of brand name products must provide a rebate equivalent to the greater of (a) 23.1% of the average manufacturer price ("AMP") paid by retail community pharmacies or by wholesalers for certain drugs distributed to retail community pharmacies, or (b) the difference between AMP and the "best price" available to essentially any customer other than the Medicaid program and certain other government programs, with certain exceptions. We negotiate rebates with drug manufacturers and, in certain circumstances, sell services to drug manufacturers. Investigations are being and have been conducted by certain governmental entities which call into question whether a drug's "best price" was properly calculated and reported with respect to rebates paid by the manufacturers to the Medicaid programs. We are not responsible for such calculations, reports or payments.

Pharmacy Regulation

Our home delivery and specialty pharmacies are licensed to do business as a pharmacy in the states in which they are located. Most of the states into which we deliver pharmaceuticals have laws that require out-of-state home delivery pharmacies to register with, or be licensed by, the board of pharmacy or a similar regulatory body in the state. These states generally permit the pharmacy to follow the laws of the state in which the home delivery service is located, although some states require compliance with certain laws in that state as it impacts or relates to drugs distributed or dispensed into those states.

Our various pharmacy facilities also maintain certain Medicare and state Medicaid provider numbers as pharmacies providing services under these programs. Participation in these programs requires our pharmacies to comply with the applicable Medicare and Medicaid provider rules and regulations, and exposes the pharmacies to various changes the federal and state governments may impose regarding reimbursement methodologies and amounts to be paid to participating providers under these programs. In addition, several of our pharmacy facilities are

participating providers under Medicare Part D and, as a condition to becoming a participating provider under Medicare Part D, the pharmacies are required to adhere to certain requirements applicable to Medicare Part D.

Other statutes and regulations affect our home delivery and specialty pharmacy operations, including the federal and state anti-kickback laws and the federal civil monetary penalty law described above. Federal and state statutes and regulations govern the labeling, packaging, advertising, adulteration and security of prescription drugs and the dispensing of controlled substances. The Federal Trade Commission requires mail order sellers of goods generally to engage in truthful advertising, to stock a reasonable supply of the product to be sold, to fill mail orders within thirty days and to provide clients with refunds when appropriate. The United States Postal Service also has significant statutory authority to restrict the delivery of drugs and medicines through the mail.

Financial Reporting, Internal Control and Corporate Governance

Regulators closely monitor the financial condition of licensed insurance companies and HMOs. States regulate the form and content of statutory financial statements, the type and concentration of permitted investments, and corporate governance over financial reporting. Our insurance and HMO subsidiaries are required to file periodic financial reports and schedules with regulators in most of the jurisdictions in which they do business as well as annual financial statements audited by independent registered public accounting firms. Certain insurance and HMO subsidiaries are required to file an annual report of internal control over financial reporting with most jurisdictions in which they do business. Insurance and HMO subsidiaries' operations and accounts are subject to examination by such agencies. Many states have expanded regulations relating to corporate governance and internal control activities of insurance and HMO subsidiaries as a result of model regulations adopted by the NAIC with elements similar to corporate governance and risk oversight disclosure requirements under federal securities laws.

Guaranty Associations, Indemnity Funds, Risk Pools and Administrative Funds

Most states and certain non-U.S. jurisdictions require insurance companies to support guaranty associations or indemnity funds that are established to pay claims on behalf of insolvent insurance companies. Some states have similar laws relating to HMOs and other payors, such as consumer operated and oriented plans (co-ops) established under the ACA. In the United States, these associations levy assessments on member insurers licensed in a particular state to pay such claims. Certain states require HMOs to participate in guaranty funds, special risk pools and administrative funds. For additional information about guaranty funds and other assessments, see Note 19 to our Consolidated Financial Statements.

Certain states continue to require health insurers and HMOs to participate in assigned risk plans, joint underwriting authorities, pools or other residual market mechanisms to cover risks not acceptable under normal underwriting standards, although some states have eliminated these requirements as a result of the ACA.

Solvency and Capital Requirements

Many states have adopted some form of the NAIC model solvency-related laws and risk-based capital rules ("RBC rules") for life and health insurance companies. The RBC rules recommend a minimum level of capital depending on the types and quality of investments held, the types of business written and the types of liabilities incurred. If the ratio of the insurer's adjusted surplus to its risk-based capital falls below statutorily required minimums, the insurer could be subject to regulatory actions ranging from increased scrutiny to conservatorship.

In addition, various non-U.S. jurisdictions prescribe minimum surplus requirements that are based upon solvency, liquidity and reserve coverage measures. Our HMOs and life and health insurance subsidiaries, as well as non-U.S. insurance subsidiaries, are compliant with applicable RBC and non-U.S. surplus rules.

The Risk Management and Own Risk and Solvency Assessment Model Act ("ORSA"), adopted by the NAIC, provides requirements and principles for maintaining a group solvency assessment and a risk management framework and reflects a broader approach to U.S. insurance regulation. ORSA includes a requirement to file an annual ORSA Summary Report in the lead state of domicile. To date, an overwhelming majority of the states have adopted the same or similar versions of ORSA. We file our ORSA report annually as required.

Holding Company Laws

Our domestic insurance companies and certain of our HMOs are subject to state laws regulating subsidiaries of insurance holding companies. Under such laws, certain dividends, distributions and other transactions between an insurance company or an HMO subsidiary and its affiliates may require notification to, or approval by, one or more state insurance commissioners. In addition, the holding company acts of states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO subsidiary without prior regulatory approval.

Marketing, Advertising and Products

In most states, our insurance companies and HMO subsidiaries are required to certify compliance with applicable advertising regulations on an annual basis. Our insurance companies and HMO subsidiaries are also required by most states to file and secure regulatory approval of products prior to the marketing, advertising, and sale of such products.

Licensing and Registration Requirements

Certain subsidiaries contract to provide claim administration, utilization management and other related services for the administration of self-insured benefit plans. These subsidiaries may be subject to state third-party administration and other licensing requirements and regulation, as well as third-party accreditation requirements.

We have received full accreditation for Utilization Review Accreditation Commission Pharmacy Benefit Management version 2.2 Standards, which includes quality standards for drug utilization management, and select subsidiaries have received full accreditation for Utilization

Review Accreditation Commission for Health Utilization Management version 7.2, which includes quality standards for medical utilization management.

Certain states have adopted pharmacy benefit management registration and/or disclosure laws. In addition to registration laws, some states have adopted legislation mandating disclosure of various aspects of our financial practices, including those concerning pharmaceutical company revenue, as well as prescribing processes for prescription switching programs and client and provider audit terms.

Our international subsidiaries are often required to be licensed when entering new markets or starting new operations in certain jurisdictions. The licensure requirements for these subsidiaries vary by country and are subject to change.

International Regulations

Our operations outside the United States expose us to laws of multiple jurisdictions and the rules and regulations of various governing bodies and regulators, including those related to financial and other disclosures, corporate governance, privacy, data protection, data mining, data transfer, intellectual property, labor and employment, consumer protection, direct-to-consumer communications activities, tax, anti-corruption and anti-money laundering. Foreign laws and rules may include requirements that are different from, or more stringent than, similar requirements in the United States.

Our operations in countries outside the United States:

- are subject to local regulations of the jurisdictions where we operate;
- in some cases, are subject to regulations in the jurisdictions where customers reside; and
- in all cases, are subject to the Foreign Corrupt Practices Act (“FCPA”).

In particular, in South Korea where we are selling insurance products directly to individual customers, regulators are focused on protecting the rights of individual customers by enforcing “Treating Customers Fairly” concepts. This regulatory focus results in rigorous data localization requirements, network separation obligations, and system monitoring restrictions, as well as obligations to closely monitor marketing communications and sales scripts. Anti-money laundering requirements in South Korea and other Asian countries where we do business also impose obligations to collect certain information about each customer at time of sale and to risk rank each customer to determine possible future money laundering risk.

The FCPA prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official or employee to obtain or retain business or otherwise secure a business advantage. Outside of the United States, we may interact with government officials in several different capacities: as regulators of our insurance business; as clients or partners who are state-owned or partially state-owned; as health care professionals who are employed by the government; as hospitals that are state-owned; and as officials issuing permits in connection with real estate transactions. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the SEC and DOJ have increased their enforcement activities with respect to FCPA. The UK Bribery Act of 2010 applies to all companies with a nexus to the United Kingdom. Under this act, any voluntary disclosures of FCPA violations may be shared with United Kingdom authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions.

Miscellaneous

Premiums and fees from CMS represented 16% of our total consolidated revenues for the year ended December 31, 2018 under a number of contracts. We are not dependent on business from one or a few customers. Other than CMS, no one customer accounted for 10% or more of our consolidated revenues in 2018. We are not dependent on business from one or a few brokers or agents. In addition, our insurance businesses are generally not committed to accept a fixed portion of the business submitted by independent brokers and agents, and generally all such business is subject to approval and acceptance.

We had approximately 73,800 employees as of December 31, 2018.

ITEM 1A. Risk Factors

As a large global health service company operating in a complex industry, we encounter a variety of risks and uncertainties that could have a material adverse effect on our business, liquidity, results of operations, financial condition or the trading price of our securities. You should carefully consider each of the risks and uncertainties discussed below, together with other information contained in this Annual Report on Form 10-K, including Management's Discussion and Analysis of Results of Operations and Financial Condition. These risks and uncertainties are not the only ones we face. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect us. The following risk factors have been organized by category for ease of use; however many of the risks may have impacts in more than one category. These categories, therefore, should be viewed as a starting point for understanding the significant risks facing us and not as a limitation on the potential impact of the matters discussed. Risk factors are not necessarily listed in order of importance.

Strategic and Operational Risks

Future performance of our business will depend on our ability to execute our strategic and operational initiatives effectively.

The future performance of our business will depend in large part on our ability to effectively implement and execute our strategic and operational initiatives. Successfully executing on these initiatives depends on a number of factors, including our ability to:

- differentiate our products and services from those of our competitors;
- develop and introduce new and innovative products or programs, particularly in response to government regulation and the increased focus on consumer-directed products;
- grow our commercial product portfolio;
- identify and introduce the proper mix or integration of products that will be accepted by the marketplace;
- identify products and solutions that focus on improving patient outcomes and assist in controlling costs;
- evaluate drugs for efficacy, value and price to assist clients in selecting a cost-effective formulary;
- offer cost-effective home delivery pharmacy and specialty services;
- leverage purchase volume to deliver discounts to health benefit providers;
- attract and retain sufficient numbers of qualified employees;
- attract, develop and maintain collaborative relationships with a sufficient number of qualified partners;
- attract new and maintain existing customer and client relationships;
- transition health care providers from volume-based fee-for-service arrangements to a value-based system;
- improve medical cost competitiveness in our targeted markets;
- manage our medical, pharmacy, administrative, and other operating costs effectively; and
- contract with pharmaceutical manufacturers and pharmacy providers on favorable terms.

For our strategic initiatives to succeed, we must effectively integrate our operations, including with Express Scripts and other acquired businesses, actively work to ensure consistency throughout the organization, and promote a global mind-set along with a focus on individual customers and clients. If we fail to do so, our business may be unable to grow as planned, or the result of expansion may be unsatisfactory. We will be unable to rapidly respond to competitive, economic and regulatory changes if we do not make important strategic and operational decisions quickly, define our appetite for risk specifically, implement new governance, managerial and organizational processes smoothly and communicate roles and responsibilities clearly. If these initiatives fail or are not executed on effectively, our consolidated financial position and results of operations could be negatively affected.

We operate in a highly competitive, evolving and rapidly changing industry and our failure to adapt could negatively impact our business.

The health service industry continues to be dynamic and rapidly evolving. Any significant shifts in the structure of the industry could alter industry dynamics and adversely affect our ability to attract or retain clients. Industry shifts could result (and have resulted) from, among other things:

- a large intra- or inter-industry merger or industry consolidation;
- strategic alliances;
- new or alternative business models;
- continuing consolidation among physicians, hospitals and other health care providers, as well as changes in the organizational structures chosen by physicians, hospitals and health care providers;
- new market entrants, including those not traditionally in the health service industry;
- the ability of larger employers and clients to contract directly with providers;

- technological changes and rapid shifts in the use of technology, such as telemedicine;
- the impact or consequences of legislation or regulatory changes;
- changes in the United States Postal Service or the consolidation of shipping carriers;
- increased drug acquisition cost or unexpected changes to drug pricing trend;
- change in the generic drug market or the failure of new generic drugs to come to market;
- a general decrease in drug utilization; or
- a general increase in utilization under risk-based contracts in the medical benefit management market.

Our failure to anticipate or appropriately adapt to changes in the industry could negatively impact our competitive position and adversely affect our business and results of operations.

Our failure to compete effectively to differentiate our products and services from those of our competitors and maintain or increase market share could materially adversely affect our results of operations, financial position and cash flows.

We operate in a highly competitive environment and an industry subject to significant market pressures brought about by customer and client needs, legislative and regulatory developments and other market factors. In particular markets, our competitors may have greater, better or more established capabilities, resources, market share, reputation or business relationships, or lower profit margin or financial return expectations. Our clients are well informed and organized and can easily move between our competitors and us. Our Express Scripts client contracts generally have three-year terms. As described in greater detail in the description of our business in Item 1 above (see page 11 of this Form 10-K), one of our key clients in the Health Services segment is the United States Department of Defense. If one or more of our large clients either terminates or does not renew a contract for any reason, including as a result of being acquired, or if the provisions of a contract with a large client are modified, renewed or otherwise changed with terms less favorable to us, our results of operations could be adversely affected and we could experience a negative reaction in the investment community resulting in decreases in the trading price of our securities or other adverse effects.

Our success depends, in part, on our ability to compete effectively in our markets, set prices appropriately in highly competitive markets to keep or increase our market share, increase customers as planned, differentiate our business offerings by innovating and delivering products and services that provide enhanced value to our customers, provide quality and satisfactory levels of service, and retain accounts with favorable medical cost experience or more profitable products versus retaining or increasing our customer base in accounts with unfavorable medical cost experience or less profitable products.

We must remain competitive to attract new customers, retain existing customers, and further integrate additional product and service offerings. To succeed in this highly competitive marketplace, it is imperative we maintain a strong reputation. The negative reputational impact of a significant event, including a failure to execute on customer or client contracts or strategic or operational initiatives, or failure to innovate and deliver products and services that demonstrate greater value to our customers, could affect our ability to grow and retain profitable arrangements, which could have a material adverse effect on our business and results of operations.

We face price competition and other pressures that could compress our margins or result in premiums that are insufficient to cover the cost of services delivered to our customers.

While we compete on the basis of many service and quality-related factors, we expect that price will continue to be a significant basis of competition. Our client contracts are subject to negotiation as clients seek to contain their costs, including by reducing benefits offered. Increasingly, our clients seek to negotiate performance guarantees that require us to pay penalties if the guaranteed performance standard is not met. Clients can easily move between our competitors and us. Our clients are well-informed and typically have knowledgeable consultants that seek competing bids from our competitors before contract renewal. In addition, as brokers and benefit consultants seek to enhance their revenue streams, they look to take on services that we typically provide. Each of these events could negatively impact our financial results.

Further, federal and state regulatory agencies may restrict our ability to implement changes in premium rates. Fiscal or other concerns related to the government-sponsored programs in which we participate, such as Medicare, may cause decreasing reimbursement rates, delays in premium payments or insufficient increases in reimbursement rates. Any limitation on our ability to maintain or increase our premium or reimbursement levels, or a significant loss of customers or clients resulting from our need to increase or maintain premium or reimbursement levels, could adversely affect our business, cash flows, financial condition and results of operations.

Premiums in the Integrated Medical segment are generally set for one-year periods and are priced well in advance of the date on which the contract commences or renews. Our revenue on Medicare policies is based on bids submitted mid-year in the year before the contract year. Although we base the premiums we charge and our Medicare bids on our estimate of future health care costs over the contract period, actual costs may exceed what we estimate in setting premiums. Our health care costs also are affected by external events that we cannot forecast or project and over which we have little or no control, as well as changes in customers' health care utilization patterns and provider billing practices. Our profitability depends, in part, on our ability to accurately predict, price for and effectively manage future health care costs. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenue can result in significant changes in our financial results.

Strong competition within the pharmacy benefit business has also generated greater demand for lower product and service pricing, increased revenue sharing and enhanced product and service offerings. These competitive factors have historically applied pressure on our operating margins and caused many companies, including us, to reduce the prices charged for products and services while sharing with clients a greater portion of the formulary fees and related rebates received from pharmaceutical manufacturers. Our inability to maintain positive trends, or

failure to identify and implement new ways to mitigate pricing pressures, could negatively impact our ability to attract or retain clients or sell additional services, which could negatively impact our margins and have a material adverse effect on our business and results of operations.

The reserves we hold for expected medical claims are based on estimates that involve an extensive degree of judgment and are inherently variable. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to contain future costs may be limited.

We maintain and record medical claims reserves on our balance sheet for estimated future payments. Our estimates of health care costs payable are based on a number of factors, including historical claim experience, but this estimation process requires extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, changes in customer base and product mix, changes in the utilization of medical and/or other covered services, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. If we are not able to accurately and promptly anticipate and detect medical cost trends, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited. Because establishing these reserves is an inherently uncertain process involving estimates of future losses, there can be no certainty that ultimate losses will not exceed existing medical claims reserves.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other health service providers, our business and results of operations may be adversely affected.

We contract with physicians, hospitals and other health service providers and facilities to provide health services to our customers. Our results of operations are substantially dependent on our ability to contract for these services at competitive prices. In any particular market, physicians, hospitals and health service providers may enter into exclusive arrangements with competitors or simply refuse to contract with us, demand higher payments or take other actions that could result in higher medical costs or less desirable products or services for our customers. In some markets, certain providers, particularly hospitals, physician/hospital organizations and multi-specialty physician groups, may have significant or controlling market positions that could result in a diminished bargaining position for us. If providers refuse to contract with us, use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected. Establishing collaborative arrangements with physician groups, specialist groups, independent practice associations, hospitals and health care delivery systems is key to our strategic focus to transition from volume-based fee-for-service arrangements to a value-based health care system. If such collaborative arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our attractiveness to customers may be reduced and our ability to profitably grow our business may be adversely affected.

Our ability to develop and maintain satisfactory relationships with providers may also be negatively impacted by other factors not associated with us, such as changes in Medicare and/or Medicaid reimbursement levels, increasing pressure on revenue and other pressures on health care providers and increasing consolidation activity among hospitals, physician groups and providers. Continuing consolidation among physicians, hospitals and other providers, the emergence of accountable care organizations, vertical integration of providers and other entities, changes in the organizational structures chosen by physicians, hospitals and providers and new market entrants, including those not traditionally in the health care industry, may affect the way providers interact with us and may change the competitive landscape in which we operate. In some instances, these organizations may compete directly with us, potentially affecting the way we price our products and services or cause us to incur increased costs if we change our operations to be more competitive.

Out-of-network providers are not limited by any agreement with us in the amounts they bill. While benefit plans place limits on the amount of charges that will be considered for reimbursement, out-of-network providers have become increasingly sophisticated and aggressive and such limitations can be difficult to enforce. As a result, the outcome of disputes where we do not have a provider contract may cause us to pay higher medical or other benefit costs than we projected.

If we lose our relationship with one or more key pharmaceutical manufacturers, or if the payments made or discounts provided by pharmaceutical manufacturers decline, our business and results of operations could be adversely affected.

We maintain contractual relationships with numerous pharmaceutical manufacturers, which provide us with, among other things:

- discounts for drugs we purchase to be dispensed from our home delivery and specialty pharmacies;
- discounts, in the form of rebates, for drug utilization;
- fees for administering rebate programs, including invoicing, allocating and collecting rebates;
- fees for services provided to pharmaceutical manufacturers by our specialty pharmacies; and
- access to limited distribution specialty pharmaceuticals by our specialty pharmacies.

Our contracts with pharmaceutical manufacturers are typically non-exclusive and terminable on relatively short notice by either party. The consolidation of pharmaceutical manufacturers, the termination or material alteration of our contractual relationships, or our failure to renew such contracts on favorable terms could have a material adverse effect on our business and results of operations. In addition, arrangements between payors and pharmaceutical manufacturers have been the subject of debate in federal and state legislatures and various other public and governmental forums. Adoption of new laws, rules or regulations or changes in, or new interpretations of, existing laws, rules or regulations, relating to any of these programs could materially adversely affect our business and results of operations.

If significant changes occur within the pharmacy provider marketplace, or if other issues arise with respect to our pharmacy networks, including the loss of or adverse change in our relationship with one or more key pharmacy providers, our business and financial results could be impaired.

More than 68,000 retail pharmacies, which represent over 99% of all United States retail pharmacies, participated in one or more of our networks as of December 31, 2018. The ten largest retail pharmacy chains represent approximately 61% of the total number of stores in our largest network. In certain geographic areas of the United States, our networks may be comprised of higher concentrations of one or more large pharmacy chains. Contracts with retail pharmacies are generally non-exclusive and are terminable on relatively short notice by either party. If one or more of the larger pharmacy chains terminates its relationship with us, or is able to renegotiate terms substantially less favorable to us, our customers' access to retail pharmacies and/or our business could be materially adversely affected. The entry of one or more additional large pharmacy chains into the pharmacy benefit management business, the consolidation of existing pharmacy chains or increased leverage or market share by the largest pharmacy providers could increase the likelihood of negative changes in our relationship with such pharmacies. Changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could have a negative impact on our claims volume and/or our competitiveness in the marketplace, which could cause us to fall short of certain guarantees in our contracts with clients or otherwise impair our business or results of operations.

Changes in drug pricing or industry pricing benchmarks could materially impact our financial performance.

Contracts in the prescription drug industry, including our contracts with retail pharmacy networks and our pharmacy and specialty pharmacy clients, generally use "average wholesale price" or "AWP," which is published by a third party, as a benchmark to establish pricing for prescription drugs. If AWP is no longer published by third parties, we adopt other pricing benchmarks for establishing prices within the industry or future changes in drug prices substantially deviate from our expectations, the short- or long-term impacts may have a material adverse effect on our business and results of operations.

As a global company, we face political, legal, operational, regulatory, economic and other risks that present challenges and could negatively affect our multinational operations and/or our long-term growth.

As a global company, our business is increasingly exposed to risks inherent in foreign operations. These risks can vary substantially by market, and include political, legal, operational, regulatory, economic and other risks, including government intervention that we do not face in our U.S. operations. The global nature of our business and operations may present challenges including, but not limited to, those arising from:

- geopolitical business conditions and demands, including the June 2016 referendum in the United Kingdom to leave the European Union;
- regulation that may discriminate against U.S. companies, favor nationalization or expropriate assets;
- price controls or other pricing issues and exchange controls; restrictions that prevent us from transferring funds out of the countries in which we operate; foreign currency exchange rates and fluctuations and restrictions on converting currencies from foreign operations into other currencies; uncertainty with respect to the interpretation of tax positions;
- reliance on local employees and interpretations of labor laws in foreign jurisdictions;
- managing our partner relationships in countries outside of the United States;
- providing data protection on a global basis and sufficient levels of technical support in different locations;
- the global trend for companies to enact local data residency requirements;
- acts of war, terrorism, natural disasters or pandemics in locations where we operate; and
- general economic and political conditions.

These factors may increase in significance as we continue to expand globally and operating in new foreign markets may require considerable management time before operations generate any significant revenues and earnings. Any one of these challenges could negatively affect our operations or long-term growth. For example, due to the concentration of our international business in South Korea, the International Markets segment is exposed to potential losses resulting from economic and regulatory changes in that country and the geopolitical climate in the Korean Peninsula, as well as foreign currency movements affecting the South Korean currency, that could have a significant impact on the segment's results and our consolidated financial results.

International operations also require us to devote significant resources to implement controls and systems in new markets to comply with, and to ensure that our vendors and partners comply with, U.S. and foreign laws prohibiting bribery, corruption and money laundering, in addition to other regulations regarding, among other things, our products, direct-to-consumer communications, customer privacy, data protection and data residency. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business and significant reputational harm. Our success depends, in part, on our ability to anticipate these risks and manage these challenges. Our failure to comply with laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could have a material adverse effect on our business, results of operations, financial condition, liquidity and long-term growth.

We are dependent on the success of our relationships with third parties for various services and functions.

To improve operating costs, productivity and efficiencies, we contract with third parties for the provision of specific services. Our operations may be adversely affected if a third party fails to satisfy its obligations to us, if the arrangement is terminated in whole or in part or if there is a

contractual dispute between us and the third party. Even though contracts are intended to provide certain protections, we have limited control over the actions of third parties. For example, noncompliance with any privacy or security laws and regulations, any security breach involving one of our third-party vendors or a dispute between us and a third-party vendor related to our arrangement could have a material adverse effect on our business, results of operations, financial condition, liquidity and reputation.

Outsourcing also may require us to change our existing operations, adopt new processes for managing these service providers and/or redistribute responsibilities to realize the potential productivity and operational efficiencies. If there are delays or difficulties in changing business processes or our third-party vendors do not perform as expected, we may not realize, or not realize on a timely basis, the anticipated economic and other benefits of these relationships. This could result in substantial costs or regulatory compliance issues, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating or transitioning in whole or in part arrangements with key vendors could result in additional costs or penalties, risks of operational delays or potential errors and control issues during the termination or transition phase. We may not be able to find an alternative vendor in a timely manner or on acceptable terms. If there is an interruption in business or loss of access to data resulting from a security breach, termination or transition in services, we may not be able to meet the demands of our customers and, in turn, our business and results of operations could be adversely impacted.

A significant disruption in service within our operations or among our key suppliers or other third parties could materially adversely affect our business and results of operations.

Our business is highly dependent upon our ability to perform, in an efficient and uninterrupted fashion, necessary business functions, such as claims processing and payment, internet support and customer call centers, data centers and corporate facilities, processing new and renewal business, maintaining appropriate shipment and storage conditions for prescriptions (such as temperature and protection from contamination) and mail order processing. In some instances, our ability to provide services or products (including processing and dispensing prescriptions) depends on the availability of services and products provided by suppliers, pharmaceutical manufacturers, vendors or shipping carriers. Any failure or disruption of our performance of, or our ability to perform, key business functions, including through unavailability or cyber-attack of our information technology systems or those of third parties, could cause slower response times, decreased levels of service satisfaction and harm to our reputation. In addition, because our information technology and other systems interface with and depend on third-party systems, we could experience service denials if demand for such service exceeds capacity or a third-party system fails or experiences an interruption. Our failure to implement adequate business continuity and disaster recovery strategies could significantly reduce our ability to provide products and services to our customers and clients, which could have material adverse effects on our business and results of operations.

Acquisitions, including our acquisition of Express Scripts, joint ventures and other transactions involve risks and we may not realize the expected benefits because of integration difficulties, underperformance relative to our expectations and other challenges.

As part of our growth strategy, we regularly consider and enter into strategic transactions, including mergers, acquisitions, joint ventures, licensing arrangements and other relationships (collectively referred to as "strategic transactions"). Our ability to achieve the anticipated benefits of these strategic transactions is subject to numerous uncertainties and risks, including our ability to integrate operations, resources and systems, including data security systems, in an efficient and effective manner.

The success of the Express Scripts acquisition will depend, in part, on our ability to successfully combine the businesses of Cigna and Express Scripts and realize the anticipated benefits, including synergies, cost savings, innovation and operational efficiencies, from the combination. This integration is a complex, costly and time-consuming process, which may divert management's attention from ongoing business concerns.

Key risks of the Express Scripts integration include, but are not limited to, retaining existing clients and attracting new clients on profitable terms; maintaining employee morale and retaining key management and other employees; integrating two unique corporate cultures; consolidating corporate and administrative infrastructures and realizing operational synergies; integrating information technology, communications programs, financial procedures and operations, and other systems, procedures and policies; coordinating geographically separate organizations; managing tax costs or inefficiencies associated with integrating the operations of the combined company; and necessary modifications to internal financial control standards.

Integration activities may result in additional and unforeseen expenses, and the anticipated benefits of integration, including with respect to Express Scripts, may not be fully realized or may take longer to realize than expected. Delays or issues encountered in the integration process could have a material adverse effect on the revenues, expenses, operating results and financial condition of the combined company.

Strategic transactions could result in increased costs, including facilities and systems consolidation costs and costs to retain key employees, decreases in expected revenues, earnings or cash flows, and goodwill or other intangible asset impairment charges. Additional unanticipated costs may be incurred in the integration of Express Scripts' businesses. Although we expect that the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of those businesses, should allow us to more than offset incremental transaction and merger-related costs over time, this net benefit may not be achieved in the near term, or at all. In addition, the trading price of our securities may decline if, among other things, we are unable to achieve the expected growth in earnings, if our operational cost savings estimates are not realized, or the transaction costs related to the acquisition and integration are greater than expected. The trading price also may decline if we do not achieve the perceived benefits of the acquisition as rapidly or to the extent anticipated by financial or industry analysts.

Further, we may finance strategic transactions by issuing common stock for some or all of the purchase price that could dilute the ownership interests of our shareholders, or by incurring additional debt that could impact our ability to access capital in the future.

In addition, effective internal controls are necessary to provide reliable and accurate financial reports and to mitigate the risk of fraud. The integration of businesses, including Express Scripts, is likely to cause increasing complexity in our systems and internal controls and make them more difficult to manage. Any difficulties in assimilating businesses into our control system could cause us to fail to meet our financial reporting

obligations. Ineffective internal controls could also cause investors to lose confidence in our reported financial information that could negatively impact the trading price of our securities and our access to capital.

Our business depends on our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems.

Our business is highly dependent on maintaining effective information systems as well as the integrity and timeliness of the data we use to serve our customers and health care professionals and to operate our business. If our data were found to be inaccurate or unreliable due to fraud or other error, or if we, or any of the third-party service providers we engage, were to fail to maintain information systems and data integrity effectively, we could experience operational disruptions that may impact our clients, customers and health care professionals and hinder our ability to provide services and products, establish appropriate pricing for products and services, retain and attract clients and customers, establish reserves and report financial results timely and accurately and maintain regulatory compliance, among other things.

Our information technology strategy and execution are critical to our continued success. We must continue to invest in long-term solutions that will enable us to anticipate customer needs and expectations, enhance the customer experience, act as a differentiator in the market and protect against cybersecurity risks and threats. Our success is dependent, in large part, on maintaining the effectiveness of existing technology systems and continuing to deliver and enhance technology systems that support our business processes in a cost-efficient and resource-efficient manner. Increasing regulatory and legislative changes will place additional demands on our information technology infrastructure that could have a direct impact on resources available for other projects tied to our strategic initiatives. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Connectivity among technologies is becoming increasingly important. We must also develop new systems to meet current market standards and keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and customer needs. Failure to do so may present compliance challenges and impede our ability to deliver services in a competitive manner. Further, because system development projects are long-term in nature, they may be more costly than expected to complete and may not deliver the expected benefits upon completion. Our failure to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems could adversely affect our results of operations, financial position and cash flow.

As a large health service company, we are subject to cyber-attacks or other privacy or data security incidents. If we are unable to prevent or contain the effects of any such attacks, we may suffer exposure to substantial liability, reputational harm, loss of revenue or other damages.

Our business depends on our clients' and customers' willingness to entrust us with their health-related and other sensitive personal information. Computer systems may be vulnerable to physical break-ins, computer viruses or malware, programming errors, attacks by third parties or similar disruptive problems. We have been, and will likely continue to be, the target of computer viruses or other malicious codes, unauthorized access, cyber-attacks or other computer-related penetrations. There have been, and will likely continue to be, large scale cyber-attacks within the health service industry. As we increase the amount of personal information that we store and share digitally, our exposure to data security and related cybersecurity risks increases, including the risk of undetected attacks, damage, loss or unauthorized access or misappropriation of proprietary or personal information, and the cost of attempting to protect against these risks also increases. If disruptions or breaches are not detected quickly, their effect could be compounded. We have implemented security technologies, processes and procedures to protect consumer identity and provide employee awareness training around phishing, malware and other cyber risks; however, there are no assurances that such measures will be effective against all types of breaches.

Cyber-security threats are rapidly evolving and those threats and the means for obtaining access to our proprietary systems are becoming increasingly sophisticated. Cyber-attacks can originate from a wide variety of sources including third parties, such as external service providers, and the techniques used change frequently or are often not recognized until after they have been launched. Those parties may also attempt to fraudulently induce employees, customers or other users of our systems to disclose sensitive information in order to gain access to our data or that of our customers. In addition, while we have certain standards for all vendors that provide us services, our vendors, and in turn, their own service providers, may become subject to the same types of security breaches. Finally, our offices may be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human error or similar events that could negatively affect our systems and our customers' and clients' data.

The costs to eliminate or address security threats and vulnerabilities before or after a cyber-incident could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service and loss of existing or potential customers.

In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers or other third-parties could expose our customers' private information and our customers to the risk of financial or medical identity theft. Unauthorized dissemination of confidential and proprietary information about our business and strategy also could negatively affect the achievement of our strategic initiatives. Such events could cause us to breach our contractual confidentiality obligations and violate applicable laws. These events would negatively affect our ability to compete, others' trust in us, our reputation, customer base and revenues and expose us to mandatory disclosure (including to the media), litigation and other enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders and other adverse actions, any of which could adversely affect our business, results of operations, financial condition or liquidity.

In managing medical practices and operating onsite clinics and other types of medical facilities, we may be subject to additional liability that could result in significant time and expense.

In addition to contracting with physicians and other health care providers for services, we employ physicians, nurses and other health care professionals at onsite low acuity and primary care practices and infusion clinics that we manage and operate for our customers, as well as certain clinics for our employees. We also provide in-home care through health care professionals that we employ, as well as, through third-party contractors. As such, we are subject to liability for negligent acts, omissions, or injuries occurring at one of these clinics or caused by one of our employees. The defense of any actions may result in significant expenses that could have a material adverse effect on our business, results of operations, financial condition, liquidity and reputation.

Legal and Compliance Risks

Our business is subject to substantial government regulation, as well as new laws or regulations or changes in existing laws or regulations that could have a material adverse effect on our business, results of operations, financial condition and liquidity.

Our business is regulated at the federal, state, local and international levels. The laws and rules governing our business and related interpretations are increasing in number and complexity, are subject to frequent change and can be inconsistent or in conflict with each other.

Noncompliance with applicable regulations by us or our third-party vendors could have material adverse effects on our business, results of operations, financial condition, liquidity and reputation.

We must identify, assess and respond to new trends in the legislative and regulatory environment, as well as comply with the various existing regulations applicable to our business. From time to time, certain legislative and/or regulatory proposals are made which seek to manage the health care industry, including managing prescription drug cost, regulating drug distribution and managing health records. The trading price of our securities may react to the announcement of such proposals. We are unable to predict whether any such policies or proposals will be enacted, or the specific terms thereof. Certain of these policies or proposals could, if enacted, adversely impact our business and results of operations.

Existing or future laws, rules, regulatory interpretations or judgments could force us to change how we conduct our business, affect the products and services we offer, restrict revenue and enrollment growth, increase our costs, including operating, health care technology and administrative costs, and require enhancements to our compliance infrastructure and internal controls environment. We are required to obtain and maintain insurance and other regulatory approvals to market many of our products, increase prices for certain regulated products and consummate some of our acquisitions and dispositions. Delays in obtaining or failure to obtain or maintain these approvals could reduce our revenue or increase our costs. Existing or future laws and rules could also require or lead us to take other actions such as changing our business practices, and could increase our liability.

Further, failure to effectively implement or adjust our strategic and operational initiatives, such as by reducing operating costs, adjusting premium pricing or benefit design or transforming our business model in response to regulatory changes may have a material adverse effect on our results of operations, financial condition and cash flows, including, but not limited to, our ability to maintain the value of our goodwill and other intangible assets.

For more information on regulations to which we are subject, see "Business – Regulation" in Part I, Item 1 of this Form 10-K.

There are various risks associated with participating in government-sponsored programs, such as Medicare, including dependence upon government funding, compliance with government contracts and increased regulatory oversight.

Through our Government business, we contract with CMS and various state governmental agencies to provide managed health care services including Medicare Advantage plans and Medicare-approved prescription drug plans. If we fail to comply with CMS's contractual requirements, including data submission, enrollment and marketing, provider network adequacy, provider directory accuracy, quality measures, claims payment, continuity of care and call center performance, we may be subject to administrative actions, fines or other penalties that could impact our profitability.

Revenues from Medicare programs are dependent, in whole or in part, upon annual funding from the federal government through CMS and/or applicable state or local governments. Funding for these programs is dependent on many factors outside our control including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities. These entities generally have the right to not renew or cancel their contracts with us on short notice without cause or if funds are not available. Unanticipated changes in funding, such as the application of sequestration by the federal or state governments or the failure to provide for continued appropriations or regular ongoing scheduled payments to us, could substantially reduce our revenues and profitability.

The Medicare program has been the subject of regulatory reform initiatives. The premium rates paid to Medicare Advantage plans and Medicare Part D plans are established by contract, although the rates differ depending on a combination of factors, many of which are outside our control. The Star Rating system is subject to change annually by CMS, which may make it more difficult to achieve four stars or greater. A plan's Star Rating affects its image in the market and plans that perform well are able to market more effectively and for longer periods of time than other plans. Our Medicare Advantage plans' and Medicare Part D plans' operating results, premium revenue and benefit offerings are likely to continue to be significantly determined by their Star Ratings. A portion of each Medicare Advantage plan's reimbursement is tied to the plan's Star Rating, with those plans receiving a rating of four or more stars eligible for quality-based bonus payments. There can be no assurances that we will be successful in maintaining or improving our Star Ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our Star Ratings. Accordingly, our plans may not be eligible for full level quality bonuses,

which could adversely affect the benefits such plans can offer, reduce membership and/or impact our financial performance. See Part II, Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Information – Health Care Industry Developments and Other Matters Affecting our Global Health Care Segment for additional information on our Star Ratings.

On November 1, 2018, CMS released a proposed rule that would revise its Risk Adjustment Data Validation methodology by, among other things, excluding an adjustment for underlying fee-for-service data errors and extrapolating RADV results at the contract level. If adopted in its current form, the rule could have a detrimental impact to all Medicare Advantage insurers and affect the ability of plans to deliver high quality health care for the population served. While it is uncertain that CMS will issue the rule as proposed, if adopted, it could have a material impact on the Company's future results of operations.

Our participation in health insurance exchanges for individuals and small employers involves uncertainties associated with mix and volume of business and could adversely affect our results of operations, financial position and cash flows. The executive order signed in October 2017 that halted payment of the cost sharing reduction subsidies has created additional uncertainty regarding the future of public health insurance exchanges. Risk adjustment balances are subject to audit and adjustment by CMS.

Any failure to comply with various state and federal health care laws and regulations, including those directed at preventing fraud and abuse in government funded programs, could result in investigations or litigation, such as actions under the federal False Claims Act and similar whistleblower statutes under state laws. This could subject us to damage awards, fines, penalties or other enforcement actions, restrictions on our ability to market or enroll new customers, limits on expansion, restrictions or exclusions from programs or other agreements with federal or state governmental agencies, which could adversely impact our business, cash flows, financial condition, results of operations and reputation.

We face risks related to litigation, regulatory audits and investigations.

We are routinely involved in numerous claims, lawsuits, regulatory audits, investigations and other legal matters arising, for the most part, in the ordinary course of business, including that of administering and insuring employee benefit programs. These legal matters could include benefit claims, breach of contract actions, tort claims, claims arising from consumer protection laws, false claims act laws, claims disputes under federal or state laws and disputes regarding reinsurance arrangements, employment and employment discrimination-related suits, antitrust claims, employee benefit claims, wage and hour claims, tax, privacy, intellectual property and whistleblower claims, shareholder suits and other securities law claims and real estate disputes. In addition, we have incurred and likely will continue to incur liability for practices and claims related to our health care business, such as marketing misconduct, failure to timely or appropriately pay for or provide health care, provider network structure, poor outcomes for care delivered or arranged, provider disputes including disputes over compensation or contractual provisions, ERISA claims, allegations related to calculations of cost sharing and claims related to our administration of self-funded business. There are currently, and may be in the future, attempts to bring class action lawsuits against the company and other companies in our industry; individual plaintiffs also may bring multiple claims regarding the same subject matter against us and other companies in our industry.

Court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic or punitive damages may be sought. We seek to procure insurance coverage to cover some of these potential liabilities. However, certain potential liabilities may not be covered by insurance, insurers may dispute coverage or the amount of insurance may be insufficient to cover the entire damages awarded. In addition, certain types of damages, such as punitive damages, may not be covered by insurance, and insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. It is possible that the resolution of current or future legal matters and claims could result in changes to our industry and business practices, losses material to our results of operations, financial condition and liquidity or damage to our reputation.

We are frequently the subject of regulatory market conduct and other reviews, audits and investigations by state insurance and health and welfare and pharmacy departments, attorneys general, CMS and the OIG and comparable authorities in foreign jurisdictions. With respect to our Medicare Advantage and Medicare Part D businesses, CMS and OIG perform audits to determine a health plan's compliance with federal regulations and contractual obligations, including compliance with proper coding practices and fraud and abuse enforcement practices through audits designed to detect and correct improper payments. The Department of Justice is conducting an industry review of the risk adjustment data submission practices and business processes, including review of medical charts, of Cigna and a number of other Medicare Advantage organizations under Medicare Parts C and D. There also continues to be heightened review by federal and state regulators of business and reporting practices within the health service, disability and life insurance industries, including with respect to claims payment and related escheat practices, and increased scrutiny by other state and federal governmental agencies (such as state attorneys general) empowered to bring criminal actions in circumstances that could have previously given rise only to civil or administrative proceedings.

In addition, various governmental agencies have conducted investigations and audits into certain pharmacy benefit management practices. Many of these investigations and audits have resulted in other companies agreeing to civil penalties, including the payment of money and corporate integrity agreements. We cannot predict what effect, if any, such governmental investigations and audits may ultimately have on us or on the industry in general. However, we may experience government scrutiny and audit activity which may result in the payment or offset of prior reimbursements from the government.

Regulatory audits or reviews or actions by other governmental agencies could result in changes to our business practices, retroactive adjustments to certain premiums, significant fines, penalties, civil liabilities, criminal liabilities or other sanctions, including restrictions on our ability to market certain products or engage in business-related activities, that could have a material adverse effect on our business, results of operation, financial condition and liquidity. In addition, disclosure of an adverse investigation or audit or the imposition of fines or other sanctions could negatively affect our reputation in certain markets and make it more difficult for us to sell our products and services.

A description of material pending legal actions and other legal and regulatory matters is included in Note 19 to our Consolidated Financial Statements included in this Form 10-K. The outcome of litigation and other legal or regulatory matters is always uncertain.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, our business and reputation could be materially and adversely affected.

Most of our activities involve the receipt, use, storage or transmission of a substantial amount of individuals' protected health information and personally identifiable information. We also use aggregated and anonymized data for research and analysis purposes, and in some cases, provide access to such data to pharmaceutical manufacturers and third-party data aggregators and analysts. The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with clients. In some cases, such laws, rules, regulations and contractual requirements also apply to our vendors and require us to obtain written assurances of their compliance with such requirements or may hold us liable for any violations by our vendors. We are also subject to various other consumer protection laws that regulate our communications with customers. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is designed to protect credit card account data as mandated by payment card industry entities. International laws, rules and regulations governing the use and disclosure of such information, such as the GDPR, are generally more stringent than in the United States, and they vary across jurisdictions.

These laws, rules, and contractual requirements are subject to change. Compliance with new privacy, security and data laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA may further restrict our ability to collect, disclose and use sensitive personal information and may impose additional compliance requirements on our business.

HIPAA requires covered entities to comply with the HIPAA privacy, security and breach rules. In addition, business associates must comply with the HIPAA security and breach requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain sensitive personal information in order to provide services to these customers. HHS has continued its audit program to assess HIPAA compliance efforts by covered entities and has expanded it to include business associates. In addition, HHS has increased its enforcement efforts. These efforts can result in enforcement actions that are the result of investigations brought on by the notification to HHS of a breach. An audit resulting in findings or allegations of noncompliance or the implementation of an enforcement action could have an adverse effect on our results of operations, financial position, cash flows and reputation.

Effective prevention, detection and control systems are critical to maintain regulatory compliance and prevent fraud and failure of these systems could adversely affect us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities including kickbacks for referral of customers, billing for unnecessary medical services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us are complex and subject to change. In addition, ongoing vigorous law enforcement, a highly technical regulatory scheme and the Dodd-Frank Act legislation and related regulations enhance regulators' enforcement powers and whistleblower incentives and protections. Our compliance efforts in this area will continue to require significant resources. Failure of our prevention, detection or control systems related to regulatory compliance or the failure of employees to comply with our internal policies including data systems security or unethical conduct by managers and employees, could adversely affect our reputation and also expose us to litigation and other proceedings, fines and penalties.

In addition, provider or customer fraud that is not prevented or detected could impact our medical costs or those of our self-insured clients. Further, during an economic downturn, we may experience increased fraudulent claims volume that may lead to additional costs due to an increase in disputed claims and litigation.

Economic Risks

Significant stock market or interest rate declines could result in additional unfunded pension obligations resulting in the need for additional plan funding by us and increased pension expenses.

We currently have unfunded obligations in our frozen pension plans. A significant decline in the value of the plans' equity and fixed income investments or unfavorable changes in applicable laws or regulations could materially increase our expenses and change the timing and amount of required plan funding. This could reduce the cash available to us, including our subsidiaries. We are also exposed to interest rate and equity risk associated with our pension and other post-retirement obligations. Sustained declines in interest rates could have an adverse impact on the funded status of our pension plans and our reinvestment yield on new investments. See Note 13 to our Consolidated Financial Statements for more information on our obligations under the pension plans.

Significant changes in market interest rates affect the value of our financial instruments that promise a fixed return or benefit and the value of particular assets and liabilities.

As an insurer, we have substantial investment assets that support insurance and contractholder deposit liabilities. Generally low levels of interest rates on investments, such as those experienced in U.S. and foreign financial markets during recent years, have negatively impacted our level of investment income earned in recent periods.

A substantial portion of our investment assets are in fixed interest-yielding debt securities of varying maturities, fixed redeemable preferred securities and commercial mortgage loans. The value of these investment assets can fluctuate significantly with changes in market conditions. A rise in interest rates would likely reduce the value of our investment portfolio and increase interest expense if we were to access our available lines of credit.

A downgrade in the financial strength ratings of our insurance subsidiaries could adversely affect new sales and retention of current business, and a downgrade in our debt ratings would increase the cost of borrowed funds and could negatively affect our ability to access capital.

Financial strength, claims paying ability and debt ratings by recognized rating organizations are each important factors in establishing the competitive position of insurance and health benefits companies. Ratings information by nationally recognized ratings agencies is broadly disseminated and generally used throughout the industry. We believe that the claims paying ability and financial strength ratings of our principal insurance subsidiaries are important factors in marketing our products to certain customers. Our debt ratings impact both the cost and availability of future borrowings and, accordingly, our cost of capital. Each of the rating agencies reviews ratings periodically and there can be no assurance that current ratings will be maintained in the future. A downgrade of any of these ratings in the future could make it more difficult to either market our products successfully or raise capital to support business growth within our insurance subsidiaries.

Global market, economic and geopolitical conditions may cause fluctuations in equity market prices, interest rates and credit spreads that could impact our ability to raise or deploy capital and affect our overall liquidity.

If the equity and credit markets experience extreme volatility and disruption, there could be downward pressure on stock prices and restricted access to capital for certain issuers without regard to those issuers' underlying financial strength. Extreme disruption in the credit markets could adversely impact our access to, and cost of, capital in the future.

In the event of adverse economic and industry conditions, we may be required to dedicate a greater percentage of our cash flow from operations to the payment of principal and interest on our debt, thereby reducing the funds we have available for other purposes, such as investments and other expenditures in ongoing businesses, acquisitions, dividends and stock repurchases. In these circumstances, our ability to execute our strategy may be limited, our flexibility in planning for or reacting to changes in business and market conditions may be reduced, or our access to capital markets may be limited such that additional capital may not be available or may be available only on unfavorable terms.

In connection with the combination with Express Scripts, we have considerably higher levels of indebtedness than Cigna and Express Scripts previously carried, which will result in higher relative debt service costs and less cash flow from operations available to fund growth, stock repurchases and other corporate purposes during our deleveraging process.

The long-term indebtedness of Cigna was approximately $39.5 billion as of December 31, 2018. This level of indebtedness:

- requires us to dedicate a greater percentage of our cash flow from operations to debt payments, thereby reducing the availability of cash flow to fund capital expenditures, pursue other acquisitions or investments in new technologies, make stock repurchases, pay dividends and for general corporate purposes;
- increases our vulnerability to general adverse economic conditions, including increases in interest rates for our borrowings that bear interest at variable rates and are in a greater amount than floating rate assets held, or if such indebtedness is refinanced at a time when interest rates are higher; and
- limits our flexibility in planning for, or reacting to, changes in or challenges relating to our business and industry.

The covenants to which we have agreed in connection with the financing, and our indebtedness and higher debt-to-equity ratio in comparison to that of Cigna or Express Scripts on a recent historical basis, may have the effect, among other things, of restricting our financial and operating flexibility to respond to changing business and economic conditions, creating competitive disadvantages compared to other competitors with lower debt levels during the deleveraging process.

Unfavorable developments in economic conditions may adversely affect our business, results of operations and financial condition.

Many factors, including geopolitical issues, future economic downturns, availability and cost of credit and other capital and consumer spending can negatively impact the U.S. and global economies. Our results of operations could be materially and adversely affected by the impact of unfavorable economic conditions on our customers (both employers and individuals), health care providers, pharmacy manufacturers, pharmacy providers and third-party vendors. For example:

- Employers may take action to reduce their operating costs by modifying, delaying or canceling plans to purchase our products or making changes in the mix of products purchased that are unfavorable to us.
- Higher unemployment rates and workforce reductions could result in lower enrollment in our employer-based plans (including an increase in the number of employees who opt out of employer-based plans) or our individual plans.
- Because of unfavorable economic conditions or the ACA, employers may stop offering health care coverage to employees or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs.
- Our historical disability claim experience and industry data indicate that submitted disability claims rise under adverse economic conditions.
- If clients are not successful in generating sufficient funds or are precluded from securing financing, they may not be able to pay, or may delay payment of, accounts receivable that are owed to us.
- Our clients or potential clients may force us to compete more vigorously on factors such as price and service to retain or obtain their business.

- Our clients may be acquired, consolidated, or otherwise fail to successfully maintain or grow their business or workforce which could reduce the number of customers we serve or otherwise result in lower than anticipated utilization of our services.
- A prolonged unfavorable economic environment could adversely impact the financial position of hospitals and other health care providers, potentially increasing our medical costs as these providers attempt to maintain revenue levels in their efforts to adjust to their own economic challenges.
- Our third-party vendors could significantly and quickly increase their prices or reduce their output to reduce their operating costs. Our business depends on our ability to perform necessary business functions in an efficient and uninterrupted fashion.

These factors could lead to a decrease in our customer base, revenues or margins and/or an increase in our operating costs.

In addition, during a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced or delayed reimbursements or payments in state and federal government programs such as Medicare and Social Security or under contracts with government entities. These state and federal budgetary pressures also could cause the government to impose new or a higher level of taxes or assessments on us, such as premium taxes on insurance companies and HMOs and surcharges or fees on select fee-for-service and capitated medical claims. Although we could attempt to mitigate or cover our exposure from such increased costs through, among other things, increases in premiums, there can be no assurance that we will be able to mitigate or cover all of such costs, which may have a material adverse effect on our business, results of operations, financial condition and liquidity.

We are subject to the credit risk of our reinsurers.

We enter into reinsurance arrangements with other insurance companies, primarily to limit losses from large exposures or to permit recovery of a portion of direct losses. We also may enter into reinsurance arrangements in connection with acquisition or divestiture transactions when the underwriting company is not being acquired or sold.

Under all reinsurance arrangements, reinsurers assume insured losses, subject to certain limitations or exceptions that may include a loss limit. These arrangements also subject us to various obligations, representations and warranties with the reinsurers. Reinsurance does not relieve us of liability as the originating insurer. We remain liable to the underlying policyholders if a reinsurer defaults on obligations under the reinsurance arrangement. Although we regularly evaluate the financial condition of reinsurers to minimize exposure to significant losses from reinsurer insolvencies, reinsurers may become financially unsound. If a reinsurer fails to meet its obligations under the reinsurance contract or if the liabilities exceed any applicable loss limit, we will be forced to cover the claims on the reinsured policies.

The collectability of amounts due from reinsurers is subject to uncertainty arising from a number of factors, including whether the insured losses meet the qualifying conditions of the reinsurance contract, whether reinsurers or their affiliates have the financial capacity and willingness to make payments under the terms of the reinsurance contract and the magnitude and type of collateral supporting our reinsurance recoverable, such as holding sufficient qualifying assets in trusts or letters of credit issued. Although a portion of our reinsurance exposures are secured, the inability to collect a material recovery from a reinsurer could have a material adverse effect on our results of operations, financial condition and liquidity.

ITEM 1B. Unresolved Staff Comments

None.

ITEM 2. Properties

Our global real estate portfolio consists of approximately 13.3 million square feet of owned and leased properties. Our domestic portfolio has approximately 11.3 million square feet in 43 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Our international properties contain approximately 2.0 million square feet located throughout the following countries: Australia, Belgium, Canada, China, Hong Kong, India, Indonesia, Kenya, Kuwait, Lebanon, Malaysia, New Zealand, Oman, Singapore, South Korea, Spain, Switzerland, Taiwan, Thailand, Turkey, United Arab Emirates, and the United Kingdom.

Our principal domestic office locations include the Wilde Building located at 900 Cottage Grove Road in Bloomfield, Connecticut (our corporate headquarters), Two Liberty Place located at 1601 Chestnut Street in Philadelphia, Pennsylvania, and Express Scripts' corporate offices located at and around One Express Way in St. Louis, Missouri. The Wilde Building measures approximately 893,000 square feet and is owned. Express Scripts' campus measures approximately 1.2 million square feet of leased space and Two Liberty Place measures approximately 322,000 square feet and is leased space.

The home delivery pharmacy operations of Express Scripts consist of five non-dispensing order processing pharmacies, five patient contact centers and four high-volume automated mail order dispensing pharmacies located throughout the United States. Express Scripts' mail order dispensing pharmacies are located in Arizona, Indiana, Missouri and New Jersey. Express Scripts also has seven specialty home delivery pharmacies and 20 specialty branch pharmacies.

We believe our properties are adequate and suitable for our business as presently conducted. The foregoing does not include information on investment properties.

ITEM 3. Legal Proceedings

The information contained under "Litigation Matters" and "Regulatory Matters" in Note 19 to our Financial Statements beginning on page 115 of this Form 10-K, is incorporated herein by reference.

EXECUTIVE OFFICERS OF THE REGISTRANT

All officers are elected to serve for a one-year term or until their successors are elected. Principal occupations and employment during the past five years are listed below.

LISA R. BACUS, 54, Executive Vice President and Chief Marketing Officer of Cigna beginning May 2013 and Chief Customer Officer beginning February 2017; Executive Vice President and Chief Marketer at American Family Insurance from February 2008 until May 2013.

MARK L. BOXER, 59, Executive Vice President and Chief Information Officer of Cigna beginning April 2011; Deputy Chief Information Officer, Xerox Corporation; and Group President, Government Health Care, for Xerox Corporation/Affiliated Computer Services from March 2009 until April 2011.

DAVID M. CORDANI, 53, Chief Executive Officer of Cigna beginning December 2009; Director since October 2009; President beginning June 2008; and Chief Operating Officer from June 2008 until December 2009.

BRIAN C. EVANKO, 42, President, Government Business beginning November 2017; President, U.S. Individual Business from August 2013 to November 2017; Business Financial Officer, Cigna Global Individual, Health, Life and Accident from September 2012 to August 2013; Chief Actuary, Cigna Global Individual, Health, Life and Accident from December 2008 to September 2012.

NICOLE S. JONES, 48, Executive Vice President and General Counsel of Cigna beginning June 2011; Senior Vice President and General Counsel of Lincoln Financial Group from May 2010 until June 2011; Vice President and Deputy General Counsel of Cigna from April 2008 until May 2010; and Corporate Secretary of Cigna from September 2006 until April 2010.

MATTHEW G. MANDERS, 57, President, Strategy and Solutions beginning November 2018; President, Government & Individual Programs and Group Insurance from February 2017 through November 2017; President, U.S. Markets from June 2014 until February 2017; President, Regional and Operations from November 2011 until June 2014; President, U.S. Service, Clinical and Specialty from January 2010 until November 2011; and President, Cigna HealthCare, Total Health, Productivity, Network & Middle Market from June 2009 until January 2010.

STEVEN B. MILLER, 61, Executive Vice President and Chief Clinical Officer beginning December 2018; Senior Vice President and Chief Medical Officer of Express Scripts from October 2007 through December 2018.

JOHN M. MURABITO, 60, Executive Vice President, Human Resources and Services of Cigna beginning August 2003.

ERIC P. PALMER, 42, Executive Vice President and Chief Financial Officer beginning June 2017; Deputy Chief Financial Officer from February 2017 until June 2017; Senior Vice President, Chief Business Financial Officer from November 2015 to February 2017; Vice President, Business Financial Officer, Health Care from April 2012 to November 2015; and Vice President, Business Financial Officer, U.S. Commercial Markets from June 2010 to April 2012.

JASON D. SADLER, 50, President, International Markets beginning June 2014; President, Global Individual Health, Life and Accident from July 2010 until June 2014; and Managing Director Insurance Business Hong Kong, HSBC Insurance Asia Limited from January 2007 until July 2010.

MICHAEL W. TRIPLETT, 57, President, U.S. Markets beginning February 2017; Regional Segment Lead from June 2009 to February 2017.

TIMOTHY C. WENTWORTH, 58, President, Health Services beginning December 2018; Chief Executive Officer of Express Scripts from May 2016 until December 2018; President from February 2014 through December 2018; and Senior Vice President and President, Sales and Account Management from April 2012 until February 2014.

PART II

ITEM 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

The information under the caption "Quarterly Financial Data – Stock and Dividend Data" appears on page 129 of this Form 10-K. As of December 31, 2018, the number of shareholders of record was 38,262. Cigna's common stock is listed with, and trades on, the New York Stock Exchange under the symbol "CI".

Issuer Purchases of Equity Securities

The following table provides information about Cigna's share repurchase activity for the quarter ended December 31, 2018:

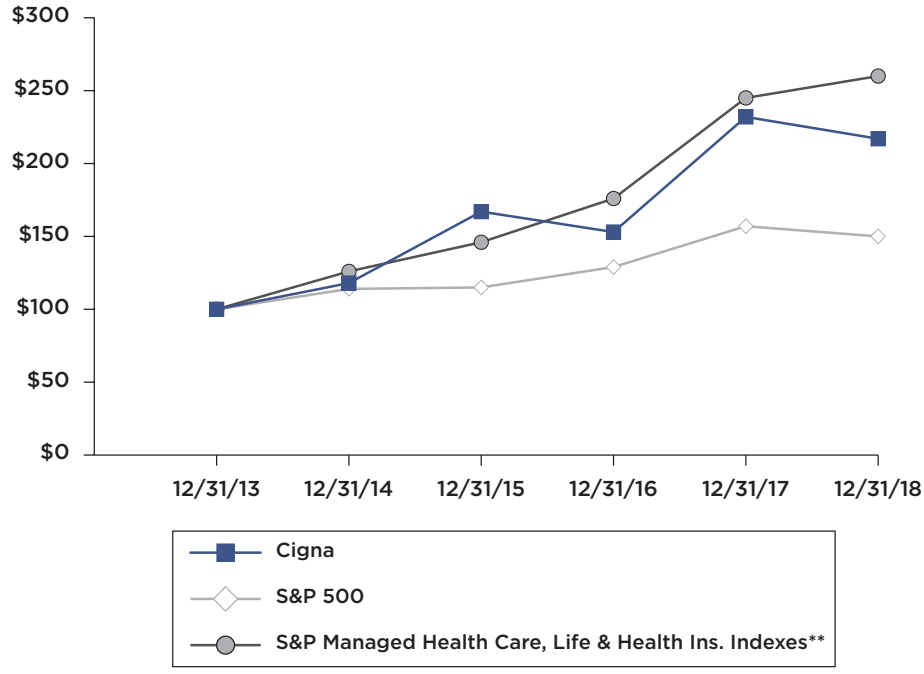
Period	Total # of shares purchased [1]	Average price paid per share	Total # of shares purchased as part of publicly announced program [2]	Approximate dollar value of shares that may yet be purchased as part of publicly announced program [3]
October 1-31, 2018	408	$ 213.81	—	$ 2,723,207,261
November 1-30, 2018	2,399	$ 217.59	—	$ 2,723,207,261
December 1-31, 2018	568,958	$ 183.94	288,644	$ 946,464,758
Total	571,765	$ 183.04	288,644	N/A

(1) Represents shares tendered by employees under the Company's equity compensation plans as follows: 1) payment of taxes on vesting of restricted stock and strategic performance shares and 2) payment of the exercise price and taxes for certain stock options exercised. Employees tendered 408 shares in October, 2,399 shares in November and 280,314 shares in December 2018.

(2) Additionally, the Company maintains a share repurchase program, authorized by the Board of Directors. Under this program, the Company may repurchase shares from time to time, depending on market conditions and alternate uses of capital. The timing and actual number of shares repurchased will depend on a variety of factors, including price, general business and market conditions and alternate uses of capital. The share repurchase program may be effected through Rule 10b5-1 plans, open market purchases or privately negotiated transactions, each in compliance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The program may be suspended or discontinued at any time. In 2018, the Company repurchased approximately 1.6 million shares for $330 million. On December 20, 2018, in connection with the merger with Express Scripts, the remaining authority of approximately $2.7 billion expired. The Board re-authorized $1 billion of share repurchase at that time. Remaining authorization under the program was approximately $950 million as of December 31, 2018. From January 1, 2019 through February 27, 2019, the Company repurchased 1.9 million shares for approximately $356 million, leaving the remaining repurchase authority at $590 million as of February 27, 2019.

(3) Approximate dollar value of shares is as of the last date of the applicable month.

Five Year Cumulative Total Shareholder Return*
December 31, 2013 – December 31, 2018



	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Cigna	$ 100	$ 118	$ 167	$ 153	$ 232	$ 217
S&P 500	$ 100	$ 114	$ 115	$ 129	$ 157	$ 150
S&P Managed Health Care, Life & Health Ins. Indexes**	$ 100	$ 126	$ 146	$ 176	$ 245	$ 260

* *Assumes that the value of the investment in Cigna common stock and each index was $100 on December 31, 2013 and that all dividends were reinvested.*

** *Weighted average of S&P Managed Health Care (75%) and Life and Health Insurance (25%) Indexes.*

ITEM 6. Selected Financial Data

The selected financial data should be read in conjunction with Management's Discussion and Analysis of Financial Condition and Results of Operations and the Consolidated Financial Statements and accompanying notes included elsewhere herein.

Highlights

(Dollars in millions, except per share amounts)	2018	2017	2016	2015	2014
Total revenues [1][2]	**$ 48,650**	$ 41,806	$ 39,838	$ 38,098	$ 35,096
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867	$ 2,094	$ 2,102
Net income	**$ 2,646**	$ 2,232	$ 1,843	$ 2,077	$ 2,094
Shareholders' net income per share					
Basic	**$ 10.69**	$ 8.92	$ 7.31	$ 8.17	$ 7.97
Diluted	**$ 10.54**	$ 8.77	$ 7.19	$ 8.04	$ 7.83
Common dividends declared per share	**$ 0.04**	$ 0.04	$ 0.04	$ 0.04	$ 0.04
Cash and investments	**$ 32,829**	$ 31,591	$ 30,000	$ 26,681	$ 25,762
Total assets	**$ 153,226**	$ 61,759	$ 59,366	$ 57,094	$ 55,876
Long-term debt	**$ 39,523**	$ 5,199	$ 4,756	$ 5,020	$ 4,979
Total liabilities	**$ 112,154**	$ 47,999	$ 45,605	$ 45,005	$ 45,021
Shareholders' equity	**$ 41,028**	$ 13,711	$ 13,699	$ 12,011	$ 10,750

(1) Effective January 1, 2018, the Company adopted Accounting Standards Update 2014-09 and related amendments that provided updated guidance on revenue recognition. This new guidance was adopted retrospectively and, accordingly, prior year amounts have been adjusted. See Note 2 to the Consolidated Financial Statements for additional information.

(2) Effective December 31, 2018, as a result of the acquisition of Express Scripts (see Note 3 to the Consolidated Financial Statements), the Company adopted Article 5 of Regulation S-X issued by the Securities and Exchange Commission. As a result, realized investment results are no longer included in revenues. Prior year revenues have been adjusted to conform to the new presentation.

ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") is intended to provide information to assist you in better understanding and evaluating our financial condition and results of operations. We encourage you to read this MD&A in conjunction with our Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K ("Form 10-K") and the "Risk Factors" contained in Part I, Item 1A of this Form 10-K.

Unless otherwise indicated, financial information in the MD&A is presented in accordance with accounting principles generally accepted in the United States of America ("GAAP"). See Note 2 to our Consolidated Financial Statements for additional information regarding the Company's significant accounting policies. In some of our financial tables in this MD&A, we present either percentage changes or "N/M" when those changes are so large as to become not meaningful. Changes in percentages are expressed in basis points ("bps").

In this MD&A, our consolidated measures "adjusted income from operations," earnings per share on that same basis, and "adjusted revenues" are not determined in accordance with GAAP and should not be viewed as substitutes for the most directly comparable GAAP measures "shareholders' net income," "earnings per share" and "total revenues." As discussed in Note 21, we also use pre-tax adjusted income from operations and adjusted revenues to measure the results of our segments.

We use adjusted income from operations as our principal financial measure of operating performance because management believes it best reflects the underlying results of our business operations and permits analysis of trends in underlying revenue, expenses and profitability. We define adjusted income from operations as shareholders' net income (or income before taxes for the segment metric) excluding realized investment gains and losses, amortization of acquired intangible assets, results of Anthem, Inc. and Coventry Health Care Inc. ("Coventry") (collectively, the "transitioning clients") (see the "Key Transactions and Developments" section of the MD&A for further discussion of transitioning clients) and special items. Beginning in 2018, Cigna's share of certain realized investment results of its joint ventures reported using the equity method of accounting are also excluded. Income or expense amounts excluded from adjusted income from operations because they are not indicative of underlying performance or the responsibility of operating segment management include:

- *Realized investment gains (losses), including changes in market values of certain financial instruments between balance sheet dates, as well as gains and losses associated with invested asset sales.*
- *Amortization of acquired intangible assets, because these relate to costs incurred for acquisitions.*
- *Results of transitioning clients, because those results are not indicative of ongoing results.*
- *Special items, if any, that management believes are not representative of the underlying results of operations due to the nature or size of these matters. See Note 21 to the Consolidated Financial Statements for descriptions of special items.*

Adjusted revenues is defined as total revenues excluding the following adjustments: revenue contributions from transitioning clients, special items and, beginning in 2018, Cigna's share of certain realized investment results of its joint ventures reported using the equity method of accounting.

Executive Overview

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us") is a global health service organization dedicated to a mission of helping those we serve improve their health, well-being and peace of mind. Our evolved strategy in support of our mission is ***Go Deeper, Go Local, Go Beyond*** using a differentiated set of medical, pharmacy, dental, disability, life and accident insurance and related products and services offered by our subsidiaries. For further information on our business and strategy, see Item 1, "Business" in this Form 10-K.

As described more fully in Note 3 to our Consolidated Financial Statements, on March 8, 2018, we entered into a merger agreement with Express Scripts Holding Company ("Express Scripts"). Following entry into the merger agreement and throughout the pendency of the transaction, Cigna and Express Scripts designed integration plans to implement a new management and business reporting structure for the combined company upon closing. On December 20, 2018, we completed the acquisition of Express Scripts and, our segments have changed effective in the fourth quarter of 2018. See Note 1 to our Consolidated Financial Statements for a description of our segments. Prior year financial information has been restated to reflect this new segment presentation. Additionally, as described further in Note 2 to the

Consolidated Financial Statements, we adopted Article 5 of Regulation S-X issued by the Securities and Exchange Commission effective December 31, 2018. Results of 2018 include 11 days of Express Scripts activity beginning December 21.

Financial Summary

Summarized below are certain key measures of our performance for the years ended December 31:

	For the Years Ended December 31,			Increase (Decrease)	Increase (Decrease)
(Dollars in millions, except per share amounts)	**2018**	**2017**	**2016**	**2018 vs. 2017**	**2017 vs. 2016**
Revenues					
Adjusted revenues by segment					
Integrated Medical	**$ 32,791**	$ 29,035	$ 27,395	13%	6%
Health Services	**6,606**	4,241	4,066	56	4
International Markets	**5,366**	4,901	4,537	9	8
Group Disability and Other	**5,061**	5,075	5,108	–	(1)
Corporate, including eliminations	**(1,713)**	(1,446)	(1,268)	(18)	(14)
Adjusted revenues	**48,111**	41,806	39,838	15	5
Revenue contributions from transitioning clients	**459**	–	–	N/M	N/M
Net realized investment (losses) from equity method subsidiaries	**(43)**	–	–	N/M	N/M
Special items reported in transaction-related costs [(1)]	**123**	–	–	N/M	N/M
Total revenues	**$ 48,650**	$ 41,806	$ 39,838	16%	5%
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867	18%	20%
Adjusted income from operations	**$ 3,557**	$ 2,668	$ 2,104	33%	27%
Earnings per share (diluted)					
Shareholders' net income	**$ 10.54**	$ 8.77	$ 7.19	20%	22%
Adjusted income from operations	**$ 14.22**	$ 10.46	$ 8.10	36%	29%
Pre-tax adjusted income from operations by segment					
Integrated Medical	**$ 3,502**	$ 2,922	$ 2,592	20%	13%
Health Services	**380**	288	268	32	7
International Markets	**735**	654	538	12	22
Group Disability and Other	**529**	517	275	2	88
Corporate	**(403)**	(375)	(362)	(7)	(4)
Consolidated pre-tax adjusted income from operations	**4,743**	4,006	3,311	18	21
Adjustment for transitioning clients	**62**	–	–	N/M	N/M
Income (loss) attributable to noncontrolling interests	**14**	(2)	(20)	800	90
Realized investment (losses) gains	**(124)**	237	169	(152)	40
Amortization of acquired intangible assets	**(235)**	(115)	(151)	(104)	24
Special items	**(879)**	(520)	(330)	(69)	(58)
Income before income taxes	**$ 3,581**	$ 3,606	$ 2,979	(1)%	21%

(1) For additional information related to net investment income included in transaction-related costs, please refer to Note 3 to the Consolidated Financial Statements in this Form 10-K.

Consolidated Results of Operations (GAAP Basis)

Financial Summary

	For the Years Ended December 31,			Increase (Decrease)		Increase (Decrease)	
(in millions)	**2018**	**2017**	**2016**	**2018 vs. 2017**		**2017 vs. 2016**	
Premiums	**$ 36,113**	$ 32,491	$ 30,824	$ 3,622	11%	$ 1,667	5%
Fees and other revenues	**5,578**	5,110	4,901	468	9	209	4
Pharmacy revenues	**5,479**	2,979	2,966	2,500	84	13	–
Net investment income	**1,480**	1,226	1,147	254	21	79	7
Total revenues	**48,650**	41,806	39,838	6,844	16	1,968	5
Medical costs and other benefit expenses	**27,528**	25,263	24,341	2,265	9	922	4
Pharmacy and other service costs	**4,793**	2,456	2,468	2,337	95	(12)	–
Selling, general and administrative expenses	**11,934**	10,030	9,790	1,904	19	240	2
Amortization of acquired intangible assets	**235**	115	151	120	104	(36)	(24)
Total benefits and expenses	**44,490**	37,864	36,750	6,626	17	1,114	3
Income from operations	**4,160**	3,942	3,088	218	6	854	28
Interest expense and other	**(498)**	(252)	(278)	(246)	(98)	26	9
Debt extinguishment costs	**–**	(321)	–	321	100	(321)	N/M
Net realized investment gains (losses)	**(81)**	237	169	(318)	(134)	68	40
Income before income taxes	**3,581**	3,606	2,979	(25)	(1)	627	21
Income taxes	**935**	1,374	1,136	(439)	(32)	238	21
Net income	**2,646**	2,232	1,843	414	19	389	21
Less: net income (loss) attributable to noncontrolling interests	**9**	(5)	(24)	14	280	19	79
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867	$ 400	18%	$ 370	20%
Consolidated effective tax rate	**26.1%**	38.1%	38.1%	1,200bps		–bps	
Medical customers (in thousands)							
Integrated Medical	**15,389**	14,828	13,970	561	4%	858	6%
International Markets	**1,572**	1,549	1,488	23	1	61	4
Total	**16,961**	16,377	15,458	584	4%	919	6%

Reconciliation of Shareholders' Net Income (GAAP) to Adjusted Income from Operations (non-GAAP):

				Diluted Earnings Per Share		
	For the Years Ended December 31,			For the Years Ended December 31,		
(Dollars in millions, except per share amounts)	**2018**	**2017**	**2016**	**2018**	**2017**	**2016**
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867	**$ 10.54**	$ 8.77	$ 7.19
– Adjustment for transitioning clients	**(47)**	–	–	**(0.19)**	–	–
– Net realized investment losses (gains)	**104**	(156)	(109)	**0.42**	(0.61)	(0.42)
– Amortization of acquired intangible assets	**177**	66	94	**0.71**	0.26	0.36
Special items						
– Transaction-related costs (see Note 3 to our Consolidated Financial Statements)	**669**	33	147	**2.67**	0.13	0.56
– Charges associated with litigation matters discussed in Note 19D. to our Consolidated Financial Statements	**19**	–	25	**0.08**	–	0.10
– U.S. tax reform (see Note 18 to our Consolidated Financial Statements)	**(2)**	196	–	**(0.01)**	0.77	–
– Debt extinguishment costs (see Note 5 to our Consolidated Financial Statements)	**–**	209	–	**–**	0.82	–
– Long-term care guaranty fund assessment (see Note 19C. to our Consolidated Financial Statements)	**–**	83	–	**–**	0.32	–
– Risk corridor allowance (see Note 21 to our Consolidated Financial Statements)	**–**	–	80	**–**	–	0.31
Adjusted income from operations	**$ 3,557**	$ 2,668	$ 2,104	**$ 14.22**	$10.46	$ 8.10

Earnings and Revenue Commentary

Shareholders' net income increased in 2018 compared with 2017, primarily driven by a lower effective tax rate. Income before income taxes was essentially flat, reflecting higher adjusted income from operations, largely offset by reduced realized investment results and higher special item charges due to transaction costs associated with the Express Scripts acquisition. In 2017, the increase in shareholders' net income as compared to 2016 was due to higher adjusted income from operations, with special item charges for debt extinguishment costs and charges resulting from U.S. Tax reform partially offsetting the increase.

Adjusted income from operations increased in 2018 compared with 2017, primarily due to earnings growth across all of our segments, including contributions from the acquired Express Scripts business and the lower effective tax rate in 2018. In 2017, the increase in adjusted income from operations compared with 2016 was due to earnings growth across all of our segments.

Medical customers increased in both 2018 and 2017, compared with each prior year primarily resulting from growth in the Commercial and Government segments. See the Integrated Medical segment section for additional discussion.

Revenues increased in both 2018 and 2017, primarily due to business growth in the Integrated Medical and International Markets segments. In 2018, revenues from the acquired Express Scripts business of $2.6 billion also contributed to the increase. Detailed revenue items are discussed further below.

- ***Premiums*** increased in 2018 compared with 2017, primarily reflecting customer growth in Integrated Medical including contributions from specialty products as well as growth in International Markets. Also contributing to the increase were higher premium rates in our Integrated Medical segment driven by: 1) underlying medical trend; 2) suspension of the government's cost share reduction subsidies; and 3) resumption of the health insurance industry tax. The increase in 2017 compared with 2016 primarily resulted from customer growth in the Commercial segment and in International Markets, partially offset by decreases in Government segment premiums due to Medicare disenrollment.
- ***Pharmacy revenues*** increased in 2018 compared with 2017 primarily resulting from contributions from the acquired Express Scripts business. See the Health Services section of this MD&A for further discussion of pharmacy revenues and costs.
- ***Fees and other revenues***. The increases in both 2018 and 2017 compared with each prior year were primarily attributable to growth in our specialty businesses and an increased customer base for our administrative services only ("ASO") business. In 2018, contributions from the acquired Express Scripts business also contributed to the increase.
- ***Net investment income*** was higher in 2018 compared with 2017, reflecting growth in average assets and higher yields, largely driven by increased partnership income. Net investment income in 2018 also included $123 million earned from proceeds on the debt issued in September 2018 that is reported as a special item. Those debt proceeds were used to finance the Express Scripts acquisition on December 20, 2018. In 2017, net investment income increased compared with 2016, driven by growth in average invested assets, partially offset by lower yields.

Commentary on Other Components of Consolidated Results of Operations

- ***Medical costs and other benefit expenses*** increased in both 2018 and 2017, compared with the prior year, reflecting customer growth in Integrated Medical and International Markets, as well as medical cost inflation in Integrated Medical.
- ***Selling, general and administrative expenses*** increased in 2018 compared with 2017, driven by higher transaction-related costs associated with the acquisition of Express Scripts, resumption of the health insurance industry tax and volume-based expenses reflecting business growth. In 2017, the increase in selling, general and administrative expenses compared with 2016 reflected a long-term care guaranty fund assessment and higher volume-based expenses reflecting business growth. These increases were offset by suspension of the health insurance industry tax in 2017 and a reduction in costs related to our Center for Medicare and Medicaid Services ("CMS") audit response.
- ***Amortization of acquired intangible assets*** increased in 2018 compared with 2017, primarily reflecting the impact of the acquired Express Scripts business. The decrease in 2017 compared with 2016 was driven by the expected continuing decline in amortization from our 2012 acquisition of HealthSpring, Inc.
- ***Interest expense and other*** increased significantly in 2018 compared with 2017, primarily due to $227 million of interest incurred on debt issued in the third quarter of 2018 prior to the acquisition of Express Scripts. This amount is included in the overall special item for transaction-related costs, net of $123 million of investment income earned on the debt proceeds through the closing date of the transaction.
- ***Realized investment results*** declined significantly in 2018 compared with 2017, resulting from lower gains on sales of alternative, partnership and fixed maturity investments as well as mark-to-market losses on equity securities reported in net income as required by Accounting Standards Update 2016-01, Recognition and Measurement of Financial Assets and Liabilities, beginning in 2018 (see Note 2 to our Consolidated Financial Statements). In 2017, realized investment results increased compared with 2016, primarily due to higher gains on sales of alternative and real estate investments, as well as lower impairment losses.
- ***The consolidated effective tax rate*** decreased in 2018 compared with 2017, primarily due to a lower U.S. tax rate in 2018, partially offset by resumption of the non-deductible health insurance industry tax and the absence of the incremental tax benefit recognized in the second quarter of 2017 for certain transaction costs associated with the terminated merger with Anthem. In 2017, the effective tax rate was flat compared with 2016. The unfavorable impact of additional tax expense associated with the U.S. tax reform legislation enacted in 2017 was offset by favorable effects of a suspension of the health insurance industry tax in 2017 and an incremental tax benefit from previously non-deductible transaction-related costs. See Note 18 to our Consolidated Financial Statements for additional information.

Key Transactions and Developments

Acquisition of Express Scripts

As discussed in more detail in Note 3 to the Consolidated Financial Statements, Cigna acquired Express Scripts on December 20, 2018 in a cash and stock transaction valued at $52.8 billion. See the "Liquidity" section of this MD&A for further discussion of the financing of this transaction.

We incurred a significant amount of costs related to this acquisition, both before and after closing. These costs are being reported in "transaction-related costs" as a special item and excluded from adjusted income from operations. The results of Express Scripts are included in Cigna's consolidated financial information from the date of the acquisition.

On January 30, 2019, Anthem exercised its early termination right and terminated the pharmacy benefit management services agreement with us, effective March 1, 2019. There is a twelve-month transition period ending March 1, 2020. It is expected that the transition of Anthem's customers will occur at various dates, as informed by Anthem's technology platform migration schedule. Over the next twelve months, we will focus on an effective transition of this relationship and related services over Anthem's accelerated timeline. We exclude the results of Express Scripts' contract with Anthem (and also Coventry) from our non-GAAP reporting metric "adjusted income from operations." We refer to this adjustment as "transitioning clients."

U.S. Tax Reform Legislation

Major U.S. tax reform legislation was signed into law on December 22, 2017. The legislation reduced the corporate income tax rate from 35% to 21% effective January 1, 2018, among other things. See Note 18 to our Consolidated Financial Statements for further discussion of the impacts of this legislation on our results of operations.

Health Care Industry Developments and Other Matters Affecting Our Integrated Medical and Health Services Segments

The "Regulation" section of this Form 10-K provides a detailed description of The Patient Protection and Affordable Care Act provisions and other legislative initiatives that impact our health care business, including regulations issued by CMS and the Departments of the Treasury and Health and Human Services ("HHS"). The table presented below provides an update of the impact of these items and other matters affecting our Integrated Medical and Health Services segments as of December 31, 2018.

Item	Description
Medicare Advantage	***Medicare Star Quality Ratings ("Star Ratings"):*** Medicare Advantage ("MA") plans must have a Star Rating of four Stars or greater to qualify for bonus payments. Approximately 60% of our Medicare Advantage customers were in a four Star or greater plan for bonus payments received in 2018. We expect this percentage to increase to 72% for bonus payments to be received in 2019 and to 76% in 2020. ***MA Rates:*** Final MA reimbursement rates for 2019 were published by CMS in April 2018. Preliminary MA reimbursement rates for 2020 were published by CMS in February 2019. We do not expect the new rates to have a material impact on our consolidated results of operations in 2019 and 2020. ***Risk Adjustment Validation ("RADV") Audits:*** As discussed in the "Regulation" and "Risk Factors" sections of this Form 10-K, our MA business is subject to reviews, including RADV audits. In 2012, CMS released a payment methodology that provided for sample audit error rates to be extrapolated to the entire MA contract after comparing audit results to a similar audit of Medicare Fee for Service (the "FFS Adjuster"), including any errors in the Medicare FFS data. This comparison is necessary to determine the true economic impact of the audit, if any, because the government uses the Medicare FFS data to determine adjustments to MA payment rates for various health conditions to establish actuarial equivalency in payment rates as required by the Medicare statute. In the fourth quarter of 2018, CMS issued a proposed rule that included, among other things, extrapolation of the error rate related to audit findings without applying the FFS Adjuster. This rule is discussed further in the Regulation section of this Form 10-K on page 20. If adopted in its current form, the rule could have a detrimental impact to all Medicare Advantage insurers and affect the ability of plans to deliver high quality health care for the population served. While it is uncertain that CMS will issue the rule as proposed, if they did, it could have a material impact on the Company's future results of operations.
Health Care Reform Act Tax	***Health Insurance Industry Tax:*** Federal legislation imposed a moratorium on the health insurance industry tax for 2017 and 2019. The industry tax was assessed in 2018 and, under current law, will be imposed in 2020. The industry tax for Cigna in 2018 was $370 million ($205 million for Commercial and $165 million for Government). For our Commercial business, the tax was reflected in our 2018 premium rates and did not have a material effect on shareholders' net income in 2018. For our Medicare business, the earnings impact in 2018 resulting from this renewed tax was somewhat offset with benefit and pricing changes. Because this tax is not deductible for federal income tax purposes, it negatively impacted our effective tax rate in 2018.
Public Health Exchanges	***Market Participation:*** For 2018, we offered individual coverage on six public health insurance exchanges in the following states: Colorado, Illinois, Missouri, North Carolina, Tennessee and Virginia. For 2019, we expanded our individual coverage to Arizona while continuing to offer coverage on all of the other six exchanges as in 2018. ***Cost Sharing Reduction Subsidies:*** The Patient Protection and the Affordable Care Act ("ACA") provides for cost sharing reductions that offset the amount that qualifying customers pay for deductibles, copayments and coinsurance. The federal government provided funding for the cost sharing reduction subsidies to the qualifying customer's insurer until October 2017 when these payments were stopped. The attorneys general of 18 states and the District of Columbia sued the current administration, seeking to require the administration to continue paying these subsidies. In October 2017, the court denied the attorney generals' request for an injunction, allowing the government to stop paying the cost sharing reduction subsidies to insurers during the pendency of the matter. In July 2018, the court granted a motion by the states to dismiss the lawsuit without prejudice, meaning the states may refile a lawsuit at a later time. Certain insurers have sued the federal government for failure to pay cost sharing reduction subsidies as well, and a judge in two of those actions has ruled in favor of the insurers. We will continue to monitor developments. Our premium rates for the 2018 and 2019 plan years reflect the government's decision to cease paying these subsidies.
Prescription Drug Pricing	As discussed in the Regulation section on page 20 of this Form 10-K, prescription drug pricing and the role of pharmacy benefit managers have been a focus of the current administration. In February 2019, the HHS proposed changes to the federal anti-kickback safe harbor to exclude regulatory protection for rebates between drug manufacturers and Medicare Part D plans, Medicaid managed care organizations and pharmacy benefit managers in the context of these government programs. The proposed regulations in their current form apply solely to Medicare Part D and Medicaid programs that include our Government business in the Integrated Medical segment. The proposed regulations also seek to create new safe harbor protections for fixed fee services arrangements between drug manufacturers and pharmacy benefit managers, as well as protections for discounts offered at the point of sale. These proposed regulations, if adopted as written, could affect current industry practices. We do not expect them to have a material effect on our business or results of operations. This area continues to be the subject of legislative and regulatory activity.

Risk Mitigation Programs

In 2016, we recorded an allowance for the balance of our risk corridor receivable based on court decisions and the large program deficit. During 2018, the U.S. Federal Circuit court ruled that health insurers are not entitled to receive amounts due under the risk corridor program that have been withheld by Congress. The plaintiffs have petitioned the U.S. Supreme Court to review this unfavorable decision. As of December 31, 2018, we continue to carry this allowance of $109 million based on the current status of court decisions.

Risk adjustment balances are subject to audit and adjustment by CMS following each program year. In February 2018, a federal judge issued a decision invalidating the use of statewide average premium for risk adjustment purposes. In response, in July 2018, CMS issued a final rule clarifying the 2017 program methodology and addressing issues raised in the ruling by the federal judge. This rule clears the way for CMS to resume risk adjustment collections and payments for the 2017 program year. Despite this final rule, resolution of the legal matter remains uncertain. As of December 31, 2018, our financial statements reflect the risk adjustment balances for the 2018 and 2017 plan years under the rules currently in effect for the program.

The following table presents our balances associated with the risk adjustment program as of December 31, 2018 and 2017.

	Net Receivable (Payable) Balance As of December 31,	
(In millions)	**2018**	**2017**
Risk Adjustment		
Receivables [1]	**$ 32**	$ 69
Payables [2]	**(187)**	(250)
Total risk adjustment balance	**$ (155)**	$ (181)

(1) Receivables, net of allowances, are reported in accounts receivable in the Consolidated Balance Sheets.

(2) Payables are reported in accrued expenses and other liabilities (current) in the Consolidated Balance Sheets.

After-tax charges for the risk adjustment program were $116 million in 2018 and $105 million in 2017, compared with after-tax benefits of $25 million in 2016.

Liquidity And Capital Resources

Financial Summary *(In millions)*	**2018**	**2017**	**2016**
Short-term investments	**$ 316**	$ 199	$ 691
Cash and cash equivalents	**$ 3,855**	$ 2,972	$ 3,185
Short-term debt	**$ 2,955**	$ 240	$ 276
Long-term debt	**$ 39,523**	$ 5,199	$ 4,756
Shareholders' equity	**$ 41,028**	$ 13,711	$ 13,699

Liquidity

We maintain liquidity at two levels: the subsidiary level and the parent company level.

Liquidity requirements at the subsidiary level generally consist of:

- medical costs, pharmacy and other benefit payments;
- expense requirements, primarily for employee compensation and benefits, information technology and facilities costs; and
- income taxes.

Our subsidiaries normally meet their operating requirements by:

- maintaining appropriate levels of cash, cash equivalents and short-term investments;
- using cash flows from operating activities;
- matching investment durations to those estimated for the related insurance and contractholder liabilities;
- selling investments; and
- borrowing from affiliates, subject to applicable regulatory limits.

Liquidity requirements at the parent company level generally consist of:

- debt service and dividend payments to shareholders;
- lending to subsidiaries as needed; and
- pension plan funding.

The parent company normally meets its liquidity requirements by:

- maintaining appropriate levels of cash and various types of marketable investments;
- collecting dividends from its subsidiaries;
- using proceeds from issuance of debt and common stock; and
- borrowing from its subsidiaries, subject to applicable regulatory limits.

Dividends from our insurance, Health Maintenance Organization ("HMO") and foreign subsidiaries are subject to regulatory restrictions. See Note 17 to the Consolidated Financial Statements for additional discussion of these restrictions. Because most of Express Scripts' subsidiaries are not subject to regulatory restrictions on paying dividends, acquiring Express Scripts provides significantly increased financial flexibility to Cigna.

Cash flows for the years ended December 31, were as follows:

(In millions)	2018	2017	2016
Net cash provided by operating activities	**$ 3,770**	$ 4,086	$ 4,026
Net cash (used in) investing activities:			
Cash used to acquire Express Scripts, net of cash acquired	**(24,062)**	–	–
Other acquisitions	**(393)**	(209)	(4)
Net investment (purchases)	**(1,383)**	(1,023)	(2,008)
Purchases of property and equipment and other	**(540)**	(471)	(562)
Net investing activities	**(26,378)**	(1,703)	(2,574)
Net cash provided by (used in) financing activities			
Debt proceeds used to finance Express Scripts acquisition	**22,856**	–	–
Other debt transactions, net	**1,356**	98	(148)
Stock repurchase	**(342)**	(2,725)	(139)
Other, net	**(355)**	(24)	62
Net financing activities	**23,515**	(2,651)	(225)
Foreign currency effect on cash	**(24)**	55	(10)
Change in cash and cash equivalents	**$ 883**	$ (213)	$ 1,217

Operating activities

Cash flows from operating activities consist principally of cash receipts and disbursements for premiums, fees, pharmacy revenues and costs, investment income, taxes, benefit costs and other expenses.

Cash flows from operating activities decreased in 2018 compared with 2017 primarily driven by the timing of settlement of pharmacy payables, partially offset by higher net income.

Cash flows from operating activities increased slightly in 2017 compared with 2016 primarily driven by higher net income, partially offset by lower receipts from Medicare Part D and Medicare Advantage programs and a voluntary pension contribution of $150 million in 2017.

Investing and Financing activities

Our most significant investing and financing activities of 2018 related to acquiring Express Scripts. See Note 3 to the Consolidated Financial Statements for additional information on the acquisition. Cigna financed a portion of the acquisition in cash, primarily with debt financing as shown above and described more fully in Note 5 to the Consolidated Financial Statements, with the remaining required cash coming from cash on hand. In 2018, Cigna also acquired OnePath Life for approximately $480 million, largely with cash held in our foreign operations.

Net investment purchases increased in 2018 compared with 2017, largely due to reinvesting our cash flows into fixed income investments. The decrease in net investment purchases in 2017 compared with 2016 primarily reflects higher cash used for share repurchases in 2017.

Stock repurchases declined in 2018 compared with 2017 as Cigna suspended stock repurchase activity to provide liquidity for the Express Scripts acquisition. Stock repurchase activity was significantly higher in 2017 than 2016, as stock repurchase activity was suspended for much of 2016 during the pendency of the Anthem transaction.

We maintain a share repurchase program authorized by our Board of Directors. Under this program, we may repurchase shares from time to time, depending on market conditions and alternate uses of capital. The timing and actual number of shares repurchased will depend on a variety of factors, including price, general business and market conditions and alternate uses of capital. The share repurchase program may be effected through open market purchases or privately negotiated transactions in compliance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended, including through Rule 10b5-1 trading plans. The program may be suspended or discontinued at any time.

In 2018, we repurchased 1.6 million shares for approximately $330 million. From January 1, 2019 through February 27, 2019 we repurchased 1.9 million shares for approximately $356 million. The remaining share repurchase authority as of February 27, 2019 was $590 million. We repurchased 15.7 million shares for $2.8 billion in 2017 and 0.8 million shares for $110 million in 2016.

Capital Resources

Our capital resources (primarily cash flows from operating activities and proceeds from the issuance of debt and equity securities) provide protection for policyholders, furnish the financial strength to underwrite insurance risks and facilitate continued business growth.

Our acquisition of Express Scripts increased our debt and shareholders' equity in 2018 as follows:

- ***Stock.*** Express Scripts shareholders received 0.2434 of a share of common stock of Cigna for every one share of Express Scripts. Cigna issued 137.6 million additional shares to Express Scripts shareholders.
- ***Debt.*** See Note 5 to the Consolidated Financial Statements for further description of the debt issued to finance the acquisition.
- ***Assumption of Express Scripts Senior Notes.*** See Note 5 to the Consolidated Financial Statements for further description of the notes assumed in the acquisition of Express Scripts.

At December 31, 2018, our debt-to-capitalization ratio was 50.9%. We expect to deleverage to the upper 30s within 18 to 24 months by using cash flows from operating activities.

Cigna entered into a new Revolving Credit Agreement and Term Loan Credit Agreement in financing the Express Scripts acquisition. A select number of subsidiaries guarantee Cigna obligations under the Revolving Credit Agreement and the Term Loan Credit Agreement. See Note 5 to the Consolidated Financial Statements for further information on these guarantees, as well as information on our Revolving Credit Agreement and the Term Loan Credit Agreement. Cigna had $22 million of letters of credit outstanding as of December 31, 2018.

Management, guided by regulatory requirements and rating agency capital guidelines, determines the amount of capital resources that we maintain. Management allocates resources to new long-term business commitments when returns, considering the risks, look promising and when the resources available to support existing business are adequate.

We prioritize our use of capital resources to:

- provide the capital necessary to support growth and maintain or improve the financial strength ratings of subsidiaries and to fund pension obligations;
- consider acquisitions that are strategically and economically advantageous; and
- return capital to investors primarily through share repurchases.

We continue to maintain a capital management strategy to retain overseas a significant portion of the earnings from our foreign operations. These undistributed earnings are deployed outside of the United States predominantly in support of the liquidity and regulatory capital requirements of our foreign operations as well as to support growth initiatives overseas. This strategy does not materially limit our ability to meet our liquidity and capital needs in the United States.

Liquidity and Capital Resources Outlook

At December 31, 2018, there was approximately $4.2 billion in cash and short-term investments, $1.2 billion of which was held by the parent or subsidiaries with no regulatory or other restrictions on transferring cash to the parent via dividend or loan. In 2019, we expect to generate an additional $6.2 billion of capital available for deployment, including $2.1 billion of dividends that our regulated insurance companies may pay without prior regulatory approval. The parent company's cash obligations in 2019 are expected to approximate $3.2 billion primarily for repayment of debt, interest and anticipated dividends. We expect to re-issue the $1.5 billion commercial paper borrowing upon its maturity.

We expect to have sufficient liquidity to meet the obligations discussed above, based on the cash currently available to the parent and current projections for subsidiary dividends and cash flows from the newly acquired Express Scripts operations. In addition, we actively monitor our debt obligations and engage in issuance or redemption activities as needed in accordance with our capital management strategy.

Our cash projections may not be realized and the demand for funds could exceed available cash if our ongoing businesses experience unexpected shortfalls in earnings, or we experience material adverse effects from one or more risks or uncertainties described more fully in the Risk Factors section of this Form 10-K. In those cases, we expect to have the flexibility to satisfy liquidity needs through a variety of measures, including intercompany borrowings. The parent company can borrow an additional $650 million from its insurance subsidiaries without additional state approval. We have additional liquidity available through short-term commercial paper borrowing capacity and the $3.25 billion revolving credit agreement discussed in Note 5 to the Consolidated Financial Statements.

As of December 31, 2018, our unfunded pension liability was $590 million, reflecting a decrease of $98 million from December 31, 2017, primarily attributable to an increase in discount rates of approximately 75 basis points. Contributions required in 2019 under the Pension Protection Act of 2006 are immaterial. See Note 13 to our Consolidated Financial Statements for additional information regarding our pension plans.

Though we believe we have adequate sources of liquidity, significant disruption or volatility in the capital and credit markets could affect our ability to access those markets for additional borrowings or increase costs associated with borrowing funds.

Guarantees and Contractual Obligations

We are contingently liable for various contractual obligations entered into in the ordinary course of business. See the "Liquidity and Capital Resources" section of this MD&A beginning on page 48 for additional background on how we manage our liquidity requirements related to these obligations. The maturities of our primary contractual cash obligations as of December 31, 2018 are estimated to be as follows:

(In millions, on an undiscounted basis)	Total	Less than 1 year	1-3 years	4-5 years	After 5 years
On-Balance Sheet					
Insurance liabilities					
Contractholder deposit funds	$ 7,133	$ 619	$ 741	$ 641	$ 5,132
Future policy benefits	11,517	709	1,224	1,153	8,431
Unpaid claims and claim expenses	8,851	4,967	1,119	719	2,046
Long-term debt	53,968	1,543	11,905	9,396	31,124
Other long-term liabilities	636	137	95	81	323
Off-Balance Sheet					
Purchase obligations	2,295	858	1,012	338	87
Operating leases	861	199	330	200	132
Total	$ 85,261	$ 9,032	$ 16,426	$ 12,528	$ 47,275

On balance sheet:

- ***Insurance liabilities.*** Excluded from the table above are $4 billion of insurance liabilities ($3 billion in contractholder deposit funds; $1 billion in future policy benefits) associated with the sold retirement benefits and individual life insurance and annuity businesses, as well as the reinsured workers' compensation, personal accident and supplemental benefits businesses as their related net cash flows are not expected to impact our cash flows. Excluding these amounts, the sum of the obligations presented above exceeds the corresponding insurance and contractholder liabilities of $22 billion recorded on the balance sheet because some of the recorded insurance liabilities reflect discounting for interest and the recorded contractholder liabilities exclude future interest crediting, charges and fees. The timing and amount of actual future cash flows may differ from those presented above.
    - ***Contractholder deposit funds:*** see Note 7 to our Consolidated Financial Statements for our accounting policy for this liability. Expected future cash flows presented above also include estimated future interest crediting on current fund balances based on current investment yields less the estimated cost of insurance charges and mortality and administrative fees for universal life policies.
    - ***Future policy benefits and unpaid claims and claim expenses:*** see Note 7 to our Consolidated Financial Statements for our accounting policies for these liabilities. Expected future cash flows for these liabilities presented in the table above are undiscounted. The expected future cash flows for guaranteed minimum death benefit ("GMDB," reported in future policy benefits) do not consider any of the related reinsurance arrangements.
- ***Long-term debt*** includes scheduled interest payments. Capital leases are included in long-term debt and primarily represent obligations for information technology network storage, servers and equipment.
- ***Other non-current liabilities*** include estimated payments for guaranteed minimum income benefit ("GMIB") contracts (without considering any related reinsurance arrangements), pension and other postretirement and postemployment benefit obligations, supplemental and deferred compensation plans, interest rate and foreign currency swap contracts, and reinsurance liabilities. Estimated payments of $78 million for deferred compensation, non-qualified and international pension plans and other postretirement and postemployment benefit plans are expected to be paid in less than one year and are included in the table above. We expect to make immaterial contributions to the qualified domestic pension plans during 2019 and they are reflected in the above table. We expect to make payments subsequent to 2019 for these obligations; however, subsequent payments have been excluded from the table as their timing is based on plan assumptions that may materially differ from actual activities. See Note 13 to our Consolidated Financial Statements for further information on pension and other postretirement benefit obligations.

The liability for uncertain tax positions that could result in future payments was $928 million as of December 31, 2018. This amount has been excluded from the table above because we are not able to provide a reasonably reliable estimate of the timing of such future tax payments. See Note 18 for additional information on uncertain tax positions.

Off-Balance Sheet:

- ***Purchase obligations.*** As of December 31, 2018, purchase obligations consisted of estimated payments required under contractual arrangements for future services and investment commitments as follows:

(In millions)	
Fixed maturities	**$ 106**
Commercial mortgage loans	**54**
Limited liability entities (other long-term investments)	**1,472**
Total investment commitments	**1,632**
Future service commitments	**663**
Total purchase obligations	**$ 2,295**

See Note 9 to our Consolidated Financial Statements for additional information.

Our estimated future service commitments primarily represent contracts for certain outsourced business processes and information technology maintenance and support. We generally have the ability to terminate these agreements, but do not anticipate doing so at this time. Purchase obligations exclude contracts that are cancelable without penalty and those that do not contractually require minimum levels of goods or services to be purchased.

- ***Operating leases.*** For additional information, see Note 16 to our Consolidated Financial Statements.

Guarantees

We are contingently liable for various financial and other guarantees provided in the ordinary course of business. See Note 19 to our Consolidated Financial Statements for additional information on guarantees.

Critical Accounting Estimates

The preparation of Consolidated Financial Statements in accordance with GAAP requires management to make estimates and assumptions that affect reported amounts and related disclosures in the Consolidated Financial Statements. Management considers an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been selected could have a material effect on our consolidated results of operations or financial condition.

Management has discussed how critical accounting estimates are developed and selected with the Audit Committee of our Board of Directors and the Audit Committee has reviewed the disclosures presented below.

In addition to the estimates presented in the following table, there are other accounting estimates used in preparing our Consolidated Financial Statements, including estimates of liabilities for future policy benefits, as well as estimates with respect to postemployment and postretirement benefits other than pensions, certain compensation accruals, and income taxes.

Management believes the current assumptions used to estimate amounts reflected in our Consolidated Financial Statements are appropriate. However, if actual experience differs from the assumptions used in estimating amounts reflected in our Consolidated Financial Statements, the resulting changes could have a material adverse effect on our consolidated results of operations and, in certain situations, could have a material adverse effect on our liquidity and financial condition. The table below presents the adverse impacts of certain possible changes in assumptions. The effect of assumption changes in the opposite direction would be a positive impact to our consolidated results of operations, liquidity or financial condition, except for assessing impairment of goodwill and fixed maturities carried at a fair value below cost. The tax rate used to calculate the after-tax impact of assumption changes is based on the new corporate income tax rate discussed in the "Key Developments" section of this MD&A.

See Note 2 to our Consolidated Financial Statements for further information on significant accounting policies.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Goodwill and other intangible assets	
Goodwill represents the excess of the cost of businesses acquired over the fair value of their net assets at the acquisition date. Intangible assets primarily reflect the value of customer relationships and other intangibles acquired in business combinations. Fair values of reporting units are estimated using models and assumptions that we believe a hypothetical market participant would use to determine a current transaction price. The significant assumptions and estimates used in determining fair value include the discount rate and future cash flows. A discount rate is used, corresponding with each reporting unit's weighted average cost of capital, consistent with that used for investment decisions considering the specific and detailed operating plans and strategies within each reporting unit. Projections of future cash flows are consistent with our annual planning process for revenues, claims, operating expenses, taxes, capital levels and long-term growth rates. In addition to these assumptions, we consider market data to evaluate the fair value of each reporting unit. The fair value of intangibles and the amortization method were determined using an income approach that relies on projected future cash flows including key assumptions for the customer attrition and discount rates. Management revises amortization periods if it believes there has been a change in the length of time that an intangible asset will continue to have value. We completed our normal annual evaluations for impairment of goodwill and intangible assets during the third quarter of 2018. The evaluations indicated that the fair value estimates of our reporting units exceed their carrying values by adequate margins and no impairment was required. As a result of the changes in our reportable segments, we reallocated existing goodwill to reporting units based on their relative fair values and updated our evaluations for impairment of goodwill. These evaluations indicated that the fair value estimates of our reporting units continue to exceed their carrying values by adequate margins and no impairments were required. During the fourth quarter of 2018, goodwill and intangible assets increased by $38.4 billion as a result of the acquiring Express Scripts and OnePath Life. Our Government operating segment contracts with CMS and various state governmental agencies to provide managed health care services, including Medicare Advantage plans and Medicare-approved prescription drug plans. Estimated future cash flows for this reporting unit's business incorporate the potential effects of Medicare Advantage reimbursement rates for 2019 and beyond as discussed in the "Executive Overview" section of this MD&A. Revenues from the Medicare programs are dependent, in whole or in part, upon annual funding from the federal government through CMS. Funding for these programs is dependent on many factors including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal level and general political issues and priorities. Goodwill and other intangibles as of December 31 were as follows (in millions): • **2018 – Goodwill $44,505; Other intangible assets $39,003** • 2017 – Goodwill $6,164; Other intangible assets $345 See Note 15 to our Consolidated Financial Statements for additional discussion of our goodwill and other intangible assets.	If we do not achieve our earnings objectives or our cost of capital rises significantly, the assumptions and estimates underlying these impairment evaluations could be adversely affected and result in future impairment charges that would negatively impact our operating results. Except for the recent acquisitions of Express Scripts and OnePath Life, where fair value equals carrying value, based on our most recent evaluations, the fair value estimates of our reporting units exceed their carrying values by adequate margins. Future changes in the funding for our Medicare programs by the federal government could materially reduce revenues and profitability in our Government reporting unit and have a significant impact on its fair value.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Income taxes – uncertain tax positions	
We evaluate tax positions to determine whether their benefits are more likely than not to be sustained on audit based on their technical merits. If not, we establish a liability for unrecognized tax benefits. These amounts have increased significantly in 2018 as a result of acquiring Express Scripts. The acquired amounts primarily relate to federal and state uncertain positions of the value and timing of deductions and uncertain positions of attributing taxable income to states. Balances that are included in other non-current liabilities on the Consolidated Balance Sheets are as follows: • **2018 – $928 million** • 2017 – $35 million See Note 18 to our Consolidated Financial Statements for additional discussion around uncertain tax positions.	The factors that could impact our estimates of uncertain tax positions include the likelihood of being sustained upon audit based on the technical merits of the tax position and related assumed interest and penalties. If our positions are upheld upon audit, our net income would increase.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Pharmaceutical Manufacturer Receivables	
We bill pharmaceutical manufacturers based on management's interpretation of the contractual terms and estimate contractual allowances at the time a claim is processed for uncertainty in the amount we are entitled to collect. We determine these contractual allowances by reviewing each manufacturer's payment experience and specific known items that potentially could be adjusted under contract terms. We may also record allowances for doubtful accounts based on a variety of factors including the length of time the receivables are past due, the financial health of the manufacturer and our past experience. In determining the fair value of Express Scripts' accounts receivable at the acquisition date, the historical allowances were eliminated. Prospectively, we expect these allowances to become significant to the consolidated financial statements. See Note 2 to our Consolidated Financial Statements for assumptions and methods used to estimate receivables and the related allowances.	Actual contractual allowances could differ from our estimates due to disputes regarding contractual terms, changes in the business environment as well as factors and risks associated with specific customers. Our estimates of the allowance for doubtful accounts could be impacted by changes in economic and market conditions as well as changes to our customers' financial condition.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Unpaid claims and claim expenses – Integrated Medical	
Unpaid claims and claim expenses include both reported claims and estimates for losses incurred but not yet reported. Unpaid claims and claim expenses in Integrated Medical are primarily impacted by assumptions related to completion factors and medical cost trend. Changes in either assumption from actual results could impact the unpaid claims balance as noted below. A large number of factors may cause the medical cost trend to vary from the Company's estimates, including: changes in medical management practices, changes in the level and mix of benefits offered and services utilized, and changes in medical practices. Completion factors may be affected if actual claims submission rates from providers differ from estimates (that can be influenced by a number of factors, including provider mix, and electronic versus manual submissions), or if changes to the Company's internal claims processing patterns occur. Unpaid claims and claim expenses for the Integrated Medical segment as of December 31 were as follows (in millions): • **2018 – gross $2,697; net $2,433** • 2017 – gross $2,420; net $2,158 These liabilities are presented above both gross and net of reinsurance and other recoverables. See Note 7 to our Consolidated Financial Statements for additional information regarding assumptions and methods used to estimate this liability.	Based on studies of our claim experience, it is reasonably possible that a 100 basis point change in the medical cost trend and a 50 basis point change in completion factors could occur in the near term. A 100 basis point increase in the medical cost trend rate would increase this liability by approximately $35 million, resulting in a decrease in net income of approximately $30 million after-tax, and a 50 basis point decrease in completion factors would increase this liability by approximately $80 million, resulting in a decrease in net income of approximately $65 million after-tax.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Unpaid claims and claim expenses – long-term disability reserves	
The liability for long-term disability reserves is the present value of estimated future benefits payments over the expected disability period and includes estimates for both reported claims and for claims incurred but not yet reported. Key assumptions in the calculation of long-term disability reserves include the discount rate and claim resolution rates, both of which are reviewed annually and updated when experience or future expectations would indicate a necessary change. The discount rate is the interest rate used to discount the projected future benefit payments to their present value. The discount rate assumption is based on the projected investment yield of the assets supporting the reserves. Claim resolution rate assumptions involve many factors including claimant demographics, the type of contractual benefit provided and the time since initially becoming disabled. The Company uses its own historical experience to develop its claim resolution rates. Long-term disability reserves as of December 31 were as follows (in millions): • **2018 – gross $4,069; net $3,975** • 2017 – gross $3,884; net $3,790 These liabilities are presented above both gross and net of reinsurance recoverables. See Note 7C. to our Consolidated Financial Statements for additional information regarding assumptions and methods used to estimate this liability.	Based on recent and historical resolution rate patterns and changes in investment portfolio yields, it is reasonably possible that a five percent change in claim resolution rates and a 25 basis point change in the discount rate could occur. A five percent decrease in the claim resolution rate would increase long-term disability reserves by approximately $90 million and decrease net income by approximately $70 million after-tax. A 25 basis point decrease in the discount rate would increase long-term disability reserves by approximately $45 million and decrease net income by approximately $35 million after-tax.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Valuation of fixed maturity investments	
Most fixed maturities are classified as available for sale and are carried at fair value with changes in fair value recorded in accumulated other comprehensive income (loss) within shareholders' equity. Fair value is defined as the price at which an asset could be exchanged in an orderly transaction between market participants at the balance sheet date. Determining fair value for a financial instrument requires management judgment. The degree of judgment involved generally correlates to the level of pricing readily observable in the markets. Financial instruments with quoted prices in active markets or with market observable inputs to determine fair value, such as public securities, generally require less judgment. Conversely, private placements including more complex securities that are traded infrequently are typically measured using pricing models that require more judgment as to the inputs and assumptions used to estimate fair value. There may be a number of alternative inputs to select based on an understanding of the issuer, the structure of the security and overall market conditions. In addition, these factors are inherently variable in nature as they change frequently in response to market conditions. Approximately two-thirds of our fixed maturities are public securities, and one-third are private placement securities. Typically, the most significant input in the measurement of fair value is the market interest rate used to discount the estimated future cash flows of the instrument. Such market rates are derived by calculating the appropriate spreads over comparable U.S. Treasury securities, based on the credit quality, industry and structure of the asset. See Notes 9A. and 10 to our Consolidated Financial Statements for a discussion of our fair value measurements, the procedures performed by management to determine that the amounts represent appropriate estimates and our accounting policy regarding unrealized appreciation on fixed maturities.	If the interest rates used to calculate fair value increased by 100 basis points, the fair value of the total fixed maturity portfolio of $23 billion would decrease by approximately $1.5 billion, resulting in an after-tax decrease to shareholders' equity of approximately $0.9 billion.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Assessment of "other-than-temporary" impairments on fixed maturities	
Certain fixed maturities with a fair value below amortized cost are carried at fair value with changes in fair value recorded in accumulated other comprehensive income. For these investments, we have determined that the decline in fair value below its amortized cost is temporary. To make this determination, we evaluated the expected recovery in value and our intent to sell or the likelihood of a required sale of the fixed maturity prior to an expected recovery. In making this evaluation, we considered a number of general and specific factors including the regulatory, economic and market environments, length of time and severity of the decline, and the financial health and specific near term prospects of the issuer. The after-tax amounts as of December 31 in accumulated other comprehensive income for fixed maturities in an unrealized loss position were as follows (in millions): • **2018 – ($370)** • 2017 – ($80) See Note 9 to our Consolidated Financial Statements for additional discussion of our review of declines in fair value, including information regarding our accounting policies for fixed maturities.	If we subsequently determine that the excess of amortized cost over fair value is other-than-temporary for any or all of these fixed maturities, the amount recorded in accumulated other comprehensive income would be reclassified to shareholders' net income as an impairment loss.

Segment Reporting

The following section of this MD&A discusses the results of each of our segments. As a result of the Express Scripts acquisition, during the fourth quarter of 2018, we changed our segment reporting to reflect the new management and business reporting structure of the combined company. Prior year financial information has been restated to conform to the new segment presentation. See Note 1 to our Consolidated Financial Statements for a description of our segments.

In segment discussions, we present adjusted revenues and "pre-tax adjusted income from operations," defined as income before taxes excluding realized investment gains (losses), amortization of acquired intangible assets, results of transitioning clients and special items. Ratios presented in this segment discussion exclude the same items as adjusted income from operations. See Note 21 to our Consolidated Financial Statements for additional discussion of these metrics and a reconciliation of income before income taxes to pre-tax adjusted income from operations.

In these segment discussions, we also present "pre-tax adjusted margin," defined as adjusted income from operations before taxes divided by adjusted revenues.

See the MD&A Executive Overview beginning on page 42 for summarized financial results of each of our reporting segments.

Integrated Medical Segment

The Integrated Medical segment includes the businesses previously reported in "Global Health Care" except as follows: 1) international health care products are now reported in the International Markets segment; 2) mail order pharmacy business is now reported in the Health Services segment; and 3) Medicare supplement business previously reported in "Global Supplemental Benefits" is now reported in Integrated Medical.

The business section of this Form 10-K (see the "Integrated Medical" section beginning on page 3) describes the various products and funding solutions offered by this segment, including the various revenue sources. As described in the introduction to Segment Reporting above, performance of the Integrated Medical segment is measured using pre-tax adjusted income from operations. Key factors affecting profitability for this segment include:

- customer growth;
- revenues from integrated specialty products, including pharmacy services, sold to clients and customers across all funding solutions;
- percentage of Medicare Advantage customers in plans eligible for quality bonus payments;
- benefit expenses as a percentage of premiums (medical care ratio or "MCR") for our insured commercial and government businesses; and
- selling, general and administrative expense as a percentage of adjusted revenues (expense ratio).

We adopted new accounting guidance for revenue recognition effective January 1, 2018. Prior year revenues along with adjusted margin and both the medical care and expense ratios for the Integrated Medical segment have been retrospectively adjusted to conform to this new basis of accounting. See Note 2 to the Consolidated Financial Statements for additional information.

Results of Operations

Financial Summary

(In millions)	For the Years Ended December 31, 2018	2017	2016	Change Favorable (Unfavorable) 2018 vs. 2017		Change Favorable (Unfavorable) 2017 vs. 2016	
Adjusted revenues	**$ 32,791**	$ 29,035	$ 27,395	**$ 3,756**	13%	$ 1,640	6%
Pre-tax adjusted income from operations	**$ 3,502**	$ 2,922	$ 2,592	**$ 580**	20%	$ 330	13%
Adjusted pre-tax margin	**10.7%**	10.1%	9.5%	**60bps**		60bps	
Medical care ratio	**78.9%**	81.0%	80.9%	**210bps**		(10)bps	
Expense ratio	**24.7%**	24.1%	24.8%	**(60)bps**		70bps	

(Dollars in millions, customers in thousands)	As of December 31, 2018	2017	2016	Increase (Decrease) 2018 vs. 2017		Increase (Decrease) 2017 vs. 2016	
Unpaid claims and claim expenses – Integrated Medical	**$ 2,697**	$ 2,420	$ 2,261	**$ 277**	11%	$ 159	7%
Integrated Medical Customers							
Commercial risk	**1,911**	1,792	1,561	**119**	7%	231	15%
Government	**1,407**	1,235	1,015	**172**	14%	220	22%
Total risk	**3,318**	3,027	2,576	**291**	10%	451	18%
Service	**12,071**	11,801	11,394	**270**	2%	407	4%
Total	**15,389**	14,828	13,970	**561**	4%	858	6%

2018 versus 2017

Adjusted revenues increased, primarily due to customer growth in our Commercial and Government segments including contributions from specialty products. Also contributing to the increase were higher premium rates across our businesses reflecting: 1) underlying medical cost trend; 2) the government's suspension of cost share reduction subsidies; and 3) resumption of the health insurance industry tax.

Pre-tax adjusted income from operations increased, reflecting improved margins in our Individual business and strong ongoing performance in our Commercial business, including increased contributions from specialty products.

Medical care ratio. The medical care ratio decreased, reflecting the pricing impact of resumption of the health insurance industry tax and improvement from our Individual business.

Expense ratio. The expense ratio increased, reflecting resumption of the health insurance industry tax and ongoing investments in growth and innovation, partially offset by higher revenues.

2017 versus 2016

Adjusted revenues increased, primarily due to customer growth in our Commercial risk and Individual businesses, partially offset by lower customer enrollment in our Medicare Advantage business.

Pre-tax adjusted income from operations increased, reflecting higher earnings in both our Commercial and Government operating segments. The increase in the Commercial segment reflects customer growth including increased contributions from our specialty products. The Government segment's earnings growth reflects lower operating expenses related to the moratorium of the health insurance industry tax in 2017 and our 2016 CMS audit response as well as favorable claims experience in our Individual business, partially offset by lower customer enrollment in our Medicare Advantage business. Pre-tax adjusted income from operations included favorable prior year reserve development of $148 million for 2017; prior year reserve development in 2016 was not material.

Medical care ratio. The medical care ratio remained fairly consistent, reflecting the 2017 moratorium on the health insurance industry tax offset by improved performance in our Government segment businesses and favorable prior year reserve development.

Expense ratio. The expense ratio decreased, reflecting suspension of the health insurance industry tax in 2017 and lower costs related to our 2016 CMS audit response.

Other Items Affecting Integrated Medical Results

Unpaid Claims and Claim Expenses

Unpaid claims and claim expenses were higher as of December 31, 2018 compared with 2017 and were higher as of December 31, 2017 compared with 2016, primarily due to customer growth and medical cost trend. See Note 7 to our Consolidated Financial Statements for additional information.

Medical Customers

A medical customer is defined as a person meeting any one of the following criteria:

- is covered under a medical insurance policy, managed care arrangement or service agreement issued by us;
- has access to our provider network for covered services under their medical plan; or
- has medical claims that are administered by us.

Medical customers now include the Medicare Supplement business. For the Integrated Medical segment, medical customers excludes international health care customers.

Our medical customer base was higher at December 31, 2018 compared to December 31, 2017, primarily reflecting growth across our targeted Commercial markets as well as our Government segment businesses. Our medical customer base increased as of December 31, 2017 compared with 2016, reflecting growth across our Commercial and Government segments. The Government segment growth was primarily driven by our Medicare Supplement and Individual businesses, partially offset by declines in our Medicare Advantage business.

Health Services Segment

We established the Health Services segment to include the pharmacy benefit management ("PBM") and health services operations of Express Scripts effective with the acquisition, as well as Cigna's legacy mail order pharmacy business. As described in the introduction to Segment Reporting on page 56, performance of the Health Services Segment is measured using pre-tax adjusted income from operations.

The key factors that impact Health Services revenues and costs of revenues are volume, mix and price. These key factors are discussed further below. See Note 2 for additional information on revenue and cost recognition policies for this segment.

- As our clients' claim volumes increase or decrease, our resulting revenues and cost of revenues correspondingly increase or decrease. Our gross profit could also increase or decrease as a result of changes in purchasing discounts.
- The mix of claims generally considers the type of drug and distribution method used for dispensing and fulfilling. As our mix of drugs changes, our resulting pharmacy revenues and cost of revenues correspondingly may increase or decrease. The primary driver of fluctuations within our mix of claims is the generic fill rate. Generally, higher generic fill rates reduce revenues, as generic drugs are typically priced lower than the branded drugs they replace. However, as ingredient cost paid to pharmacies on generic drugs is incrementally lower than the price charged to our clients, higher generic fill rates generally have a favorable impact on our gross profit. The home delivery generic fill rate is currently lower than the network generic fill rate as fewer generic substitutions are available among maintenance medications (such as therapies for chronic conditions) commonly dispensed from home delivery pharmacies as compared to acute medications that are primarily dispensed by pharmacies in our retail networks.
- Our contract pricing is impacted by our ability to negotiate contracts for pharmacy network, pharmaceutical and wholesaler purchasing, and manufacturer rebates. We are able to reduce the rate of drug price increases and, in some cases, lower our clients' prescription drug spend through our integrated set of solutions, including sharing of significant amounts of pharmaceutical manufacturer rebates with our clients. We refer to this as "management of the supply chain." Inflation also impacts our pricing because most of our contracts provide that we bill clients and pay pharmacies based on a generally recognized price index for pharmaceuticals. Therefore, the rate of inflation for prescription drugs and our efforts to manage this inflation for our clients can affect our revenues and cost of revenues.

In this MD&A, we present revenues, gross profit and pre-tax adjusted income from operations "excluding transitioning clients" in addition to those metrics including transitioning clients. See the "Key Transactions and Developments" section on page 46 of this MD&A for further discussion of transitioning clients and why we present this information.

Results of Operations

Financial Summary

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2018**	**2017**	**2016**	**2018 vs. 2017**		**2017 vs. 2016**	
Total revenues	**$ 7,065**	$ 4,241	$ 4,066	**$ 2,824**	67%	$ 175	4%
Less: revenue contributions from transitioning clients	**(459)**	-	-	**(459)**	N/M	-	N/M
Adjusted revenues	**$ 6,606**	$ 4,241	$ 4,066	**$ 2,365**	56	$ 175	4
Gross profit	**$ 604**	$ 371	$ 344	**$ 233**	63	$ 27	8
Gross profit excluding transitioning clients	**$ 531**	$ 371	$ 344	**$ 160**	43	$ 27	8
Pre-tax adjusted income from operations	**$ 380**	$ 288	$ 268	**$ 92**	32%	$ 20	7%
Pre-tax adjusted margin	**5.8%**	6.8%	6.6%	**(100)bps**		20bps	

2018 versus 2017

Adjusted revenues increased, primarily due to the acquisition of Express Scripts. Excluding the acquired business, revenues increased slightly, reflecting increased utilization of specialty medications and higher prices.

Pre-tax adjusted income from operations before taxes increased, due to the acquisition of Express Scripts. Excluding the acquired business, adjusted income from operations increased, reflecting volume growth due to increased specialty utilization and net savings related to management of supply chain.

2017 versus 2016

Adjusted revenues increased, reflecting increased Commercial customers, specialty medication prices and utilization (e.g., certain injectables), offset by lower oral medication volumes and Medicare customers.

Pre-tax adjusted income from operations before taxes increased, due to Commercial customer growth including increased margin contributions from specialty medications.

International Markets Segment

As described in the business section of this Form 10-K, the International Markets segment includes supplemental health, life and accident business previously reported in the "Global Supplemental Benefits" segment, except for Medicare Supplement business that is now reported in the Integrated Medical segment and certain international businesses in run-off that are now reported in Group Disability and Other. International health care products previously reported in the "Global Health Care" segment are now reported in International Markets.

As described in the introduction to Segment Reporting on page 56, performance of the International Markets segment is measured using pre-tax adjusted income from operations. Key factors affecting pre-tax adjusted income from operations for this segment are:

- premium growth, including new business and customer retention;
- benefit expenses as a percentage of premiums (loss ratio);
- selling, general and administrative expense and acquisition expense as a percentage of revenues (expense ratio and acquisition cost ratio); and
- the impact of foreign currency movements.

Results of Operations

Financial Summary

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2018**	**2017**	**2016**	**2018 vs. 2017**		**2017 vs. 2016**	
Adjusted revenues	**$ 5,366**	$ 4,901	$ 4,537	**$ 465**	9%	$ 364	8%
Pre-tax adjusted income from operations	**$ 735**	$ 654	$ 538	**$ 81**	12%	$ 116	22%
Pre-tax adjusted margin	**13.7%**	13.3%	11.9%	**40bps**		140bps	
Loss ratio	**57.4%**	57.5%	60.0%	**(10)bps**		250bps	
Acquisition cost ratio	**13.1%**	12.8%	12.9%	**30bps**		10bps	
Expense ratio (excluding acquisition costs)	**18.9%**	19.7%	19.1%	**(80)bps**		(60)bps	

2018 versus 2017

Adjusted revenues increased primarily due to business growth mainly in South Korea, Middle East, Hong Kong and Europe.

Pre-tax adjusted income from operations increased primarily due to business growth, largely in South Korea, and a lower expense ratio, partially offset by a less favorable acquisition cost ratio.

The segment's ***loss ratio*** decreased slightly, reflecting favorable claims experience in South Korea and Europe, largely offset by unfavorable claims experience in North America and other Asian markets.

The ***acquisition cost ratio*** increased due to higher amortization primarily in Korea and Taiwan.

The decrease in the ***expense ratio*** (excluding acquisition costs) was primarily driven by lower value added tax and disciplined expense management.

2017 versus 2016

Adjusted revenues were higher primarily due to business growth mainly in South Korea and the Middle East.

Pre-tax adjusted income from operations increased primarily due to business growth, largely in South Korea, and lower loss ratios, partially offset by higher expense ratios.

The segment's ***loss ratio*** decreased, reflecting favorable claims in South Korea and Europe.

The ***acquisition cost ratio*** decreased slightly due to lower spending in certain markets.

The increase in the ***expense ratio*** (excluding acquisition costs) was primarily driven by strategic investment in the Middle East and higher value added tax, partially offset by strong expense management.

Other Items Affecting International Markets Results

South Korea is the single largest geographic market for our International Markets segment. South Korea generated 40% of the segment's revenues and 68% of the segment's pre-tax adjusted income from operations in 2018. In 2018, our International Markets segment operations in South Korea represented 5% of our consolidated revenues and 11% of consolidated pre-tax adjusted income from operations.

Group Disability and Other

Group Disability and Other includes the results of the business previously reported in the "Group Disability and Life" segment and "Other Operations" comprising the corporate-owned life insurance ("COLI") business along with run-off of the following businesses: 1) reinsurance; 2) settlement annuity; and 3) the sold individual life insurance and annuity and retirement benefits businesses. In addition, certain international run-off business previously reported in the "Global Supplemental Benefits" segment is now reported in Group Disability and Other.

As described in the introduction of Segment Reporting on page 56, performance of Group Disability and Other is measured using pre-tax adjusted income from operations. Key factors affecting pre-tax adjusted income from operations are:

- premium growth, including new business and customer retention;
- net investment income;
- benefit expenses as a percentage of premiums (loss ratio); and
- selling, general and administrative expense as a percentage of revenues excluding net investment income (expense ratio).

Results of Operations

Financial Summary

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2018**	**2017**	**2016**	**2018 vs. 2017**		**2017 vs. 2016**	
Adjusted revenues	**$ 5,061**	$ 5,075	$ 5,108	**$ (14)**	-%	$ (33)	(1)%
Pre-tax adjusted income from operations	**$ 529**	$ 517	$ 275	**$ 12**	2%	$ 242	88%
Pre-tax adjusted margin	**10.5%**	10.2%	5.4%	**30bps**		480bps	

2018 versus 2017

Adjusted revenues decreased slightly, due to the continued run-off of international business and lower life premiums, mostly offset by moderate growth in the group disability business and higher investment income.

Pre-tax adjusted income from operations increased, reflecting improved results in the life business and run-off operations, partially offset by unfavorable disability claims experience.

2017 versus 2016

Adjusted revenues were relatively flat, with higher investment income driven by higher asset levels offset by cancelations in non-core specialty and association products.

Pre-tax adjusted income from operations increased, reflecting significantly improved claim experience in the group disability and life segment.

Corporate

Corporate reflects amounts not allocated to operating segments, including net interest expense (defined as interest on corporate debt less net investment income on investments not supporting segment and other operations), certain litigation matters, compensation cost for stock options, expense associated with our frozen pension plans, charitable contributions, severance, certain overhead and project costs and intersegment eliminations for products and services sold between segments.

Financial Summary

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	2018	2017	2016	2018 vs. 2017		2017 vs. 2016	
Pre-tax adjusted loss from operations	**$ (403)**	$ (375)	$ (362)	**$ (28)**	(7)%	$ (13)	(4)%

2018 versus 2017

Pre-tax adjusted loss from operations was higher, primarily due to higher interest expense.

2017 versus 2016

Pre-tax adjusted loss from operations was higher, primarily due to higher charitable contributions and operating expenses, partially offset by higher net investment income.

Investment Assets

The following table presents our invested asset portfolio, excluding separate account assets, as of December 31, 2018 and 2017. Additional information regarding our investment assets and related accounting policies is included in Notes 2, 9, 10, 11, and 12 to our Consolidated Financial Statements.

(In millions)	2018	2017
Fixed maturities	**$ 22,928**	$ 23,138
Equity securities	**548**	588
Commercial mortgage loans	**1,858**	1,761
Policy loans	**1,423**	1,415
Other long-term investments	**1,901**	1,518
Short-term investments	**316**	199
Total	**$ 28,974**	$ 28,619

Fixed Maturities

Investments in fixed maturities include publicly traded and privately placed debt securities, mortgage and other asset-backed securities and preferred stocks redeemable by the investor. These investments are classified as available for sale and are carried at fair value on our balance sheet. Additional information regarding valuation methodologies, key inputs and controls is included in Note 10 to our Consolidated Financial Statements. More detailed information about fixed maturities by type of issuer and maturity dates is included in Note 9 to our Consolidated Financial Statements.

The following table reflects our fixed maturity portfolio by type of issuer as of December 31, 2018 and 2017.

(In millions)	2018	2017
Federal government and agency	**$ 710**	$ 779
State and local government	**985**	1,287
Foreign government	**2,362**	2,487
Corporate	**18,361**	18,088
Mortgage and other asset-backed	**510**	497
Total	**$ 22,928**	$ 23,138

The fixed maturity portfolio decreased during 2018, reflecting decreased valuations due to increases in market yields and weakening foreign currencies, partially offset by increased investment in fixed maturities. As of December 31, 2018, $20.6 billion, or 90% of the fixed maturities in our investment portfolio were investment grade (Baa and above, or equivalent), and the remaining $2.3 billion were below investment grade. The majority of the bonds that are below investment grade are rated at the higher end of the non-investment grade spectrum. These quality characteristics have not materially changed from the prior year and are consistent with our investment strategy. Fixed maturity investments are diversified by issuer, geography, and industry as appropriate.

Foreign government obligations are concentrated in Asia, primarily South Korea, consistent with our risk management practice and local regulatory requirements of our international business operations. Corporate fixed maturities include private placement assets of $6 billion.

These investments are generally less marketable than publicly-traded bonds; however yields on these investments tend to be higher than yields on publicly-traded bonds with comparable credit risk. We perform a credit analysis of each issuer, and require financial and other covenants that allow us to monitor issuers for deteriorating financial strength and pursue remedial actions, if warranted.

In addition to amounts classified in fixed maturities on our Consolidated Balance Sheets, we participate in an insurance joint venture in China in which we have a 50% ownership interest. We account for this joint venture on the equity basis of accounting and report it in other assets. This entity had an investment portfolio of approximately $6.3 billion supporting this business that is primarily invested in Chinese corporate and government fixed maturities. There were no investments with a material unrealized loss as of December 31, 2018.

Commercial Mortgage Loans

Our commercial mortgage loans are fixed rate loans, diversified by property type, location and borrower. Loans are secured by high quality commercial properties and are generally made at less than 70% of the property's value at origination of the loan. Property value, debt service coverage, quality, building tenancy and stability of cash flows are all important financial underwriting considerations. We hold no direct residential mortgage loans and do not originate or service securitized mortgage loans.

Commercial real estate capital markets remain very active for well-leased, quality commercial real estate located in strong institutional investment markets. The vast majority of properties securing the mortgages in our mortgage loan portfolio possess these characteristics.

As of December 31, 2018, the $1.9 billion commercial mortgage loan portfolio consisted of approximately 66 loans that are all in good standing. Given the quality and diversity of the underlying real estate, positive debt service coverage and significant borrower cash investment generally ranging between 30 and 40%, we remain confident that borrowers will continue to perform as expected under their contract terms.

Other Long-term Investments

Other long-term investments of $1.9 billion included investments in securities limited partnerships and real estate limited partnerships as well as direct investments in real estate joint ventures. These entities typically invest in mezzanine debt or equity of privately held companies (securities partnerships) and equity real estate. Given our subordinate position in the capital structure of these underlying entities, we assume a higher level of risk for higher expected returns. To mitigate risk, these investments are diversified across approximately 135 separate partnerships, and approximately 70 general partners who manage one or more of these partnerships. Also, the underlying investments are diversified by industry sector or property type, and geographic region. No single partnership investment exceeded 4% of our securities and real estate partnership portfolio.

Problem and Potential Problem Investments

"Problem" bonds and commercial mortgage loans are either delinquent by 60 days or more or have been restructured as to terms, including concessions by us for modification of interest rate, principal payment or maturity date. "Potential problem" bonds and commercial mortgage loans are considered current (no payment is more than 59 days past due), but management believes they have certain characteristics that increase the likelihood that they may become problems.

There were no significant problem or potential problem investments at December 31, 2018 and 2017.

Investment Outlook

Despite the continued strength of the U.S. economy, concerns related to trade and tariffs and rising interest rates contributed to a return of financial market volatility and public equity market declines in 2018. We continue to closely monitor global macroeconomic conditions and trends, including the uncertainty caused by the United Kingdom's decision to exit the European Union, and their potential impact to our investment portfolio. Certain sectors, such as retail, energy and natural gas have been volatile and we expect that to continue. Future realized and unrealized investment results will be driven largely by market conditions that exist when a transaction occurs or at the reporting date. These future conditions are not reasonably predictable; however, we believe that the vast majority of our investments will continue to perform under their contractual terms. Based on our strategy to match the duration of invested assets to the duration of insurance and contractholder liabilities, we expect to hold a significant portion of these assets for the long term. Although future impairment losses resulting from interest rate movements and credit deterioration due to both investment-specific and the global economic uncertainties discussed above remain possible, we do not expect these losses to have a material adverse effect on our financial condition or liquidity.

Market Risk

Financial Instruments

Our assets and liabilities include financial instruments subject to the risk of potential losses from adverse changes in market rates and prices. Consistent with disclosure requirements, the following items have been excluded from this consideration of market risk for financial instruments:

- changes in the fair values of insurance-related assets and liabilities because their primary risks are insurance rather than market risk;
- changes in the fair values of investments recorded using the equity method of accounting and liabilities for pension and other postretirement and postemployment benefit plans (and related assets); and
- changes in the fair values of other significant assets and liabilities such as goodwill, deferred policy acquisition costs, taxes, and various accrued liabilities. Because they are not financial instruments, their primary risks are other than market risk.

Excluding these items, our primary market risk exposures from financial instruments are:

- ***Interest-rate risk*** on fixed-rate, medium-term instruments. Changes in market interest rates affect the value of instruments that promise a fixed return.
- ***Foreign currency exchange rate risk*** of the U.S. dollar primarily to the South Korean won, Euro, New Zealand dollar, Chinese yuan renminbi, and Taiwan dollar. An unfavorable change in exchange rates reduces the carrying value of net assets denominated in foreign currencies.

Our Management of Market Risks

We predominantly rely on three techniques to manage our exposure to market risk:

- ***Investment/liability matching.*** We generally select investment assets with characteristics (such as duration, yield, currency and liquidity) that correspond to the underlying characteristics of our related insurance and contractholder liabilities so that we can match the investments to our obligations. Shorter-term investments generally support shorter-term life and health liabilities. Medium-term, fixed-rate investments support interest-sensitive and health liabilities. Longer-term investments generally support products with longer pay out periods such as annuities and long-term disability liabilities.
- ***Use of local currencies for foreign operations.*** We generally conduct our international business through foreign operating entities that maintain assets and liabilities in local currencies. This technique limits exchange rate risk to our net assets.
- ***Use of derivatives.*** We use derivative financial instruments to minimize certain market risks.

See Note 9 to our Consolidated Financial Statements for additional information about derivative financial instruments.

Effect of Market Fluctuations

Assuming a 100 basis point increase in interest rates and 10% strengthening in the U.S. dollar to foreign currencies, the effect of hypothetical changes in market rates or prices on the fair value of certain financial instruments, subject to the exclusions noted above (particularly insurance liabilities), would have been as follows as of December 31:

	Loss in fair value	
Market scenario for certain non-insurance financial instruments (in billions)	**2018**	**2017**
100 basis point increase in interest rates (excluding long-term debt)	**$ 1.6**	$ 1.6
10% strengthening in U.S. dollar to foreign currencies	**$ 0.4**	$ 0.5

The effect of a hypothetical increase in interest rates, primarily on fixed maturities and commercial mortgage loans, was determined by estimating the present value of future cash flows using various models, primarily duration modeling. The impact of a hypothetical increase to interest rates at December 31, 2018 is consistent with the impact at December 31, 2017, which has been restated to exclude long-term debt, as discussed below.

In the event of a hypothetical 100 basis point increase in interest rates, the fair value of the Company's long-term debt would decrease approximately $2.4 billion at December 31, 2018 and $0.5 billion at December 31, 2017. The impact at December 31, 2018 was greater than that at December 31, 2017 due to additional long-term debt issued in acquiring Express Scripts. Changes in the fair value of our long-term debt do not impact our financial position or operating results. See Note 5 to our Consolidated Financial Statements for additional information about the Company's debt.

The effect of a hypothetical strengthening of the U.S. dollar relative to the foreign currencies of certain financial instruments held by us was estimated to be 10% of the U.S. dollar equivalent fair value. Our foreign operations hold investment assets, such as fixed maturities, cash, and cash equivalents, that are generally invested in the currency of the related liabilities. The effect of a hypothetical 10% strengthening in the U.S. dollar to foreign currencies at December 31, 2018 is consistent with that at December 31, 2017.

ITEM 7A. Quantitative and Qualitative Disclosures About Market Risk

The information contained under the caption "Market Risk" in the MD&A section of this Form 10-K is incorporated by reference.

ITEM 8. Financial Statements and Supplementary Data

Report of Independent Registered Public Accounting Firm

To the Board of Directors
and Shareholders of Cigna Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Cigna Corporation and its subsidiaries (the "Company") as of December 31, 2018 and 2017, and the related consolidated statements of income, comprehensive income, changes in total equity and cash flows for each of the three years in the period ended December 31, 2018, including the related notes (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control – Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018 based on criteria established in *Internal Control – Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Annual Report on Internal Control over Financial Reporting. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) ("PCAOB") and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

As described in Management's Annual Report on Internal Control over Financial Reporting, management has excluded Express Scripts Holding Company ("legacy Express Scripts") from its assessment of internal control over financial reporting as of December 31, 2018 because it was acquired by the Company in a purchase business combination during 2018. We have also excluded legacy Express Scripts from our audit of internal control over financial reporting. Legacy Express Scripts is a wholly-owned subsidiary whose total assets and total revenues excluded from management's assessment and our audit of internal control over financial reporting represent 10% and 5%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2018.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Hartford, Connecticut
February 28, 2019

We have served as the Company's auditor since 1983.

Cigna Corporation
Consolidated Statements of Income

(In millions, except per share amounts)	For the years ended December 31, 2018	2017	2016
Revenues			
Premiums	**$ 36,113**	$ 32,491	$ 30,824
Fees and other revenues	**5,578**	5,110	4,901
Pharmacy revenues	**5,479**	2,979	2,966
Net investment income	**1,480**	1,226	1,147
TOTAL REVENUES	**48,650**	41,806	39,838
Benefits and expenses			
Medical costs and other benefit expenses	**27,528**	25,263	24,341
Pharmacy and other service costs	**4,793**	2,456	2,468
Selling, general and administrative expenses	**11,934**	10,030	9,790
Amortization of acquired intangible assets	**235**	115	151
TOTAL BENEFITS AND EXPENSES	**44,490**	37,864	36,750
Income from operations	**4,160**	3,942	3,088
Interest expense and other	**(498)**	(252)	(278)
Debt extinguishment costs	**—**	(321)	—
Net realized investment (losses) gains	**(81)**	237	169
Income before income taxes	**3,581**	3,606	2,979
TOTAL INCOME TAXES	**935**	1,374	1,136
Net income	**2,646**	2,232	1,843
Less: net income (loss) attributable to noncontrolling interests	**9**	(5)	(24)
SHAREHOLDERS' NET INCOME	**$ 2,637**	$ 2,237	$ 1,867
Shareholders' net income per share			
Basic	**$ 10.69**	$ 8.92	$ 7.31
Diluted	**$ 10.54**	$ 8.77	$ 7.19

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation
Consolidated Statements of Comprehensive Income

(In millions)	For the years ended December 31, 2018	2017	2016
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867
Shareholders' other comprehensive income (loss), net of tax			
Net unrealized (depreciation) on securities and derivatives	**(365)**	(37)	(60)
Net translation (losses) gains on foreign currencies	**(152)**	304	(95)
Postretirement benefits liability adjustment	**127**	33	23
Shareholders' other comprehensive (loss) income, net of tax	**(390)**	300	(132)
Shareholders' comprehensive income	**2,247**	2,537	1,735
Comprehensive income attributable to noncontrolling interests			
Net income (loss) attributable to redeemable noncontrolling interests	**9**	—	(7)
Net (loss) attributable to other noncontrolling interests	**—**	(5)	(17)
Other comprehensive (loss) attributable to redeemable noncontrolling interests	**(15)**	(3)	(10)
Total comprehensive (loss) attributable to noncontrolling interests	**(6)**	(8)	(34)
TOTAL COMPREHENSIVE INCOME	**$ 2,241**	$ 2,529	$ 1,701

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation
Consolidated Balance Sheets

(In millions, except per share amounts)	As of December 31, 2018	2017
Assets		
Cash and cash equivalents	**$ 3,855**	$ 2,972
Investments	**2,045**	2,136
Accounts receivable, net	**10,473**	3,155
Inventories	**2,821**	228
Other current assets	**1,236**	820
Total current assets	**20,430**	9,311
Long-term investments	**26,929**	26,483
Reinsurance recoverables	**5,507**	5,763
Deferred policy acquisition costs	**2,821**	2,237
Property and equipment	**4,562**	1,563
Deferred tax assets, net	**–**	39
Goodwill	**44,505**	6,164
Other intangible assets	**39,003**	345
Other assets	**1,630**	1,431
Separate account assets	**7,839**	8,423
TOTAL ASSETS	**153,226**	61,759
Liabilities		
Current insurance and contractholder liabilities	**6,801**	6,317
Pharmacy and service costs payable	**10,702**	305
Accounts payable	**4,366**	184
Accrued expenses and other liabilities	**7,071**	3,963
Short-term debt	**2,955**	240
Total current liabilities	**31,895**	11,009
Non-current insurance and contractholder liabilities	**19,974**	20,530
Deferred tax liabilities, net	**9,453**	—
Other non-current liabilities	**3,470**	2,838
Long-term debt	**39,523**	5,199
Separate account liabilities	**7,839**	8,423
TOTAL LIABILITIES	**112,154**	47,999
Contingencies – Note 19		
Redeemable noncontrolling interests	**37**	49
Shareholders' equity		
Common stock [1]	**4**	74
Additional paid-in capital	**27,751**	2,940
Accumulated other comprehensive loss	**(1,711)**	(1,082)
Retained earnings	**15,088**	15,800
Less: treasury stock, at cost	**(104)**	(4,021)
TOTAL SHAREHOLDERS' EQUITY	**41,028**	13,711
Noncontrolling interests	**7**	–
Total equity	**41,035**	13,711
Total liabilities and equity	**$ 153,226**	$ 61,759
SHAREHOLDERS' EQUITY PER SHARE	**$ 107.71**	$ 56.20

(1) Par value per share, $0.01 in 2018 and $0.25 in 2017; shares issued, 381 million in 2018 and 296 million in 2017; authorized shares, 600 million in 2018 and 2017.

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation
Consolidated Statements of Changes in Total Equity

(In millions, except per share amounts)	Common Stock	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Shareholders' Equity	Non-controlling Interests	Total Equity	Redeemable Non-controlling Interests
Balance at December 31, 2015	**$ 74**	**$ 2,859**	**$ (1,250)**	**$ 12,121**	**$ (1,769)**	**$ 12,035**	**$ 9**	**$ 12,044**	**$ 69**
Cumulative effect of accounting for revenue recognition				(24)		(24)		(24)	
Balance at December 31, 2015, as retrospectively adjusted	74	2,859	(1,250)	12,097	(1,769)	12,011	9	12,020	69
2016 Activity									
Effect of issuing stock for employee benefit plans		51		(123)	163	91		91	
Other comprehensive (loss)			(132)			(132)		(132)	(10)
Net income (loss)				1,867		1,867	(17)	1,850	(7)
Common dividends declared (per share: $0.04)				(10)		(10)		(10)	
Repurchase of common stock					(110)	(110)		(110)	
Other transactions impacting noncontrolling interests		(18)				(18)	12	(6)	6
Balance at December 31, 2016	**74**	**2,892**	**(1,382)**	**13,831**	**(1,716)**	**13,699**	**4**	**13,703**	**58**
2017 Activity									
Effect of issuing stock for employee benefit plans		51		(258)	455	248		248	
Other comprehensive income (loss)			300			300		300	(3)
Net income (loss)				2,237		2,237	(5)	2,232	-
Common dividends declared (per share: $0.04)				(10)		(10)		(10)	
Repurchase of common stock					(2,760)	(2,760)		(2,760)	
Other transactions impacting noncontrolling interests		(3)				(3)	1	(2)	(6)
Balance at December 31, 2017	**74**	**2,940**	**(1,082)**	**15,800**	**(4,021)**	**13,711**	**-**	**13,711**	**49**
2018 Activity									
Cumulative effect of accounting for financial instruments and hedging			**(10)**	**68**		**58**		**58**	
Reclassification adjustment related to U.S. tax reform legislation			**(229)**	**229**		**-**		**-**	
Retirement of treasury stock	**(13)**	**(529)**		**(3,498)**	**4,040**	**-**		**-**	
Exchange of Old Cigna common stock	**(58)**	**58**				**-**		**-**	
Acquisition of Express Scripts (see Note 3)	**1**	**25,223**				**25,224**	**7**	**25,231**	
Effect of issuing stock for employee benefit plans		**59**		**(138)**	**206**	**127**		**127**	
Other comprehensive (loss)			**(390)**			**(390)**		**(390)**	**(15)**
Net income				**2,637**		**2,637**		**2,637**	**9**
Common dividends declared (per share: $0.04)				**(10)**		**(10)**		**(10)**	
Repurchase of common stock					**(329)**	**(329)**		**(329)**	
Other transactions impacting noncontrolling interests						**-**		**-**	**(6)**
Balance at December 31, 2018	**$ 4**	**$ 27,751**	**$ (1,711)**	**$ 15,088**	**$ (104)**	**$ 41,028**	**$ 7**	**$ 41,035**	**$ 37**

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation
Consolidated Statements of Cash Flows

(In millions)	For the years ended December 31, 2018	2017	2016
Cash Flows from Operating Activities			
Net income	**$ 2,646**	$ 2,232	$ 1,843
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	**695**	566	610
Realized investment losses (gains), net	**81**	(237)	(169)
Deferred income tax (benefit) expense	**(101)**	242	74
Debt extinguishment costs	**–**	321	–
Net changes in assets and liabilities, net of non-operating effects:			
Accounts receivable	**705**	(233)	663
Inventories	**(107)**	(72)	30
Deferred policy acquisition costs	**(237)**	(282)	(213)
Reinsurance recoverable and other assets	**(234)**	115	246
Insurance liabilities	**560**	506	683
Pharmacy and service costs payable	**(842)**	35	(46)
Accounts payable and accrued expenses and other liabilities	**332**	696	171
Other, net	**272**	197	134
NET CASH PROVIDED BY OPERATING ACTIVITIES	**3,770**	4,086	4,026
Cash Flows from Investing Activities			
Proceeds from investments sold:			
Fixed maturities and equity securities	**2,655**	2,012	1,544
Investment maturities and repayments:			
Fixed maturities and equity securities	**2,151**	2,051	1,755
Commercial mortgage loans	**215**	335	316
Other sales, maturities and repayments (primarily short-term and other long-term investments)	**734**	1,702	1,431
Investments purchased or originated:			
Fixed maturities and equity securities	**(5,637)**	(5,628)	(5,191)
Commercial mortgage loans	**(312)**	(430)	(165)
Other (primarily short-term and other long-term investments)	**(1,189)**	(1,065)	(1,698)
Property and equipment purchases, net	**(528)**	(471)	(461)
Acquisitions, net of cash acquired	**(24,455)**	(209)	(4)
Other, net	**(12)**	–	(101)
NET CASH (USED IN) INVESTING ACTIVITIES	**(26,378)**	(1,703)	(2,574)
Cash Flows from Financing Activities			
Deposits and interest credited to contractholder deposit funds	**1,040**	1,230	1,460
Withdrawals and benefit payments from contractholder deposit funds	**(1,151)**	(1,363)	(1,362)
Net change in short-term debt	**1,487**	80	(148)
Payments for debt extinguishment	**–**	(313)	–
Repayment of long-term debt	**(131)**	(1,250)	–
Net proceeds on issuance of long-term debt	**22,856**	1,581	–
Repurchase of common stock	**(342)**	(2,725)	(139)
Issuance of common stock	**68**	131	36
Other, net	**(312)**	(22)	(72)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	**23,515**	(2,651)	(225)
Effect of foreign currency rate changes on cash and cash equivalents	**(24)**	55	(10)
Net increase (decrease) in cash and cash equivalents	**883**	(213)	1,217
Cash and cash equivalents, January 1,	**2,972**	3,185	1,968
Cash and cash equivalents, December 31,	**$ 3,855**	$ 2,972	$ 3,185
Supplemental Disclosure of Cash Information:			
Income taxes paid, net of refunds	**$ 1,019**	$ 1,036	$ 1,064
Interest paid	**$ 267**	$ 240	$ 244

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Notes to the Consolidated Financial Statements

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Note 1 Description of Business

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us" is a global health service organization dedicated to a mission of helping those we serve improve their health, well-being and peace of mind. Our evolved strategy in support of our mission is ***Go Deeper, Go Local, Go Beyond*** using a differentiated set of medical, pharmacy, dental, disability, life and accident insurance and related products and services offered by our subsidiaries.

The majority of these products are offered through employers and other groups such as governmental and non-governmental organizations, unions and associations. Cigna also offers commercial health and dental insurance, Medicare and Medicaid products and health, life and accident insurance coverages to individuals in the United States and selected international markets. In addition to these ongoing operations, Cigna also has certain run-off operations.

As described more fully in Note 3, on March 8, 2018, the Company entered into a merger agreement with Express Scripts Holding Company ("Express Scripts"). Following entry into the merger agreement and throughout the pendency of the transaction, Cigna and Express Scripts designed integration plans to implement a new management and business reporting structure for the combined company immediately upon closing. On December 20, 2018, Cigna completed the acquisition of Express Scripts. As a result, our segments have changed as described below, effective in the fourth quarter of 2018. Financial data for all prior periods presented was restated to reflect this new segment presentation.

Integrated Medical offers a variety of medical solutions to employers and individuals.

- The ***Commercial*** operating segment serves employers (also referred to as "clients") and their employees (also referred to as "customers") and other groups. This segment provides deeply integrated medical and specialty offerings including medical, pharmacy, dental, behavioral health and vision, health advocacy programs and other products and services to insured and self-insured clients.
- The ***Government*** operating segment offers Medicare Advantage, Medicare Supplement, and Medicare Part D plans to Medicare-eligible beneficiaries as well as Medicaid plans. This operating segment also offers health insurance coverage to individual customers both on and off the public exchanges. This segment includes the acquired Express Scripts' Medicare Part D business.

Health Services includes pharmacy benefits management ("PBM"), pharmacy home delivery, and certain medical management services. This segment includes Express Scripts' business from the date of acquisition with the exception of Express Scripts' Medicare Part D business that is reported in the Government operating segment.

International Markets includes supplemental health, life and accident insurance products and health care coverage in our international markets as well as health care benefits to globally mobile employees of multinational organizations.

The remainder of our business operations are reported in ***Group Disability and Other,*** consisting of the following:

- ***Group Disability and Life*** provides group long-term and short-term disability, group life, accident, voluntary and specialty insurance products and related services.
- ***Corporate-Owned Life Insurance ("COLI")*** offers permanent insurance contracts sold to corporations to provide coverage on the lives of certain employees for the purpose of financing employer-paid future benefit obligations.
- ***Run-off businesses:***
    - ***Reinsurance:*** predominantly comprised of guaranteed minimum death benefit ("GMDB") and guaranteed minimum income benefit ("GMIB") business effectively exited through reinsurance with Berkshire Hathaway Life Insurance Company of Nebraska ("Berkshire") in 2013.
    - ***Settlement Annuity*** business in run-off.
    - ***Individual Life Insurance and Annuity and Retirement Benefits Businesses:*** deferred gains from the sales of these businesses.
    - ***Certain international run-off businesses***

Corporate reflects amounts not allocated to operating segments, including interest expense, net investment income on investments not supporting segment and other operations, interest on uncertain tax positions, certain litigation matters, compensation cost for stock options and related excess tax benefits, expense associated with our frozen pension plans, severance, certain overhead and project costs and intersegment eliminations for products and services sold between segments.

Note 2 Summary of Significant Accounting Policies

Basis of Presentation

The Consolidated Financial Statements include the accounts of Cigna Corporation and its consolidated subsidiaries. Intercompany transactions and accounts have been eliminated in consolidation. These Consolidated Financial Statements were prepared in conformity with accounting principles generally accepted in the United States of America ("GAAP"). The Company adopted Article 5 of Regulation S-X issued by the Securities and Exchange Commission effective December 31, 2018 in conjunction with the acquisition of Express Scripts. As a result, the Company now presents current assets and liabilities on its balance sheet. The Company reclassified realized investment gains (losses) from revenue and now reports them below income from operations with interest expense in our Consolidated Statements of Income, in conformity with Article 5. Prior years' information was reclassified to conform to this new presentation.

Amounts recorded in the Consolidated Financial Statements necessarily reflect management's estimates and assumptions about medical costs, investment valuation, interest rates and other factors. Significant estimates are discussed throughout these Notes; however, actual results could differ from those estimates. The impact of a change in estimate is generally included in earnings in the period of adjustment. Certain reclassifications have been made to prior year amounts to conform to the current presentation.

Variable interest entities. See Note 11 for a discussion of variable interest entities.

Recent Accounting Guidance

Accounting Standard and Adoption Date	Requirements and Effects of Adopting New Guidance
GUIDANCE ADOPTED JANUARY 1, 2018	
Revenue from Contracts with Customers (Accounting Standards Update ("ASU") 2014-09 and related amendments)	Requires: • Revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the Company expects to be entitled in exchange for those goods or services • Additional revenue-related disclosures Effects of adoption: • Applies to the Company's service and pharmacy contracts with customers • Adopted through full retrospective restatement • Cumulative-effect adjustment of $24 million after-tax was recorded, reducing the December 31, 2015 balance of retained earnings. This adjustment established a contract liability for service fee revenue billed that must be deferred and allocated to services performed after a customer contract terminates. Subsequent changes in the contract liability and the related impact to net income and per share amounts since adoption were immaterial. • Immaterial reclassifications were made to prior periods in the Consolidated Statements of Income to conform to the current presentation. The ASU and related interpretive guidance provide clarification on topics including whether all or a part of a contract is within its scope, and the definition of a customer. Companies are required to identify and evaluate distinct performance obligations within their contracts. These clarifications resulted in reclassifications within the Integrated Medical segment affecting premiums, fees and other revenues, benefit expenses, and selling, general and administrative expenses and had no impact on revenue recognition patterns or net income. Expedients and exemptions elected: • Incremental costs of obtaining service and pharmacy contracts for short-term arrangements are expensed as incurred. • The Company does not disclose information about the aggregate amount of transaction price allocated to remaining performance obligations as its contracts are either short-term, or the remaining transaction price consists of variable consideration that relates specifically to wholly unsatisfied future periods of service. See the discussion of the Company's accounting policies for fees and pharmacy revenues beginning on page 79.
Recognition and Measurement of Financial Assets and Financial Liabilities (ASU 2016-01)	Requires: • Entities to measure equity investments at fair value in net income if they are neither consolidated nor accounted for under the equity method Effects of adoption: • Certain limited partnership interests previously carried at cost of approximately $200 million were increased to fair value of approximately $275 million on January 1, 2018. Subsequent changes in fair value are reported in net investment income. • Changes in fair value for equity securities having a readily determinable fair value that were previously reported in accumulated other comprehensive income ("AOCI") are now reported in net realized investment gains (losses). • Cumulative-effect adjustment of $62 million after-tax was recorded, increasing the opening balance of retained earnings in 2018. • See Notes 9 and 10 for updated disclosures about equity securities.

Accounting Standard and Adoption date	Requirements and Effects of Adopting New Guidance
GUIDANCE ADOPTED JANUARY 1, 2018	
Targeted Improvements to Accounting for Hedging Activities (ASU 2017-12) **Early adopted as of January 1, 2018**	Guidance: • Relaxes eligibility requirements for financial and nonfinancial hedging strategies for hedge accounting and changes how companies assess effectiveness • Amends presentation and disclosure requirements to improve transparency about the uses and results of hedging programs Effects of adoption: • An immaterial amount of retained earnings was reclassified to AOCI, decreasing the opening balance in 2018, for a portion of the hedging instruments that was previously excluded from the assessment of hedge effectiveness for fair value hedges. • See Note 9 for the Company's disclosures about derivatives.
Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income (ASU 2018-02) **Early adopted as of January 1, 2018**	Guidance: • Allows companies to reclassify the tax effects stranded in AOCI to retained earnings as a result of H.R.1, An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (referred to throughout this Form 10-K as "U.S. tax reform" or "U.S. tax reform legislation") • Requires additional disclosures of the Company's accounting policy for releasing income tax effects from AOCI • Allows companies to apply the guidance retrospectively or in the period of adoption Effects of adoption: AOCI of $229 million was reclassified to retained earnings, increasing the opening balance in 2018. See Note 12 for additional information including accounting policy disclosures.

In addition to these standards, the Company adopted the following guidance in first quarter 2018 with no material impact to our financial statements: Intra-Entity Transfers of Assets Other than Inventory (ASU 2016-16), Clarifying the Definition of a Business (ASU 2017-01), Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost (ASU 2017-07), Statement of Cash Flows: Restricted Cash (ASU 2016-18), Gains and Losses from the Derecognition of Nonfinancial Assets (ASU 2017-05), and Stock Compensation Scope of Modification Accounting (ASU 2017-09).

Accounting Guidance Not Yet Adopted

Accounting Standard and Effective Date	Requirements and Expected Effects of New Guidance Not Yet Adopted
Leases (ASU 2016-02 and related amendments) **Required as of January 1, 2019**	Requires: • Balance sheet recognition of assets and liabilities arising from leases, including leases embedded in other contracts • Additional disclosures of the amount, timing and uncertainty of cash flows from leases • Modified retrospective approach for leases in effect as of and after the date of adoption with a cumulative-effect adjustment recorded in retained earnings Expected effects: • The Company will adopt this ASU in the first quarter of 2019 on a modified retrospective basis and will not restate comparative periods. While we are still finalizing our adoption procedures, we estimate the primary impact to our Consolidated Balance Sheet will be an increase to assets and liabilities of approximately $700 million for the right-of-use asset and corresponding lease liability related to existing operating leases. We do not expect the impact to retained earnings to be material. • The Company elected the optional practical expedient to retain the current classification of leases, and therefore, we do not expect a material impact to the Consolidated Statements of Income or Cash Flows. • The Company has implemented a new lease system and developed requisite changes to internal controls over financial reporting. • The Company is continuing to work to develop required disclosures. • The Company adopted this new guidance as of the effective date and will not present comparative periods in the financial statements, as recently allowed.

Accounting Standard and Effective Date	Requirements and Expected Effects of New Guidance Not Yet Adopted
Measurement of Credit Losses on Financial Instruments (ASU 2016-13) **Required as of January 1, 2020, with early adoption permitted as of January 1, 2019**	Requires: • A new approach using expected credit losses to estimate and recognize credit losses for certain financial instruments such as mortgage loans, reinsurance recoverables and other receivables when such instruments are first originated or acquired. • Changes in the criteria for impairment of available-for-sale debt securities • Adoption using a modified retrospective approach with a cumulative-effect adjustment recorded in retained earnings Expected effects: • The Company is continuing to evaluate this new standard and its effects on our financial statements and disclosures. We expect to adopt the standard as of January 1, 2020. • An additional allowance for future expected credit losses for certain financial instruments may be required at adoption.
Simplifying the Test for Goodwill Impairment (ASU 2017-04) **Required as of January 1, 2020, with early adoption permitted as of January 1, 2017**	Guidance: • Simplifies the accounting for goodwill impairment by eliminating the need to determine the fair value of individual assets and liabilities of a reporting unit to measure a goodwill impairment • Redefines the amount of goodwill impairment to equal the amount by which a reporting unit's carrying value exceeds its fair value, limited to the total amount of goodwill of the reporting unit • Requires prospective adoption Expected effects: • The Company is evaluating this new standard and its expected timing of adoption.

Targeted Improvements to the Accounting for Long-Duration Contracts (ASU 2018-12)
 	
Required as of January 1, 2021
	Requires (for insurance entities that issue long-duration contracts):
	• Cash flow assumptions used to measure the liability for future policy benefits for traditional and limited-pay contract to be reconsidered at least annually with any changes reflected in net income.
	• Discount rate assumptions to be reviewed quarterly (based on an upper-medium grade (low credit risk) fixed-income instrument yield that maximizes the use of observable market inputs) with any changes reflected in other comprehensive income.
	• Deferred policy acquisition costs to be amortized on a constant-level basis over the expected term of the related contract.
	• Fair value measurement of all market risk benefits.
	• Additional disclosures, including liability rollforwards and information about significant inputs, judgments, assumptions and methods used in measurement.
	• Transition methods at adoption vary:
	  • Changes to the liability for future policy benefits will use a modified retrospective approach (applied to all contracts on the basis of their carrying amounts as of the beginning of the earliest period presented), with an option to elect a full retrospective transition under certain criteria.
	  • Deferred policy acquisition costs are to be transitioned consistent with the method applied to the liability for future policyholder benefits.
	  • Market risk benefits are required to transition using retrospective application.
	Expected effects:
	• The Company is evaluating the impact of this newly-issued guidance, but it is expected to have a significant impact on our processes, controls, systems and financial results. The new guidance will apply to insurance products predominantly sold in the International Markets segment and Group Disability and Other.

Significant Accounting Policies

The Company's accounting policies are described either in this Note or in the applicable Notes to the Consolidated Financial Statements as indicated in the table below.

A. Cash and Cash Equivalents

Cash and cash equivalents are carried at cost that approximates fair value. Cash equivalents consist of short-term investments with maturities of three months or less from the time of purchase. The Company reclassifies cash overdraft positions to liabilities when the legal right of offset does not exist.

B. Accounts Receivable, Net

The following amounts are included within accounts receivable, net:

(In millions)	2018	2017
Insurance customer receivables	**$ 1,888**	$ 1,818
Noninsurance customer receivables	**4,988**	441
Pharmaceutical manufacturers receivable [1]	**3,321**	645
Other receivables	**276**	251
Total accounts receivable, net	**$ 10,473**	$ 3,155

(1) Includes $406 million at December 31, 2018 and $336 million at December 31, 2017 of receivables under noninsurance customer contracts.

These accounts receivable balances primarily include amounts due from clients, third-party payors, customers and pharmaceutical manufacturers. Receivables totaling $1.2 billion related to the acquired Express Scripts business are unbilled as of December 31, 2018 and are typically billed to PBM clients within 30 days based on contractual billing schedules. Unbilled receivables for medical benefit management

services represent amounts due from clients at contracted rates, and are billed when settlement provisions for capitated risk contracts are met, at least annually.

The receivables balances above are reported net of allowances for doubtful accounts of $217 million as of December 31, 2018 and $210 million as of December 31, 2017. The allowances are based on the current status of each customer's receivable balance as well as current economic and market conditions and a variety of other factors including the length of time the receivables are past due, the financial health of customers and our past experience. Receivables are written off against allowances only when such amounts are determined to be not recoverable and all collection attempts have failed. We regularly review the adequacy of these allowances based on a variety of factors, including age of the outstanding receivable and collection history. When circumstances related to specific collection patterns change, estimates of the recoverability of receivables are adjusted.

Express Scripts' receivables were recorded at their estimated fair values at the acquisition date. These fair values considered estimated discounts and claims adjustments issued to customers in the form of client credits, and amounts from third-party payors and pharmaceutical manufacturers that are not considered realizable based on contract terms and historical payment experience.

C. Inventories

Inventories consist of prescription drugs and medical supplies and are stated at the lower of first-in-first-out cost or net realizable value.

D. Reinsurance Recoverables

Reinsurance recoverables represent amounts due from reinsurers for both paid and unpaid claims of the Company's insurance businesses. Most reinsurance recoverables are classified as non-current assets. The current portion of reinsurance recoverables is reported in other current assets and consists primarily of recoverables on paid claims expected to be settled within one year. Reinsurance recoverables are presented net of allowances for uncollectible reinsurance that were immaterial as of December 31, 2018 and 2017.

E. Deferred Policy Acquisition Costs

Costs eligible for deferral include incremental, direct costs of acquiring new or renewal insurance and investment contracts and other costs directly related to successful contract acquisition. Examples of deferrable costs include commissions, sales compensation and benefits, policy issuance and underwriting costs and premium taxes. The Company records acquisition costs differently depending on the product line. Acquisition costs for:

- ***Supplemental health, life and accident insurance products*** (primarily individual products) that comprise the majority of the Company's deferred policy acquisition costs and ***group health and accident insurance products*** are deferred and amortized, generally in proportion to the ratio of periodic revenue to the estimated total revenues over the contract periods.
- ***Universal life products*** are deferred and amortized in proportion to the present value of total estimated gross profits over the expected lives of the contracts.
- ***Other products*** are expensed as incurred.

Deferred policy acquisition costs also include the value of business acquired ("VOBA") for certain acquisitions with material long-duration insurance contracts. The Company recorded amortization of deferred policy acquisition costs of $406 million in 2018, $322 million in 2017 and $292 million in 2016 primarily in selling, general and administrative expenses.

Each year, deferred policy acquisition costs are tested for recoverability. For universal life and other individual products, management estimates the present value of future revenues less expected payments. For group health and accident insurance products, management estimates the sum of unearned premiums and anticipated net investment income less future expected claims and related costs. If management's estimates of these sums are less than the deferred costs, the Company reduces deferred policy acquisition costs and records an additional expense.

F. Other Assets (Current and Non-Current)

Other current assets consist primarily of prepaid expenses, accrued investment income and the current portion of reinsurance recoverables. Other non-current assets consist primarily of GMIB assets and various other insurance-related assets. See Note 8 for the Company's accounting policy for GMIB assets. Additionally, other non-current assets include the carrying value of our equity-method investments in joint ventures in China, India, the U.S. and other foreign jurisdictions.

G. Redeemable Noncontrolling Interests

Products and services are offered in Turkey and India through joint venture entities. The Company is the principal equity holder and primary beneficiary of the Turkey joint venture and accordingly, this entity is consolidated. In 2017, Cigna modified the agreement governing its joint venture in India due to changes in the local regulatory environment that require control by a local partner. As a result of the changes in the joint venture agreement, the Company determined that it is no longer the primary beneficiary of the joint venture and, effective with the third quarter of 2017, no longer consolidates its results.

Redeemable noncontrolling interests on our Consolidated Balance Sheets represent the Turkey joint venture partner's preferred and common stock interests in the entity as of December 31, 2018 and 2017. Our joint venture partner may choose to require the Company to purchase their redeemable noncontrolling interests. We also have the right to require our joint venture partner to sell their redeemable noncontrolling

interests to us. The redeemable noncontrolling interests were recorded at fair value as of the dates of purchase. When the estimated redemption value for a redeemable noncontrolling interest exceeds its carrying value, an adjustment to increase the redeemable noncontrolling interest is recorded with an offsetting reduction to additional paid-in capital. When an adjustment is made to the carrying value of the redeemable noncontrolling interest, the calculation of shareholders' net income per share will be adjusted if the redemption value exceeds the greater of the carrying value or fair value.

H. Accrued Expenses and Other Current and Non-Current Liabilities

Accrued expenses (current) includes financial and performance guarantee liabilities under pharmacy contracts (see section L), management compensation, and various insurance-related liabilities, including experience-rated refunds, reinsurance contracts and the risk adjustment and minimum medical loss ratio rebate accruals under The Patient Protection and Affordable Care Act. Other non-current liabilities include obligations for pension, other postretirement and postemployment benefits (see Note 13), GMIB contract liabilities (see Note 8) and self-insured exposures not expected to be settled within one year. Legal costs to defend the Company's litigation and arbitration matters are expensed when incurred in cases where the Company cannot reasonably estimate the ultimate cost to defend. If the Company can reasonably estimate the cost to defend, a liability for these costs is accrued when the claim is reported.

I. Translation of Foreign Currencies

The Company generally conducts its international business through foreign operating entities that maintain assets and liabilities in local currencies that are generally their functional currencies. The Company uses exchange rates as of the balance sheet date to translate assets and liabilities into U.S. dollars. Translation gains or losses on functional currencies, net of applicable taxes, are recorded in accumulated other comprehensive income (loss). The Company uses average monthly exchange rates during the year to translate revenues and expenses into U.S. dollars.

J. Premiums and Related Expenses

Premiums for group life, accident and health insurance and managed care coverages are recognized as revenue on a pro rata basis over the contract period. Benefits and expenses are recognized when incurred and, for our Integrated Medical insured business, are presented net of pharmaceutical manufacturer rebates. For experience-rated contracts, premium revenue includes an adjustment for experience-rated refunds based on contract terms and calculated using the customer's experience (including estimates of incurred but not reported claims).

Premium revenue also includes an adjustment to reflect the estimated effect of rebates due to customers under the commercial minimum medical loss ratio provisions of the ACA. These rebates are settled in the year following the policy year.

Premiums received for the Company's Medicare Advantage plans and Medicare Part D products from the Centers for Medicare and Medicaid Services ("CMS") and customers are recognized as revenue ratably over the contract period. CMS provides risk-adjusted premium payments for Medicare Advantage Plans and Medicare Part D products based on the demographics and wellness of customers. The Company recognizes periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured. Additionally, Medicare Part D premiums include payments from CMS for risk sharing adjustments. The risk sharing adjustments are estimated quarterly based on claim experience by comparing actual incurred drug benefit costs to estimated costs submitted in original contracts. These adjustments may result in more or less revenue from CMS. Final revenue adjustments are determined and settled with CMS in the year following the contract year. Premium revenue also includes an adjustment to reflect the estimated effect of rebates due to CMS under the Medicare Advantage and Medicare Part D minimum medical loss ratio provisions of the ACA.

The ACA prescribed three programs to mitigate the risk for participating health insurance companies selling coverage on the public exchanges: risk adjustment, reinsurance and risk corridor. The reinsurance and risk corridor programs expired at the end of 2016, while the permanent risk adjustment program continues.

The risk adjustment program reallocates funds from insurers with lower risk populations to insurers with higher risk populations based on the relative risk scores of participants in non-grandfathered plans in the individual and small group markets, both on and off the exchanges. We estimate our receivable or payable based on the risk of our members compared to the risk of other members in the same state and market, considering data obtained from industry studies and the United States Department of Health and Human Services ("HHS"). Receivables or payables are recorded as adjustments to premium revenue based on our year-to-date experience when the amounts are reasonably estimable and collection is reasonably assured. Final revenue adjustments are determined by HHS in the year following the policy year.

Premiums for individual life, accident and supplemental health insurance and annuity products, excluding universal life and investment-related products, are recognized as revenue when due. Benefits and expenses are matched with premiums.

Revenue for universal life products is recognized as follows:

- Investment income on assets supporting universal life products is recognized in net investment income as earned.
- Charges for mortality, administration and policy surrender are recognized in premiums as earned. Administrative fees are considered earned when services are provided.

Benefits and expenses for universal life products consist of benefit claims in excess of policyholder account balances and income earned by policyholders. Expenses are recognized when claims are incurred, and income is credited to policyholders in accordance with contract provisions.

The unrecognized portion of premiums received is recorded as unearned premiums included in insurance and contractholder liabilities (see Note 7 for further information).

K. Fees and Related Expenses

The majority of the Company's service fees are derived from administrative services only ("ASO") arrangements that allow corporate clients to self-fund claims and assume the risk of medical or other benefit costs. Most of the Company's ASO arrangements are for medical and specialty services, including pharmacy benefits. Generally, the Company's ASO arrangements are short-term. Contract modifications typically occur on renewal and are prospective in nature.

In return for fees from these clients, the Company provides or makes available various services supporting benefit management and claims administration. In addition, services offered through our Integrated Medical segment include access to the Company's participating provider networks, disease management, utilization management, and cost containment services.

In general, the Company considers these services to be a combined performance obligation to provide cost effective administration of plan benefits over the contract period. Fees are billed, due and recognized monthly at contracted rates based on current membership or utilization. This recognition pattern aligns with the benefits from services provided to clients. These revenues are reported in fees and other revenues in the Consolidated Statements of Income.

For most ASO arrangements, the Company is required to perform services for a limited period after a client cancels. If these services will not be separately billed to the client as they are performed, the Company estimates and defers a portion of compensation attributable to this service obligation received in advance. Deferred revenue is recorded as a contract liability and recognized when the related services are performed. The balance was immaterial as of December 31, 2018 and 2017.

The Company may also provide performance guarantees that provide potential refunds to clients if certain service standards, clinical outcomes or financial metrics are not met. If these standards, outcomes and metrics are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. The Company defers revenue by recording a liability for estimated payouts associated with these guarantees within accrued expenses and other liabilities (current). The amount of revenue deferred is estimated for each type of guarantee, using either a most likely amount or expected value method depending upon the nature of the guarantee and the information available to estimate refunds. Estimates are refined each reporting period as additional information on the Company's performance becomes available, and upon final reconciliation and settlement at the end of the guarantee period. Amounts accrued and paid for performance guarantees during the reporting periods were not material.

Rebates from pharmaceutical manufacturers resulting from ASO client utilization at retail pharmacies, net of amounts payable to ASO clients, are compensation for pharmacy services and recorded in fees and other revenues. Rebates generally represent a per-script amount from the manufacturer and are determined based on scripts filled during the reporting period.

Expenses associated with administrative programs and services are recognized in selling, general and administrative expenses as incurred.

The Company also earns fees by providing integrated medical benefit management solutions that drive cost reductions and improve quality outcomes. These solutions were part of the business acquired from Express Scripts. Clients are primarily sponsors of health benefit plans and fees may be stated as a per-member-per-month fee or as a per-claim fee. The Company considers the services to be a single performance obligation to stand ready to provide utilization management services over the contract period (generally three years). In certain arrangements, the Company assumes the financial obligation for third-party provider costs for medical services provided to the health plan's members. Fees are recorded gross in revenues because the Company is acting as a principal in arranging for and controlling the services provided by third-party network providers. Contractual fees vary based on enrollment and provider costs and are estimated, billed, due and recognized monthly. Direct costs associated with these programs are included in pharmacy and service costs.

Certain medical benefit management contracts require the Company to share the results of medical cost experience that differs from specified targets. This variable consideration is estimated at contract inception and adjusted through the contract period. The estimated profits and costs are recognized net in revenues.

L. Pharmacy Revenues and Costs

Pharmacy Revenues. Pharmacy revenues include revenue from the acquired Express Scripts business and the Company's legacy mail order pharmacy business. Pharmacy revenues are recognized when control of the promised goods or services is transferred to clients, in an amount that reflects the consideration the Company expects to receive for those goods or services.

The Express Scripts business provides or makes available various services supporting benefit management and claims administration and is generally obligated to provide prescription drugs to clients' members through multiple distribution methods including retail networks, home delivery and specialty pharmacies. These goods and services are integrated into a single performance obligation to process claims, dispense prescription drugs, and provide other services over the contract period (generally three years). The Company has elected the practical expedient to account for shipping and handling as a fulfillment activity. This performance obligation is satisfied as the business stands ready to fulfill its obligation.

Fees are billed, due and recognized at contract rates either on a periodic basis or as services are provided (such as, based on volume of claims processed). This recognition pattern aligns with the benefits from services provided.

Revenues for dispensing prescription drugs through retail pharmacies consist of the prescription price (ingredient cost and dispensing fee) contracted with clients, including the member co-payment, and any associated fees for services because we act as principal in these arrangements. When a prescription is presented to a retail network pharmacy, we are solely responsible for member eligibility, drug utilization review, drug-to-drug interaction review, any required clinical intervention, plan provision information, payment to the pharmacy and client billing. These revenues are recognized based on the full prescription price when the pharmacy claim is processed and approved for payment. We also provide benefit design and formulary consultation services to clients, and negotiate separate contractual relationships with clients and network pharmacies. These factors indicate that we have control over these transactions until the prescription is dispensed.

Home delivery and specialty pharmacy revenues are due and recognized as each prescription is shipped, net of reserves for discounts and contractual allowances estimated based on historical experience. Any differences between estimates and actual collections are reflected in operations when payments are received. Historically, adjustments to original estimates and returns have not been material.

We may also provide certain financial and performance guarantees, including a minimum level of discounts a client may receive, generic utilization rates and various service levels. Clients may be entitled to receive performance penalties if we fail to meet guarantees. Actual performance is compared to the guarantee for each measure throughout the period and the Company defers revenue for any estimated payouts within accrued expenses and other liabilities (current). These estimates are adjusted at the end of the guarantee period. Historically, adjustments to original estimates have not been material. The balance was $895 million as of December 31, 2018 and immaterial as of December 31, 2017.

The acquired Express Scripts business and Cigna's legacy home delivery business administer a program through which we receive rebates and administrative fees from pharmaceutical manufacturers. If these rebates and administrative fees are provided in conjunction with claims processing and home delivery services provided to clients, the amount payable to clients is recorded as a reduction of pharmacy revenues. These amounts are based on expected sharing percentages in contractual arrangements. These estimated payables are adjusted when amounts are collected from pharmaceutical manufacturers. Historically, these adjustments have not been material. If pharmacy rebates and administrative fees are provided in a contract that does not include claims processing, the performance obligation is to arrange for the customer to receive these rebates. In these cases, rebates and administrative fees are recorded as pharmacy revenue, net of contractual amounts payable to the client.

Other pharmacy service revenues are earned by distributing specialty pharmaceuticals and medical supplies to providers, clinics and hospitals and services to specialty pharmacy manufacturers. These revenues are recognized as prescriptions and supplies are shipped and services provided.

Pharmacy costs. Pharmacy costs include the cost of prescriptions sold and for the acquired Express Scripts business, network pharmacy claim costs and co-payments. Also included are direct costs of dispensing prescriptions including supplies, shipping and handling. Home delivery costs are recognized when the drug is shipped and retail network costs are recognized when the drug is dispensed. Pharmacy rebates and administrative fees received for providing claims processing and home delivery services are recorded as a reduction of pharmacy costs. Rebates are recognized as prescriptions are shipped or dispensed. For periods following completion of the merger with Express Scripts, the Company records a pharmacy and service costs payable for certain retail network claims based on our performance throughout the period against the contractual pricing guarantee with each pharmacy network.

Note 3 Mergers, Acquisitions and Dispositions

A. Acquisition of Express Scripts

On December 20, 2018, Cigna acquired Express Scripts through a series of mergers (collectively, the "Merger"). Cigna Holding Company (formerly named Cigna Corporation and referred to as "Old Cigna") and Express Scripts each merged with and into a wholly-owned subsidiary of Cigna. As a result of these transactions, Cigna became the parent of the combined company.

Old Cigna shareholders received one share of Cigna common stock in exchange for each share of Old Cigna common stock held immediately prior to the Merger. Express Scripts shareholders received (1) 0.2434 of a share of Cigna common stock and (2) cash of $48.75, without interest, subject to applicable withholding taxes (the "Merger Consideration"), in exchange for each share of Express Scripts common stock held immediately prior to the Merger. Cash consideration was funded primarily through a combination of cash available and debt financing discussed further in Note 5. After completion of the Merger, shares of Cigna common stock were listed for trading on the New York Stock Exchange.

The acquired Express Scripts business accelerates Cigna's ***Go Deeper, Go Local, Go Beyond*** strategy by greatly increasing the Company's ability to put medicine within reach of customers and also helping to make it more affordable. We can improve patient outcomes and help control the cost of the drug benefit by: 1) identifying products and offering solutions that improve patient outcomes and assist in controlling costs; 2) evaluating drugs for efficacy, value and price to select a cost-effective formulary; 3) offering cost-effective home delivery pharmacy and specialty services that produce cost savings for plan sponsors and better care for members; 4) leveraging purchasing volume to provide discounts to health benefit providers; and 5) promoting generic and lower-cost brands.

Merger consideration: The estimated merger consideration of $52.8 billion was calculated as follows:

(Dollars and shares in millions, except per share amounts)		
Cash consideration		
Express Scripts common stock outstanding		**564.3**
Cash consideration per share	**$**	**48.75**
Cash consideration paid to Express Scripts common stockholders	**$**	**27,510**
Cash paid in lieu of fractional shares	**$**	**4**
Cash consideration paid to Express Scripts performance share holders	**$**	**65**
Total cash consideration	**$**	**27,579**
Stock consideration		
Express Scripts common stock outstanding		**564.3**
Per share exchange ratio		**0.2434**
Shares of Cigna issued to Express Scripts common stockholders		**137.3**
Shares of Cigna issued to Express Scripts performance share holders and other equity holders		**0.3**
Shares of Cigna issued to Express Scripts shareholders		**137.6**
Closing price of Cigna common stock on December 20, 2018	**$**	**179.80**
Total stock consideration	**$**	**24,745**
Noncontrolling interest	**$**	**7**
Fair value of other share-based compensation awards	**$**	**479**
Total merger consideration	**$**	**52,810**

Fair value of share-based compensation award. Express Scripts employees' awards of options and restricted stock units of Express Scripts stock were rolled over to Cigna stock options and restricted stock units on the date of the acquisition. Each holder of an Express Scripts stock option or restricted stock unit received 0.4802 of a Cigna stock option or restricted stock award. The Cigna stock option exercise price was determined by using this same conversion ratio. Vesting periods and the remaining life of the options remained consistent with the original Express Scripts awards.

The Company valued the restricted stock units at Cigna's stock price and stock options using a Black-Scholes pricing model as of the acquisition date. The assumptions used were generally consistent with those disclosed in Note 14, except the expected life of these options averaged 4.3 years and the exercise price did not equal the market value at the date of grant.

The fair value of these options and restricted stock unit awards was included in the purchase price to the extent that services had been provided prior to the acquisition based on the grant date of the original Express Scripts award and vesting period. The remaining fair value not included in the purchase price will be recorded as compensation expense in future periods over the remaining vesting periods. Most of the expense is expected to be recognized in 2019 and 2020.

Purchase price allocation: In accordance with GAAP, the total purchase price has been allocated to the tangible and intangible net assets acquired based on management's preliminary estimates of their fair values and may change as additional information becomes available over the next several months. Most of the goodwill ($33.7 billion) is assigned to the Health Services segment, with the remainder to the Integrated Medical segment and is not deductible for federal income tax purposes. The following table summarizes the estimated fair values of assets acquired and liabilities assumed at the closing date.

(In millions)		
Cash and cash equivalents	**$**	**3,517**
Receivables		**7,802**
Inventory		**2,483**
Other current assets		**600**
Property and equipment		**2,973**
Goodwill		**38,361**
Other identifiable intangible assets		**38,725**
Other assets acquired, non-current		**314**
Total assets acquired		**94,775**
Other current liabilities		**18,616**
Long-term debt, including current portion		**12,816**
Deferred income tax liabilities		**9,511**
Other liabilities, non-current assumed		**1,022**
Total liabilities acquired		**41,965**
Total	**$**	**52,810**

A portion of the purchase price has been allocated to intangible assets that are presented and discussed below.

(In millions)	Estimated Fair Value	Estimated Useful Life in Years	Amortization Method
Customer relationships	**$ 30,210**	**14 - 29**	**Cash flow trended**
Internal-use software [1]	**2,443**	**3 - 7**	**Straight Line**
Trade name – Express Scripts	**8,400**	**N/A**	**Indefinite**
Trade name – Other	**115**	**10**	**Straight Line**
Total	**$ 41,168**		

(1) Reported in property and equipment.

The fair value of the customer relationships and the amortization period and method were determined using an income approach that relies heavily on projected future net cash flows including key assumptions for customer attrition, margins, and discount rates. The estimated useful life reflects the time period and pattern that Cigna expects to receive the benefits of the related cash flows.

The results of Express Scripts have been included in the Company's Consolidated Financial Statements from the date of the acquisition. Revenues of Express Scripts included in the Company's results for 2018 approximated $2.6 billion and Express Scripts' results of operations were immaterial to Cigna's net income.

Unaudited pro forma information. The following table presents selected unaudited pro forma information for the Company assuming the acquisition of Express Scripts had occurred on January 1, 2017. The primary adjustments reflected in the pro forma results relate to the interest expense on the debt issued to fund the Merger, the amortization of the acquired intangible assets and the presentation of transaction related costs. Transaction related costs incurred by the Company and Express Scripts in 2018 have been presented as if they had been incurred on January 1, 2017. The pro forma information does not purport to represent what the Company's actual results would have been if the acquisition had occurred as of the date indicated or what such results would be for any future periods.

	Unaudited	
	Year Ended December 31,	
(In millions, except per share amounts)	2018	2017
Total revenues	**$ 149,544**	$ 143,288
Shareholders' net income	**$ 5,632**	$ 4,435

Pro forma shareholders' net income for the year ended December 3l, 2017 includes $1.2 billion in transaction-related costs incurred in connection with the acquisition.

B. Acquisition of OnePath Life NZ Limited ("OnePath Life")

On November 30, 2018, the Company acquired OnePath Life for NZ$700 million (approximately $480 million at closing) using internal cash resources. OnePath Life is one of the largest life insurance companies in New Zealand. This acquisition will support diversifying distribution capabilities and product offerings in the New Zealand market. It will also enable better service delivery to clients and customers. The purchase price has been allocated to the tangible and intangible net assets acquired based on management's preliminary estimates of their fair value and may change as additional information becomes available over the next several months. Goodwill has been assigned to the International Markets segment as of December 31, 2018 and is not tax deductible.

The results of this business have been included in the Company's Consolidated Financial Statements from the date of acquisition and were not material. In addition, the pro forma effects on total revenues and net income assuming the acquisition had occurred January 1, 2017 were not material to the Company for the years ended December 31, 2018 and 2017.

C. Transaction-related Costs

The Company has incurred costs detailed in the table below in the acquisition of Express Scripts, the terminated merger with Anthem, Inc. ("Anthem") and other transactions. These costs consisted primarily of fees for legal, advisory and other professional services, amortization of the Bridge Facility fees in 2018 and interest expense on debt issued to fund the Express Scripts merger through the closing date, net of investment income earned on the debt proceeds. A portion of the costs, primarily legal and advisory fees, related to the completed Express Scripts acquisition are not deductible for federal income tax purposes.

	2018		2017		2016	
(In millions)	Before-tax	After-tax	Before-tax	After-tax	Before-tax	After-tax
Interest expense on newly issued debt	**$ 227**	**$ 179**	$ –	$ –	$ –	$ –
Net investment income on debt proceeds	**(123)**	**(97)**	–	–	–	–
Charitable contributions	**200**	**158**	–	–	–	–
Legal and advisory fees	**204**	**185**	36	23	96	95
Bridge facility fees	**140**	**111**	–	–	–	–
All other transaction-related costs	**204**	**133**	90	69	70	52
Tax (benefit) – previously non-deductible costs	**–**	**–**	–	(59)	–	–
Transaction-related costs, net	**$ 852**	**$ 669**	$ 126	$ 33	$166	$147

Note 4 Earnings Per Share ("EPS")

Accounting policy. The Company computes basic earnings per share using the weighted-average number of unrestricted common and deferred shares outstanding. Diluted earnings per share also includes the dilutive effect of outstanding employee stock options and restricted stock using the treasury stock method and the effect of strategic performance shares.

Basic and diluted earnings per share were computed as follows:

(Shares in thousands, dollars in millions, except per share amounts)	2018 Basic	2018 Effect of Dilution	2018 Diluted	2017 Basic	2017 Effect of Dilution	2017 Diluted	2016 Basic	2016 Effect of Dilution	2016 Diluted
Shareholders' net income	**$ 2,637**	**$ –**	**$ 2,637**	$ 2,237	$ –	$ 2,237	$ 1,867	$ –	$ 1,867
Shares									
Weighted average	**246,652**	**–**	**246,652**	250,892	–	250,892	255,360	–	255,360
Common stock equivalents		**3,573**	**3,573**		4,180	4,180		4,287	4,287
Total shares	**246,652**	**3,573**	**250,225**	250,892	4,180	255,072	255,360	4,287	259,647
EPS	**$ 10.69**	**$ (0.15)**	**$ 10.54**	$ 8.92	$ (0.15)	$ 8.77	$ 7.31	$ (0.12)	$ 7.19

The following outstanding employee stock options were not included in the computation of diluted earnings per share because their effect was anti-dilutive.

(In millions)	2018	2017	2016
Anti-dilutive options	**0.9**	0.9	2.3

Note 5 Debt

The outstanding amounts of debt and capital leases for the years ended December 31 were as follows:

(In millions)	Issuer	2018	2017
Short-term debt			
Current maturities: $1,000 million, 2.25% Senior Notes	Express Scripts	**$ 995**	$ –
Current maturities: $337 million, 7.25% Senior Notes	ESI	**343**	–
Commercial paper	Old Cigna	**1,500**	100
Current maturities: $131 million, 6.35% Notes	Old Cigna	**–**	131
Other, including capital leases	various	**117**	9
Total short-term debt		**$ 2,955**	$ 240
Long-term uncollateralized debt			
Cigna debt (issued to finance acquisition)			
$1,000 million, Floating Rate Notes due 2020	Cigna	**$ 997**	$ –
$1,750 million, 3.2% Notes due 2020	Cigna	**1,743**	–
$1,000 million, Floating Rate Notes due 2021	Cigna	**996**	–
$1,250 million, 3.4% Notes due 2021	Cigna	**1,245**	–
$3,000 million, Floating Rate Term Loan due 2021	Cigna	**2,997**	–
$700 million, Floating Rate Notes due 2023	Cigna	**697**	–
$3,100 million, 3.75% Notes due 2023	Cigna	**3,085**	–
$2,200 million, 4.125% Notes due 2025	Cigna	**2,187**	–
$3,800 million, 4.375% Notes due 2028	Cigna	**3,774**	–
$2,200 million, 4.8% Notes due 2038	Cigna	**2,178**	–
$3,000 million, 4.9% Notes due 2048	Cigna	**2,964**	–
Express Scripts debt (assumed in acquisition)			
$500 million, 4.125% Senior Notes due 2020	Medco	**506**	–
$500 million, 2.600% Senior Notes due 2020	Express Scripts	**493**	–
$400 million, Floating Rate Senior Notes due 2020	Express Scripts	**399**	–
$500 million, 3.300% Senior Notes due 2021	Express Scripts	**499**	–
$1,250 million, 4.750% Senior Notes due 2021	Express Scripts	**1,285**	–
$1,000 million, 3.900% Senior Notes due 2022	Express Scripts	**998**	–
$500 million, 3.050% Senior Notes due 2022	Express Scripts	**481**	–
$1,000 million, 3.000% Senior Notes due 2023	Express Scripts	**959**	–
$1,000 million, 3.500% Senior Notes due 2024	Express Scripts	**966**	–
$1,500 million, 4.500% Senior Notes due 2026	Express Scripts	**1,508**	–
$1,500 million, 3.400% Senior Notes due 2027	Express Scripts	**1,386**	–
$449 million, 6.125% Senior Notes due 2041	Express Scripts	**493**	–
$1,500 million, 4.800% Senior Notes due 2046	Express Scripts	**1,465**	–
Old Cigna debt (pre-acquisition)			
$250 million, 4.375% Notes due 2020	Old Cigna	**248**	249
$300 million, 5.125% Notes due 2020	Old Cigna	**298**	299
$78 million, 6.37% Notes due 2021	CGC	**78**	78
$300 million, 4.5% Notes due 2021	Old Cigna	**297**	299
$750 million, 4% Notes due 2022	Old Cigna	**746**	745
$100 million, 7.65% Notes due 2023	Old Cigna	**100**	100
$17 million, 8.3% Notes due 2023	Old Cigna	**17**	17
$900 million, 3.25% Notes due 2025	Old Cigna	**895**	894
$600 million, 3.05% Notes due 2027	Old Cigna	**595**	594
$259 million, 7.875% Debentures due 2027	Old Cigna	**259**	258
$45 million, 8.3% Step Down Notes due 2033	Old Cigna	**45**	45
$191 million, 6.15% Notes due 2036	Old Cigna	**190**	190
$121 million, 5.875% Notes due 2041	Old Cigna	**119**	119
$317 million, 5.375% Notes due 2042	Old Cigna	**315**	315
$1,000 million, 3.875% Notes due 2047	Old Cigna	**988**	988
Other, including capital leases	Other	**32**	9
Total long-term debt		**$ 39,523**	$ 5,199

Notes issued to fund the Express Scripts acquisition. As presented in the table above, the Company issued private placement Notes with registration rights in the third quarter of 2018 to finance the Express Scripts acquisition. Total proceeds were approximately $20.0 billion. Interest on this debt is generally paid semi-annually except for quarterly interest payments on the floating rate notes.

Term Loan Credit Agreement. Cigna borrowed $3.0 billion under its Term Loan Credit Agreement (the "Term Loan Credit Agreement") to finance the Merger and to pay fees and expenses of the Merger. The Term Loan Credit Agreement is diversified among 26 banks and contains customary covenants and restrictions, including a financial covenant that Cigna's leverage ratio may not exceed 60%. There is no remaining amount available for borrowing under this agreement.

Bridge Facility. In March 2018, Cigna entered into a commitment letter (the "Commitment Letter") with Morgan Stanley Senior Funding, Inc., The Bank of Tokyo-Mitsubishi UFJ, Ltd and 21 additional banks, to provide a $26.7 billion, 364-day senior unsecured bridge facility (the "Bridge Facility") in connection with the Merger. The Company incurred approximately $140 million in fees in 2018 for the Bridge Facility that expired upon the close of the Merger.

Revolving Credit Agreement. Cigna has a Revolving Credit and Letter of Credit Agreement (the "Revolving Credit Agreement") that matures on April 6, 2023 and is diversified among 23 banks.

Cigna can borrow up to $3.25 billion for general corporate purposes, with up to $500 million available for issuance of letters of credit, decreased by $22 million of letters of credit under the Revolving Credit Agreement as of December 31, 2018. The Revolving Credit Agreement also includes an option to increase the facility amount up to $500 million and an option to extend the termination date for additional one year periods, subject to consent of the banks.

The Revolving Credit Agreement contains customary covenants and restrictions, including a financial covenant that the Company's leverage ratio may not exceed 60%.

Cigna is the borrower under the Revolving Credit Agreement and the Term Loan Credit Agreement and certain subsidiaries of Cigna may be required to guarantee these obligations under certain circumstances.

Commercial Paper. Old Cigna issued $1.5 billion under the commercial paper program to finance the Merger.

Assumption of Express Scripts Debt. The Company assumed debt obligations of Express Scripts, ESI and Medco as described in the table above in the acquisition under substantially unchanged terms.

The Company was in compliance with its debt covenants as of December 31, 2018.

Other debt financing transactions. In the third quarter of 2017, Old Cigna entered into the following debt transactions:

- On September 14, 2017, Old Cigna issued $1.6 billion long-term debt and the proceeds were used to pay for the cash tender offer described below. Old Cigna also used the proceeds for general corporate purposes, including the repayment of its Notes that matured in 2018.
- Old Cigna completed a cash tender offer to purchase $1.0 billion of aggregate principal amount of certain of its outstanding debt securities in the third quarter of 2017 and recorded a pre-tax loss of $321 million ($209 million after-tax), primarily for premiums paid.

Old Cigna repaid $131 million and $250 million of long-term notes that matured during the first quarter of 2018 and 2017 respectively.

Maturities of outstanding long-term debt and capital leases are as follows:

	Scheduled Maturities	
(In millions)	Long-term Debt [1]	Capital Leases
2019	**$ 1,337**	$ 17
2020	**$ 4,700**	$ 14
2021	**$ 7,378**	$ 4
2022	**$ 2,250**	$ 4
2023	**$ 4,917**	$ 4
Maturities after 2023	**$ 20,582**	$ 7

(1) Long-term debt maturity amounts exclude capital leases.

Interest expense on long-term and short-term debt was $507 million in 2018, $243 million in 2017, and $251 million in 2016, excluding losses on the early extinguishment of debt.

Note 6 Common and Preferred Stock

As more fully described in Note 3, Cigna acquired Express Scripts on December 20, 2018. Old Cigna shareholders exchanged each of their shares for a share of Cigna common stock and shareholders of Express Scripts received 0.2434 of a share of Cigna (and $48.75 in cash) for each share of Express Scripts. Following the Merger, Old Cigna was de-listed and shares of Cigna were listed on the New York Stock Exchange for trading.

Cigna (and, prior to the Merger, Old Cigna) has a total of 25 million shares of $1 par value preferred stock authorized for issuance. No shares of preferred stock were outstanding at December 31, 2018, 2017 or 2016.

The following table presents the share activity of Old Cigna and Cigna for the years ended December 31, 2018, 2017 and 2016.

(Shares in thousands)	2018	2017	2016
Common: Par value $0.25; 600,000 shares authorized – Old Cigna			
Outstanding – January 1,	**243,967**	256,869	256,544
Issued for stock option exercises and other benefit plans	**1,118**	2,761	1,110
Repurchased common stock	**(1,300)**	(15,663)	(785)
Balance, December 20, 2018 (Merger Date)	**243,785**	–	–
Exchange of Old Cigna shares for shares of Cigna	**(243,785)**	–	–
Outstanding – December 31,	**–**	243,967	256,869
Retirement of treasury stock on December 20, 2018	**(52,358)**	–	–
Exchange of Old Cigna certificated treasury stock for new Cigna certificated treasury stock	**(2)**	–	–
Treasury stock – December 31, 2018	**–**	52,178	39,276
Issued – December 31,	**–**	296,145	296,145
Common: Par value $0.01; 600,000 shares authorized – Cigna			
Shares issued to Old Cigna shareholders	**243,785**	–	–
Shares issued to Express Scripts shareholders	**137,337**	–	–
Issued for stock option exercises and other benefit plans including Express Scripts performance share holders	**91**	–	–
Repurchased common stock	**(289)**	–	–
Outstanding – December 31, 2018	**380,924**	–	–
Treasury stock	**570**	–	–
Issued – December 31, 2018	**381,494**	–	–

Note 7 Insurance and Contractholder Liabilities

A. Account Balances – Insurance and Contractholder Liabilities

As of December 31, 2018 and 2017, the Company's insurance and contractholder liabilities comprised the following:

	December 31, 2018			December 31, 2017		
(In millions)	Current	Non-current	Total	Current	Non-current	Total
Contractholder deposit funds	**$ 641**	**$ 7,365**	**$ 8,006**	$ 713	$ 7,483	$ 8,196
Future policy benefits	**740**	**8,981**	**9,721**	706	9,334	10,040
Unpaid claims and claim expenses						
Integrated Medical	**2,678**	**19**	**2,697**	2,401	19	2,420
Other segments	**2,394**	**3,230**	**5,624**	2,178	3,289	5,467
Unearned premiums	**348**	**379**	**727**	319	405	724
Total insurance and contractholder liabilities	**$ 6,801**	**$ 19,974**	**$ 26,775**	$ 6,317	$ 20,530	$ 26,847

Insurance and contractholder liabilities expected to be paid within one year are classified as current.

Accounting Policy – Contractholder Deposit Funds: Liabilities for contractholder deposit funds primarily include deposits received from customers for investment-related and universal life products and investment earnings on their fund balances. These liabilities are adjusted to reflect administrative charges and, for universal life fund balances, mortality charges. In addition, this caption includes: 1) premium stabilization reserves under group insurance contracts representing experience refunds left with the Company to pay future premiums; 2) deposit administration funds used to fund non-pension retiree insurance programs; 3) retained asset accounts; and 4) annuities or supplementary contracts without significant life contingencies. Interest credited on these funds is accrued ratably over the contract period.

Accounting Policy – Future Policy Benefits: Future policy benefits represent the present value of estimated future obligations under long-term life and supplemental health insurance policies and annuity products currently in force. These obligations are estimated using actuarial methods and consist primarily of reserves for annuity contracts, life insurance benefits, GMDB contracts (see Note 8 for additional information) and certain health, life and accident insurance products of our International Markets segment.

Obligations for annuities represent specified periodic benefits to be paid to an individual or groups of individuals over their remaining lives. Obligations for life insurance policies and GMDB contracts represent benefits expected to be paid to policyholders, net of future premiums expected to be received. Management estimates these obligations based on assumptions as to premiums, interest rates, mortality or morbidity, future claim adjudication expenses and surrenders, allowing for adverse deviation as appropriate. Mortality, morbidity and surrender assumptions are based on the Company's own experience and published actuarial tables. Interest rate assumptions are based on management's judgment considering the Company's experience and future expectations, and range from 1% to 9%. Obligations for the run-off settlement annuity business include adjustments for realized and unrealized investment returns consistent with GAAP when a premium deficiency exists.

B. Unpaid Claims and Claim Expenses – Integrated Medical

This liability reflects estimates of the ultimate cost of claims that have been incurred but not reported, including expected development on reported claims, those that have been reported but not yet paid (reported claims in process), and other medical care expenses and services payable that are primarily comprised of accruals for incentives and other amounts payable to health care professionals and facilities. This liability no longer includes amounts from the international health care business now reported in International Markets following our change in segment reporting in 2018. Prior year rollforwards have been updated to reflect this segment change.

Accounting policy. The Company uses actuarial principles and assumptions that are consistently applied each reporting period and recognizes the actuarial best estimate of the ultimate liability along with a margin for adverse deviation. This approach is consistent with actuarial standards of practice that the liabilities be adequate under moderately adverse conditions.

The Company compares key assumptions used to establish the medical costs payable to actual experience for each reporting period. The unpaid claims liability is adjusted through current period shareholders' net income when actual experience differs from these assumptions. Additionally, the Company evaluates expected future developments and emerging trends that may impact key assumptions. The process used to determine this liability requires the Company to make critical accounting estimates that involve considerable judgment, reflecting the variability inherent in forecasting future claim payments. These estimates are highly sensitive to changes in the Company's key assumptions, specifically completion factors and medical cost trends.

The liability is primarily calculated using "completion factors" developed by comparing the claim incurral date to the date claims were paid. Completion factors are impacted by several key items including changes in: 1) electronic (auto-adjudication) versus manual claim processing; 2) provider claims submission rates; 3) membership; and 4) the mix of products. The Company uses historical completion factors combined with an analysis of current trends and operational factors to develop current estimates of completion factors. The Company estimates the liability for claims incurred in each month by applying the current estimates of completion factors to the current paid claims data. This approach implicitly assumes that historical completion rates will be a useful indicator for the current period.

The Company relies more heavily on medical cost trend analysis that reflects expected claim payment patterns and other relevant operational considerations for more recent months. Medical cost trend is primarily impacted by medical service utilization and unit costs that are affected by changes in the level and mix of medical benefits offered, including inpatient, outpatient and pharmacy, the impact of copays and deductibles, changes in provider practices and changes in consumer demographics and consumption behavior.

This liability predominately consists of incurred but not reported amounts and reported claims in process including expected development on reported claims. The total of incurred but not reported liabilities plus expected development on reported claims, including reported claims in process, was $2.5 billion at December 31, 2018 and $2.3 billion at December 31, 2017. The remaining balance in both periods reflects amounts due for physician incentives and other medical care expenses and services payable.

Activity in the unpaid claims liability for the Integrated Medical segment for the years ended December 31 was as follows:

(In millions)	2018	2017	2016
Balance at January 1,	**$ 2,420**	$ 2,261	$ 2,105
Less: Reinsurance and other amounts recoverable	**262**	273	237
Balance at January 1, net	**2,158**	1,988	1,868
Acquired, net	**40**	—	—
Incurred costs related to:			
Current year	**21,331**	19,334	18,085
Prior years	**(173)**	(227)	(70)
Total incurred	**21,158**	19,107	18,015
Paid costs related to:			
Current year	**18,978**	17,179	16,142
Prior years	**1,945**	1,758	1,753
Total paid	**20,923**	18,937	17,895
Balance at December 31, net	**2,433**	2,158	1,988
Add: Reinsurance and other amounts recoverable	**264**	262	273
Balance at December 31,	**$ 2,697**	$ 2,420	$ 2,261

Reinsurance and other amounts recoverable reflect amounts due from reinsurers and policyholders to cover incurred but not reported and pending claims for certain business where the Company administers the plan benefits but the right of offset does not exist. See Note 8 for additional information on reinsurance.

Variances in incurred costs related to prior years' unpaid claims and claims expenses that resulted from the differences between actual experience and the Company's key assumptions were as follows for the years ended December 31:

	2018		2017	
($ in millions)	$	% [1]	$	% [2]
Actual completion factors	**$ 92**	**0.5%**	$ 87	0.6%
Medical cost trend	**72**	**0.4**	131	0.7
Other	**9**	**—**	9	—
Total favorable variance	**$ 173**	**0.9%**	$ 227	1.3%

(1) Percentage of current year incurred costs as reported for 2017.

(2) Percentage of current year incurred costs as reported for 2016.

Incurred costs related to prior years in the table above, although adjusted through shareholders' net income, do not directly correspond to an increase or decrease to shareholders' net income. The primary reason for this difference is that decreases to prior year incurred costs pertaining to the portion of the liability established for moderately adverse conditions are not considered as impacting shareholders' net income if they are offset by increases in the current year provision for moderately adverse conditions.

Prior year development increased shareholders' net income by $77 million ($97 million before tax) for the year ended December 31, 2018, compared with $96 million ($148 million before tax) in 2017. Favorable prior year development implies primarily lower than expected utilization of medical services while unfavorable prior year development implies higher than expected utilization of medical services. Prior year development amounts close to zero imply utilization of medical services that are consistent with expectations.

The following table depicts the incurred and paid claims development as of December 31, 2018 (net of reinsurance), claims frequency metrics and incurred but not reported liabilities reported in the Integrated Medical segment. The information about incurred and paid claims development for the year ended December 31, 2017 is presented as supplementary information and is unaudited.

	Incurred Costs			
Incurral Year (in millions)	2017 (Unaudited)	2018	Unpaid Claims & Claim Expenses	Claims Frequency
2017	$ 18,692	**$ 18,528**	$ 22	2.6 million
2018		**20,458**	$ 2,266	2.9 million
Cumulative incurred costs plus acquired for the periods presented		**$ 38,986**		

	Cumulative Costs Paid	
Incurral Year	2017 (Unaudited)	2018
2017	$ 16,628	**$ 18,506**
2018		**18,192**
Cumulative paid costs for the periods presented		**$ 36,698**
Outstanding liabilities for the periods presented, net of reinsurance		**$ 2,288**
Other long-duration liabilities not included in development table above		**145**
Net unpaid claims and claims expenses — Integrated Medical		**2,433**
Reinsurance and other amounts recoverable		**264**
Unpaid claims and claim expenses — Integrated Medical		**$ 2,697**

More than 95% of health claims for an accident year are paid within one year of their incurred date.

There is no single or common claim frequency metric used in the health care industry. The Company believes a relevant metric for its health insurance business is the number of customers for whom an insured medical claim was paid. Customers for whom no insured medical claim was paid are excluded from the calculation. Claims that did not result in a liability are not included in the frequency metric.

C. Unpaid Claims and Claim Expenses – International Markets and Group Disability and Other

This liability now includes amounts from international health care following our change in segment reporting in 2018. Prior year rollforwards have been updated to reflect this segment change.

Accounting policy. Liabilities for unpaid claims and claim expenses are established by book of business within the Company's International Markets segment and Group Disability and Other. Liabilities for unpaid claims and claim expenses within the group disability and life business consist of the following primary products: long-term and short-term disability, life insurance, and accident coverages. Unpaid claims and claim expenses consist of (1) case or claims reserves for reported claims that are unpaid as of the balance sheet date; (2) incurred but not reported reserves for claims when the insured event has occurred but has not been reported to the Company; and (3) loss adjustment expense reserves for the expected costs of settling these claims. The Company consistently estimates incurred but not yet reported losses using actuarial principles and assumptions based on historical and projected claim incidence patterns, claim size and the expected payment period. The Company recognizes the actuarial best estimate of the ultimate liability within a level of confidence, consistent with actuarial standards of practice that the liabilities be adequate under moderately adverse conditions. The Company immediately records an adjustment in medical costs and other benefit expenses when estimates of these liabilities change.

The majority of the Company's liability for disability claims consists of the present value of estimated future benefit payments, including expected development, for each reported claim that is currently receiving benefit payments, or pending a decision on eligibility for benefits, over the expected disability period. The Company projects the expected disability period by using historical resolution rates combined with an analysis of current trends and operational factors to develop current estimates of resolution rates. Expected claim resolution rates may vary based upon the Company's experience for the anticipated disability period, the covered benefit period, the cause of disability, the benefit design and the claimant's age, gender and income level. The gross monthly benefit is reduced (offset) by disability income received under other benefit programs, most commonly Social Security Disability Income, workers' compensation, statutory disability or other group benefit plans. The Company estimates the probability and amount of future offset awards and lapses based on the Company's experience for certain offsets not yet finalized.

The Company also establishes a liability for the expected present value of future benefit payments for known claims that have recently been resolved but may reopen in the future, based on Company experience. Prior to a claim becoming known, the Company establishes a liability for incurred but not reported claims, using standard actuarial techniques and calculations based on completion factors and loss ratio assumptions using the Company's experience combined with an analysis of current trends and operational factors. Completion factors are impacted by several key items including changes in claim inventory levels, claim payment patterns, changes in business volume and other factors. Loss ratio assumptions are developed using historical Company experience, adjusted prospectively for expected changes in the underlying business including rate actions, persistency and inforce growth.

Liability balance details. The liability details for unpaid claims and claim expenses as of December 31 are as follows:

(In millions)	2018	2017
Group Disability and Other		
Group Disability and Life	**$ 4,674**	$ 4,491
Other Operations	**192**	193
Total Group Disability and Other	**4,866**	4,684
International Markets	**758**	783
Unpaid claims and claim expenses Group Disability and Other and International Markets	**$ 5,624**	$ 5,467

The Company discounts certain liabilities, predominantly long-term disability, because benefits payments are made over extended periods. Discount rate assumptions for these liabilities are based on projected investment returns for the supporting asset portfolios. Details of the Company's unpaid claim discounted liability balances as of December 31 were as follows:

(In billions)	2018	2017
Discounted liabilities	**$ 4.2**	$ 4.0
Aggregate amount of discount	**$ 1.1**	$ 1.0
Range of discount rates	**4.2% - 5.2%**	4.5% - 5.2%

Interest is accreted and recognized in medical costs and other benefit expenses in the Consolidated Statements of Income.

Activity in the Company's liabilities for unpaid claims and claim expenses, excluding Other Operations, are presented in the following table. Liabilities associated with Other Operations are excluded because they pertain to obligations for long-duration insurance contracts or, if short-duration, the liabilities have been fully reinsured.

(In millions)	2018	2017	2016
Balance at January 1,	**$ 5,274**	$ 4,997	$ 4,609
Less: Reinsurance	**140**	123	121
Balance at January 1, net	**5,134**	4,874	4,488
Incurred claims related to:			
Current year	**5,350**	5,097	5,116
Prior years			
Interest accretion	**156**	163	161
All other incurred	**(147)**	(43)	85
Total incurred	**5,359**	5,217	5,362
Paid claims related to:			
Current year	**3,391**	3,229	3,221
Prior years	**1,808**	1,757	1,739
Total paid	**5,199**	4,986	4,960
Acquisitions	**23**	—	
Foreign currency	**(41)**	29	(16)
Balance at December 31, net	**5,276**	5,134	4,874
Add: Reinsurance	**156**	140	123
Balance at December 31,	**$ 5,432**	$ 5,274	$ 4,997

Reinsurance in the previous table reflects amounts due from reinsurers related to unpaid claims liabilities. The Company's insurance subsidiaries enter into agreements with other companies primarily to limit losses from large exposures and to permit recovery of a portion of incurred losses. See Note 8 for additional information on reinsurance.

The majority of the liability for unpaid claims and claim expenses is related to disability claims with long-tailed payouts. Interest earned on assets backing these liabilities is an integral part of pricing and reserving. Therefore, interest accreted on prior year balances is shown as a separate component of prior year incurred claims. This interest is calculated by applying the average discount rate used in determining the liability balance to the average liability balance over the period. The remaining prior year incurred claims amount primarily reflects updates to the Company's liability estimates and variances between actual experience during the period relative to the assumptions and expectations reflected in determining the liability. Assumptions reflect the Company's expectations over the life of the book of business and will vary from actual experience in any period, both favorably and unfavorably, with variation in resolution rates being the most significant driver for the long-term disability business. Favorable prior year incurred claims reported in 2018 largely reflect favorable loss ratio experience for long-term disability and life relative to expectations. Favorable prior year incurred claims reported in 2017 largely reflect improved resolution rate experience for long-term disability relative to expectations. Prior year incurred claims reported in 2016 included the impact of changes made to our disability claims management process and a period of elevated life claims.

Long-term disability development tables. The table below presents information about incurred and paid claims development as of December 31, 2018 (net of reinsurance), total incurred but not reported liabilities, and cumulative claims frequency for the Company's long-term disability book of business. The information about incurred and paid claims development for the years ended 2012 through 2017 is presented as supplementary information and is unaudited. As permitted under GAAP, the Company presented development table information beginning in 2012 because obtaining information beyond this period was impracticable as historical data was not maintained in such detail.

(In millions, except for claims frequency)

	Incurred Claims (undiscounted)							Incurred But Not	
	Unaudited								
Accident Year	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**Reported Liabilities [1]**	**Claims Frequency**
2012	$ 995	$ 951	$ 889	$ 876	$ 883	$ 880	**$ 861**	$ —	21,183
2013		1,063	1,037	1,062	1,072	1,057	**1,032**	—	23,526
2014			1,158	1,129	1,167	1,146	**1,094**	—	25,314
2015				1,184	1,154	1,185	**1,160**	—	25,737
2016					1,246	1,184	**1,199**	3	25,349
2017						1,226	**1,193**	10	23,382
2018							**1,348**	515	12,025
Cumulative incurred claims for the periods presented							**$ 7,887**		

(1) Incurred but not reported amounts are included in 2018 incurred claims.

	Cumulative Paid Claims						
	Unaudited						
Accident Year	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
2012	$ 81	$ 288	$ 429	$ 504	$ 571	$ 621	**$ 661**
2013		92	342	503	600	670	**732**
2014			111	379	575	667	**743**
2015				114	417	603	**702**
2016					122	411	**598**
2017						110	**396**
2018							**116**
Cumulative paid claims for the periods presented							**$ 3,948**
All outstanding liabilities for the periods presented, net of reinsurance							**$ 3,939**
All outstanding liabilities prior to 2012, net of reinsurance							**921**
Impact of discounting							**(885)**
Liability for long-term disability unpaid claims and claim expenses, net of reinsurance							**$ 3,975**

The claims frequency metric used for the Company's long-term disability line of business represents the number of unique claim events for which benefits have been approved and payments made. Claim events are identified using a unique claimant identifier and incurral date. Thus, if an individual has multiple claims for different disabling events (and therefore different incurral dates), each will be determined to be a unique claim event. However, if an individual receives multiple benefits under more than one policy (for example for supplemental disability benefits such as pension contribution benefits or survivor benefits), the Company treats this as a single claim occurrence because they related to the same claim event. Claims frequency metrics for the most recent year are expected to be low reflecting the long-term disability product features including waiting and elimination periods that result in delayed eligibility for contract benefits. Claims that did not result in a liability are not included in the frequency metric.

The following is supplementary and unaudited information about average historical claims payout patterns for the long-term disability business for the years presented in the development table as of December 31, 2018. The average annual percentage payout of incurred claims, net of reinsurance, is approximately 9% in year one, 24% in year two, 16% in year three, 9% in year four, 7% in year five, 6% in year six and 5% in year seven.

The following table reconciles the long-term disability net incurred and paid claims development table to the liability for unpaid claims and claim expenses in the Company's Consolidated Balance Sheets as of December 31, 2018.

(In millions)	
Net outstanding liabilities — Group Disability and Life businesses	
Long-term disability liabilities, net of reinsurance	**$ 3,975**
Other short-duration insurance books of business, net of reinsurance	**594**
Liabilities for unpaid claims and claim expenses, net of reinsurance	**4,569**
Reinsurance recoverable on unpaid claims — Group Disability and Life businesses	
Long-term disability	**94**
Other short-duration insurance books of business	**11**
Total reinsurance recoverable on unpaid claims	**105**
Total liability for unpaid claims and claim expenses — Group Disability and Life businesses	**4,674**
International Markets segment	**758**
Other Operations	**192**
Unpaid claims and claim expenses — Group Disability and Other and International Markets	**$ 5,624**

The other short-duration insurance books of business, net of reinsurance, primarily include liabilities for life, accident and short-term disability insurance products. Liabilities for these products are typically complete within one year. Claim development on these liabilities is largely driven by completion factors and loss ratio assumptions.

Note 8 Reinsurance

The Company's insurance subsidiaries enter into agreements with other insurance companies to assume and cede reinsurance. Reinsurance is ceded primarily in acquisition and disposition transactions when the underwriting company is not being acquired. Reinsurance is also used to limit losses from large exposures and to permit recovery of a portion of direct or assumed losses. Reinsurance does not relieve the originating insurer of liability. Therefore, reinsured liabilities must continue to be reported along with the related reinsurance recoverables. The Company regularly evaluates the financial condition of its reinsurers and monitors concentrations of its credit risk.

A. Reinsurance Recoverables

The majority of the Company's reinsurance recoverables resulted from acquisition and disposition transactions in which the underwriting company was not acquired. Components of the Company's reinsurance recoverables are presented in the following table. Included in the table below is $297 million as of December 31, 2018 and $282 million as of December 31, 2017 of current reinsurance recoverables that are reported in other current assets.

(Dollars in millions) **Line of Business**	**Reinsurer(s)**	**December 31, 2018**	**December 31, 2017**	**Collateral and Other Terms at December 31, 2018**
Ongoing Operations				
Integrated Medical, International Markets, Group Disability, COLI	Various	**$ 464**	$ 454	Balances range from less than $1 million up to $70 million. Over 70% of the balance is from companies rated as investment grade by Standard & Poor's.
Total recoverables related to ongoing operations		**464**	454	
Acquisition, disposition or runoff activities				
Individual Life and Annuity (sold in 1998)	Lincoln National Life and Lincoln Life & Annuity of New York	**3,312**	3,436	Both companies' ratings were well above the level that would trigger a contractual obligation to fully secure the outstanding balance.
GMDB (effectively exited in 2013)	Berkshire	**893**	928	100% secured by assets in a trust.
Retirement Benefits Business (sold in 2004)	Prudential Retirement Insurance and Annuity	**787**	850	100% secured by assets in a trust.
Supplemental Benefits Business (2012 acquisition)	Great American Life	**261**	283	100% secured by assets in a trust.
Other	Various	**87**	95	100% secured by assets in a trust or other deposits.
Total recoverables related to acquisition, disposition or runoff activities		**5,340**	5,592	
Total reinsurance recoverables		**$ 5,804**	$ 6,046	

The Company bears the risk of loss if its reinsurers and retrocessionaires do not meet or are unable to meet their reinsurance obligations to the Company. The Company reviews its reinsurance arrangements and establishes reserves against the recoverables if recovery is not considered probable.

B. Effects of Reinsurance

The following table presents direct, assumed and ceded premiums for both short-duration and long-duration insurance contracts. It also presents reinsurance recoveries that have been netted against benefit expenses in the Company's Consolidated Statements of Income.

(In millions)	2018	2017	2016
Premiums			
Short-duration contracts			
Direct	**$ 32,148**	$ 28,838	$ 27,694
Assumed	**77**	199	247
Ceded	**(182)**	(150)	(229)
Total short-duration contract premiums	**32,043**	28,887	27,712
Long-duration contracts			
Direct	**4,268**	3,748	3,259
Assumed	**116**	130	137
Ceded			
Individual life insurance and annuity business sold	**(133)**	(143)	(153)
Other	**(181)**	(131)	(131)
Total long-duration contract premiums	**4,070**	3,604	3,112
Total premiums	**$ 36,113**	$ 32,491	$ 30,824
Reinsurance recoveries			
Individual life insurance and annuity business sold	**$ 249**	$ 259	$ 279
Other	**203**	66	261
Total reinsurance recoveries	**$ 452**	$ 325	$ 540

The effects of reinsurance on written premiums for short-duration contracts were not materially different from the recognized premium amounts shown in the table above.

C. Effective Exit of GMDB and GMIB Business

The Company entered into an agreement with Berkshire to effectively exit the GMDB and GMIB business via a reinsurance transaction in 2013. Berkshire reinsured 100% of the Company's future claim payments in this business, net of other reinsurance arrangements existing at that time. The reinsurance agreement is subject to an overall limit with approximately $3.4 billion remaining at December 31, 2018.

GMDB is accounted for as reinsurance and GMIB assets and liabilities are reported as derivatives at fair value as discussed below. GMIB assets are reported in other current assets and other assets, and GMIB liabilities are reported in accrued expenses and other liabilities and other non-current liabilities.

GMDB

The GMDB exposure arises under annuities written by ceding companies that guarantee the benefit received at death. The Company's exposure arises when the guaranteed minimum death benefit exceeds the fair value of the related mutual fund investments at the time of a contractholder's death.

Accounting policy. The Company estimates the gross liability and reinsurance recoverable with an internal model based on the Company's experience and future expectations over an extended period, consistent with the long-term nature of this product. As a result of the reinsurance transaction, reserve increases have a corresponding increase in the recorded reinsurance recoverable, provided the increased recoverable remains within the overall Berkshire limit (including the GMIB asset presented below).

The following table presents the account value, net amount at risk and average attained age of underlying contractholders for guarantees assumed by the Company in the event of death. The net amount at risk is the amount that the Company would have to pay if all contractholders died as of the specified date. Unless the Berkshire reinsurance limit is exceeded, the Company should be reimbursed in full for these payments.

(Dollars in millions, excludes impact of reinsurance ceded)	2018	2017
Account value	**$ 8,402**	$ 10,109
Net amount at risk	**$ 2,466**	$ 2,112
Average attained age of contractholders (weighted by exposure)	**74**	75
Number of contractholders	**220,000**	245,000

GMIB

The Company reinsured contracts with issuers of GMIB products. The Company's exposure represents the excess of a contractually guaranteed amount over the level of variable annuity account values. Payment by the Company depends on the actual account value in the underlying mutual funds and the level of interest rates when the contractholders elect to receive minimum income payments that must occur within 30 days of a policy anniversary after the appropriate waiting period. The Company has purchased retrocessional coverage ("GMIB assets"), including retrocessional coverage from Berkshire, for these contracts.

Accounting policy. The Company reports GMIB liabilities and assets as derivatives at fair value because cash flows of these liabilities and assets are affected by equity markets and interest rates, but are without significant life insurance risk and are settled in lump sum payments. The Company receives and pays fees periodically based on either contractholders' account values or deposits increased at a contractual rate. The Company will also pay and receive cash depending on changes in account values and interest rates when contractholders first elect to receive minimum income payments. Cash flows on these contracts are reported in operating activities.

Assumptions used in fair value measurement. GMIB assets and liabilities are established using capital market assumptions and assumptions related to future annuitant behavior (including mortality, lapse, and annuity election rates). The Company classifies GMIB assets and liabilities in Level 3 in the fair value hierarchy described in Note 10 because assumptions related to future annuitant behavior are largely unobservable.

The only assumption expected to impact future shareholders' net income is non-performance risk. The non-performance risk adjustment reflects a market participant's view of nonpayment risk by adding an additional spread to the discount rate in the calculation of both (a) the GMIB liabilities to be paid by the Company, and (b) the GMIB assets to be paid by the reinsurers, after considering collateral.

The Company regularly evaluates each of the assumptions used in establishing these assets and liabilities. Significant decreases in assumed lapse rates or spreads used to calculate non-performance risk of the Company, or significant increases in assumed annuity election rates or spreads used to calculate the non-performance risk of the reinsurers, would result in higher fair value measurements. A change in one of these assumptions is not necessarily accompanied by a change in another assumption.

GMIB liabilities totaling $706 million as of December 31, 2018 and $762 million as of December 31, 2017 were reported in accrued expenses and other liabilities and other non-current liabilities. There were three reinsurers covering 100% of the GMIB exposures as of December 31, 2018 and 2017 as follows:

(In millions) Line of Business	Reinsurer	December 31, 2018	December 31, 2017	Collateral and Other Terms at December 31, 2018
GMIB	Berkshire	**$ 341**	$ 359	100% were secured by assets in a trust.
	Sun Life Assurance Company of Canada	**208**	221	
	Liberty Re (Bermuda) Ltd.	**184**	197	86% were secured by assets in a trust.
Total GMIB recoverables reported in other current assets and other assets		**$ 733**	$ 777	

Amounts included in shareholders net income for GMIB assets and liabilities were not material in 2018, 2017 and 2016.

Note 9 Investments, Investment Income and Gains and Losses

Cigna's investment portfolio consists of a broad range of investments including fixed maturities, equity securities, commercial mortgage loans, policy loans, other long-term investments, short-term investments, and derivative financial instruments. The sections below provide more detail regarding our accounting policies, investment balances, net investment income and realized investment gains and losses. See Note 10 for information about valuation of the Company's investment portfolio. Fixed maturities, commercial mortgage loans, derivative financial instruments, and short-term investments with contractual maturities during the next 12 months are classified on the balance sheet as current investments, unless they are held as statutory deposits or restricted for other purposes, where they are classified in long-term investments. Equity securities classified as current include exchange traded funds that are used in our cash management process. All other investments are classified in long-term investments. The following table summarizes the Company's investments by category and current or long-term classification.

	December 31, 2018			December 31, 2017		
(In millions)	Current	Long-term	Total	Current	Long-term	Total
Fixed Maturities	**$ 1,320**	**$ 21,608**	**$ 22,928**	$ 1,516	$ 21,622	$ 23,138
Equity securities	**377**	**171**	**548**	406	182	588
Commercial mortgage loans	**32**	**1,826**	**1,858**	15	1,746	1,761
Policy loans	**–**	**1,423**	**1,423**	–	1,415	1,415
Other long-term investments	**–**	**1,901**	**1,901**	–	1,518	1,518
Short-term investments	**316**	**–**	**316**	199	–	199
Total	**$ 2,045**	**$ 26,929**	**$ 28,974**	$ 2,136	$ 26,483	$ 28,619

A. Investment Portfolio

Fixed Maturities

Accounting policy. Fixed maturities (including bonds, mortgage and other asset-backed securities and preferred stocks redeemable by the investor) are classified as available for sale and are carried at fair value with changes in fair value recorded in accumulated other comprehensive income (loss) within shareholders' equity. Net unrealized appreciation on investments supporting the Company's run-off settlement annuity business is reported in future policy benefit liabilities rather than accumulated other comprehensive income (loss).

The Company records impairment losses in net income for fixed maturities with fair value below amortized cost that meet either of the following conditions:

- If the Company intends to sell or determines that it is more likely than not to be required to sell these fixed maturities before their fair values recover, an impairment loss is recognized for the excess of the amortized cost over fair value.

- If the net present value of projected future cash flows of a fixed maturity (based on qualitative and quantitative factors, including the probability of default, and the estimated timing and amount of recovery) is below the amortized cost basis, that difference is recognized as an impairment loss. For mortgage and asset-backed securities, estimated future cash flows are also based on assumptions about the collateral attributes including prepayment speeds, default rates and changes in value.

Debt securities are classified as either current or long-term investments based on their contractual maturities. The amortized cost and fair value by contractual maturity periods for fixed maturities were as follows at December 31, 2018:

(In millions)	Amortized Cost	Fair Value
Due in one year or less	$ 1,323	$ 1,327
Due after one year through five years	6,452	6,522
Due after five years through ten years	10,205	9,992
Due after ten years	4,064	4,577
Mortgage and other asset-backed securities	506	510
Total	$ 22,550	$ 22,928

Actual maturities of these securities could differ from their contractual maturities used in the table above. This could occur because issuers may have the right to call or prepay obligations, with or without penalties.

Gross unrealized appreciation (depreciation) on fixed maturities by type of issuer is shown below.

(In millions)	Amortized Cost	Unrealized Appreciation	Unrealized Depreciation	Fair Value
December 31, 2018				
Federal government and agency	$ 507	$ 204	$ (1)	$ 710
State and local government	920	66	(1)	985
Foreign government	2,214	155	(7)	2,362
Corporate	18,403	411	(453)	18,361
Mortgage and other asset-backed	506	16	(12)	510
Total	$ 22,550	$ 852	$ (474)	$ 22,928
Investments supporting liabilities of the Company's run-off settlement annuity business (included in total above) [1]	$ 2,264	$ 479	$ (40)	$ 2,703
December 31, 2017				
Federal government and agency	$ 541	$ 239	$ (1)	$ 779
State and local government	1,196	93	(2)	1,287
Foreign government	2,360	142	(15)	2,487
Corporate	17,301	868	(81)	18,088
Mortgage and other asset-backed	469	29	(1)	497
Total	$ 21,867	$ 1,371	$ (100)	$ 23,138
Investments supporting liabilities of the Company's run-off settlement annuity business (included in total above) [1]	$ 2,200	$ 681	$ (2)	$ 2,879

(1) Net unrealized appreciation for these investments is excluded from accumulated other comprehensive income.

The Company had commitments to purchase $106 million of fixed maturities as of December 31, 2018, all of which bear interest at a fixed market rate.

Review of declines in fair value. Management reviews fixed maturities with a decline in fair value from cost for impairment based on criteria that include:

- length of time and severity of decline;
- financial health and specific near term prospects of the issuer;
- changes in the regulatory, economic or general market environment of the issuer's industry or geographic region; and
- the Company's intent to sell or the likelihood of a required sale prior to recovery.

Management believes the unrealized depreciation below to be temporary based on this review, and therefore has not impaired these amounts. The table below summarizes fixed maturities with a decline in fair value from amortized cost by the length of time these securities have been in an unrealized loss position.

	December 31, 2018				December 31, 2017			
(Dollars in millions)	Fair Value	Amortized Cost	Unrealized Depreciation	Number of Issues	Fair Value	Amortized Cost	Unrealized Depreciation	Number of Issues
One year or less								
Investment grade	**$ 7,127**	**$ 7,367**	**$ (240)**	**1,324**	$ 3,272	$ 3,309	$ (37)	797
Below investment grade	**$ 1,185**	**$ 1,240**	**$ (55)**	**1,190**	$ 543	$ 553	$ (10)	643
More than one year								
Investment grade	**$ 3,023**	**$ 3,181**	**$ (158)**	**784**	$ 1,503	$ 1,549	$ (46)	373
Below investment grade	**$ 249**	**$ 270**	**$ (21)**	**245**	$ 155	$ 162	$ (7)	42

Equity Securities

Accounting policy. Upon adopting ASU 2016-01 beginning in 2018, changes in the fair values of equity securities that have a readily determinable fair value (primarily exchange-traded funds) are reported in net realized investment gains (losses). As of December 31, 2018, the fair values of these securities were $415 million and cost was $433 million. Also beginning in 2018, private equity securities of $89 million as of December 31, 2018 without a readily determinable fair value are carried at cost minus impairment, if any, plus or minus changes resulting from observable price changes. The amount of impairments or value changes resulting from observable price changes was not material.

Equity securities also include hybrid investments consisting of preferred stock with call features that are carried at fair value with changes in fair value reported in net realized investment gains (losses) and dividends reported in net investment income. As of December 31, 2018, fair values of these securities were $44 million and cost was $58 million, compared with fair value of $49 million and cost of $61 million as of December 31, 2017.

Commercial Mortgage Loans

Mortgage loans held by the Company are made exclusively to commercial borrowers and are diversified by property type, location and borrower. Loans are generally issued at a fixed rate of interest and are secured by high quality, primarily completed and substantially leased operating properties.

Accounting policy. Commercial mortgage loans are carried at unpaid principal balances or, if impaired, the lower of unpaid principal or fair value of the underlying real estate. See the "Impaired commercial mortgage loans" section below for the Company's accounting policy for impaired commercial mortgage loans. Commercial mortgage loans are classified as either current or long-term investments based on their contractual maturities.

As of December 31, 2018, approximately 93% of the Company's commercial mortgage loan portfolio is scheduled to mature in 2022 or thereafter.

Actual maturities could differ from contractual maturities for several reasons: borrowers may have the right to prepay obligations with or without prepayment penalties; the maturity date may be extended; and loans may be refinanced.

Credit quality. The Company regularly evaluates and monitors credit risk, beginning with the initial underwriting of a mortgage loan and continuing throughout the investment holding period. Mortgage origination professionals employ an internal credit quality rating system designed to evaluate the relative risk of the transaction at origination that is then updated each year as part of the annual portfolio loan review. The Company evaluates and monitors credit quality on a consistent and ongoing basis, classifying each loan as a loan in good standing, potential problem loan or problem loan.

Quality ratings are based on our evaluation of a number of key inputs related to the loan, including real estate market-related factors such as rental rates and vacancies, and property-specific inputs such as growth rate assumptions and lease rollover statistics. However, the two most significant contributors to the credit quality rating are the debt service coverage and loan-to-value ratios. The debt service coverage ratio measures the amount of property cash flow available to meet annual interest and principal payments on debt, with a ratio below 1.0 indicating that there is not enough cash flow to cover the required loan payments. The loan-to-value ratio, commonly expressed as a percentage, compares the amount of the loan to the fair value of the underlying property collateralizing the loan.

The following table summarizes the credit risk profile of the Company's commercial mortgage loan portfolio based on loan-to-value and debt service coverage ratios as of December 31, 2018 and 2017:

	2018			2017		
(Dollars in millions) **Loan-to-Value Ratio**	Carrying Value	Average Debt Service Coverage Ratio	Average Loan-to-Value Ratio	Carrying Value	Average Debt Service Coverage Ratio	Average Loan-to-Value Ratio
Below 60%	**$ 1,132**	**2.14**		$ 1,109	2.03	
60% to 79%	**650**	**1.93**		652	2.24	
80% to 100%	**76**	**1.49**		—	—	
Total	**$ 1,858**	**2.04**	**58%**	$ 1,761	2.11	57%

The Company's annual in-depth review of its commercial mortgage loan investments is the primary mechanism for identifying emerging risks in the portfolio. The most recent review was completed by the Company's investment professionals in the second quarter of 2018 and included an analysis of each underlying property's most recent annual financial statements, rent rolls, operating plans, budgets, a physical inspection of the property and other pertinent factors. Based on historical results, current leases, lease expirations and rental conditions in each market, the Company estimated the current year and future stabilized property income and fair value for each loan.

The Company re-evaluates a loan's credit quality between annual reviews if new property information is received or an event such as delinquency or a borrower's request for restructure causes management to believe that the Company's estimate of financial performance, fair value or the risk profile of the underlying property has been impacted.

Impaired commercial mortgage loans. A commercial mortgage loan is considered impaired when it is probable that the Company will not collect all amounts due per the terms of the promissory note. Impaired loans are carried at the lower of the unpaid principal balance or fair value of the underlying collateral. Interest income on impaired mortgage loans is only recognized when a payment is received.

There were no impaired commercial mortgage loans as of December 31, 2018 and 2017.

Policy Loans

Accounting policy. Policy loans, primarily associated with our corporate owned life insurance business, are carried at unpaid principal balances plus accumulated interest, the total of which approximates fair value. These loans are collateralized by life insurance policy cash values and therefore have minimal exposure to credit loss. Interest rates are reset annually based on a rolling average of benchmark interest rates.

Other Long-Term Investments

Accounting policy. Other long-term investments include investments in unconsolidated entities. These entities include certain limited partnerships and limited liability companies holding real estate, securities or loans. These investments are carried at cost plus the Company's ownership percentage of reported income or loss, based on the financial statements of the underlying investments that are generally reported at fair value. Income from these investments is reported on a one quarter lag due to the timing of when financial information is received from the general partner or manager of the investments.

Other long-term investments also include investment real estate carried at depreciated cost less any impairment write-downs to fair value when cash flows indicate that the carrying value may not be recoverable. Depreciation is generally recorded using the straight-line method based on the estimated useful life of each asset. Investment real estate as of December 31, 2018 and 2017 is expected to be held longer than one year and includes real estate acquired through the foreclosure of commercial mortgage loans.

Additionally, other long-term investments includes foreign currency swaps carried at fair value. See discussion below for information on the Company's accounting policies for these derivative financial instruments.

Other long-term investments and related commitments are diversified by issuer, property type and geographic regions. The following table provides unfunded commitment and carrying value information for these investments. The Company expects to disburse approximately 26% of the committed amounts in 2019.

	Carrying value as of December 31,		Unfunded Commitments as of
(In millions)	**2018**	**2017**	**December 31, 2018**
Real estate investments	**$ 679**	$ 591	**$ 376**
Securities partnerships	**1,045**	863	**1,063**
Other	**177**	64	**33**
Total	**$ 1,901**	$ 1,518	**$ 1,472**

Short-Term Investments and Cash Equivalents

Accounting policy. Security investments with maturities of greater than three months to one year from time of purchase are classified as short-term, available for sale and carried at fair value that approximates cost. Cash equivalents consist of short-term investments with maturities of three months or less from the time of purchase and are carried at cost that approximates fair value.

Short-term investments and cash equivalents included the following types of issuers:

(In millions)	December 31, 2018	December 31, 2017
Corporate securities	**$ 581**	$ 1,143
Federal government securities	**$ 82**	$ 604
Foreign government securities	**$ 238**	$ 159
Money market funds	**$ 1,174**	$ 12

Derivative Financial Instruments

The Company uses derivative financial instruments to manage the characteristics of investment assets (such as duration, yield, currency and liquidity) to meet the varying demands of the related insurance and contract holder liabilities. The Company also uses derivative financial instruments to hedge the risk of changes in the net assets of certain of its foreign subsidiaries due to changes in foreign currency exchange rates. The Company has written and purchased GMIB reinsurance contracts in its run-off reinsurance business that are accounted for as freestanding derivatives and discussed further in Note 8. Derivatives in the Company's separate accounts are excluded from the following discussion because associated gains and losses generally accrue directly to separate account policyholders.

Derivative instruments used by the Company typically include foreign currency swap contracts and foreign currency forward contracts. Foreign currency swap contracts periodically exchange cash flows between two currencies for principal and interest. Foreign currency forward contracts require the Company to purchase a foreign currency in exchange for the functional currency of its operating unit at a future date, generally within three months from the contracts' trade dates.

The Company manages the credit risk of these derivative instruments by diversifying its portfolio among approved dealers of high credit quality, and through routine monitoring of credit risk exposures. Certain of the Company's over-the-counter derivative instruments require either the Company or the counterparty to post collateral or demand immediate payment depending on the amount of the net liability position of the derivative instrument and predefined financial strength or credit rating thresholds. These collateral posting requirements vary by counterparty and amounts posted were not significant as of December 31, 2018 or 2017.

Accounting policy. Derivatives are recorded on our balance sheet at fair value and are classified as current or non-current according to their contractual maturities. Further information on our policies for determining fair value are discussed in Note 10. Derivative cash flows are generally reported in operating activities. The Company applies hedge accounting when derivatives are designated, qualified and highly effective as hedges. Under hedge accounting, the changes in fair value of the derivative and the hedged risk are generally recognized together and offset each other when reported in shareholders' net income. Various qualitative or quantitative methods appropriate for each hedge are used to formally assess and document hedge effectiveness at inception and each period throughout the life of a hedge.

- *Fair value hedges of the foreign exchange-related changes in fair values of certain fixed maturity foreign-denominated bonds:* Swap fair values are reported in long-term investments or other non-current liabilities. Changes in fair values attributable to foreign exchange risk of the swap contracts and the hedged bonds are reported in other realized investment gains and losses. The portion of the swap contracts' changes in fair value excluded from the assessment of hedge effectiveness is recorded in accumulated other comprehensive income and recognized in net investment income as swap coupon payments are accrued, offsetting the foreign denominated coupons received on the designated bonds.
- *Net investment hedges of certain foreign subsidiaries that conduct their business principally in Euros:* The fair values of the swap contracts are reported in other assets or other non-current liabilities. The changes in fair values of these instruments are reported in other comprehensive income, specifically in translation of foreign currencies. The portion of the change in swap fair values relating to foreign exchange spot rates will be recognized in earnings upon deconsolidation of the hedged foreign subsidiaries. The remaining changes in swap fair value are excluded from the effectiveness assessment and recognized in selling, general and administrative expenses as swap coupon payments are accrued. The notional value of hedging instruments matches the hedged amount of subsidiary net assets.
- *Economic hedges for derivatives not designated as accounting hedges:* Fair values of derivative instruments are reported in current investments or accrued expenses and other liabilities. The changes in fair values are reported in net realized investment gains and losses.

Gross fair values of our derivative financial instruments are presented in Note 10. As of December 31, 2018 and 2017, the effects of derivative instruments on the Consolidated Financial Statements were not material, including gains or losses reclassified from accumulated other comprehensive income into shareholders' net income, as well as amounts excluded from the assessment of hedge effectiveness. The following table summarizes the types and notional quantity of derivative instruments held by the Company.

(In millions)		Notional Value as of December 31,	
Type of Instrument	**Purpose**	**2018**	**2017**
Foreign currency swap contracts	*Fair value hedge:* To hedge the foreign exchange-related changes in fair values of certain fixed maturity foreign-denominated bonds. The notional value of these derivatives matches the amortized cost of the hedged bonds.	**$ 525**	$ 318
Foreign currency swap contracts	*Net investment hedge:* To reduce the risk of changes in net assets due to changes in foreign currency spot exchange rates for certain foreign subsidiaries that conduct their business principally in Euros. The notional value of hedging instruments matches the hedged amount of subsidiary net assets.	**$ 439**	$ —
Foreign currency forward contracts	*Economic hedge:* To hedge the foreign exchange related changes in fair values of a U.S. dollar-denominated fixed maturity bond portfolio to reflect the local currency for the Company's foreign subsidiary in South Korea. The notional value of hedging instruments generally aligns with the fair value of the hedged bond portfolio.	**$ 309**	$ 255

Concentration of Risk

The Company did not have a concentration of investments in a single issuer or borrower exceeding 10% of shareholders' equity as of December 31, 2018 and 2017.

B. Net Investment Income

Accounting policy. When interest and principal payments on investments are current, the Company recognizes interest income when it is earned. The Company recognizes interest income on a cash basis when interest payments are delinquent based on contractual terms or when certain terms (interest rate or maturity date) of the investment have been restructured. For unconsolidated entities that are included in Other long-term investments, investment income is generally recognized according to the Company's share of the reported income or loss on the underlying investments. Investment income attributed to the Company's separate accounts is excluded from our earnings because associated gains and losses generally accrue directly to separate account policyholders.

The components of pre-tax net investment income for the years ended December 31 were as follows:

(In millions)	2018	2017	2016
Fixed maturities	**$ 1,009**	$ 946	$ 899
Equity securities	**28**	14	4
Commercial mortgage loans	**78**	81	91
Policy loans	**70**	69	72
Other long-term investments	**156**	124	98
Short-term investments and cash	**194**	42	26
Total investment income	**1,535**	1,276	1,190
Less investment expenses	**55**	50	43
Net investment income	**$ 1,480**	$ 1,226	$ 1,147

Real estate investments and securities partnerships with a carrying value of $150 million at December 31, 2018 and $191 million at December 31, 2017 were non-income producing during the preceding twelve months.

C. Realized Investment Gains And Losses

Accounting policy. Realized investment gains and losses are based on specifically identified assets and results from sales, investment asset write-downs, changes in the fair values of certain derivatives and equity securities and changes in valuation reserves on commercial mortgage loans.

The following realized gains and losses on investments for the years ended December 31 exclude amounts required to adjust future policy benefits for the run-off settlement annuity business, as well as realized gains and losses attributed to the Company's separate accounts because those gains and losses generally accrue directly to separate account policyholders.

(In millions)	2018	2017	2016
Net realized investment (losses) gains, excluding investment asset write-downs	**$ (34)**	$ 268	$ 227
Write-downs on debt securities	**(43)**	(26)	(35)
Write-downs on other invested assets	**(4)**	(5)	(23)
Net realized investment (losses) gains, before income taxes	**$ (81)**	$ 237	$ 169

Net realized investment losses, excluding investment asset write-downs in 2018 represent primarily mark to market losses on equity securities and derivatives and net losses on sales of fixed maturities, partially offset by net gains on sales of real estate properties held in joint ventures. Net realized investment gains, excluding asset write-downs in 2017 and 2016 represented primarily gains on sales of real estate properties held in joint ventures and gains on sales of fixed maturities and equity securities. Realized losses on equity securities still held at December 31, 2018 were $33 million in 2018.

The following table presents sales information for available-for-sale securities (fixed maturities for the year ended in 2018, and fixed maturities and equity securities for the years ended in 2017 and 2016). Gross gains on sales and gross losses on sales exclude amounts required to adjust future policy benefits for the run-off settlement annuity business.

(In millions)	2018	2017	2016
Proceeds from sales	**$ 2,625**	$ 2,012	$ 1,544
Gross gains on sales	**$ 28**	$ 103	$ 83
Gross losses on sales	**$ (47)**	$ (18)	$ (7)

Note 10 Fair Value Measurements

The Company carries certain financial instruments at fair value in the financial statements including fixed maturities, certain equity securities, short-term investments and derivatives. Other financial instruments are measured at fair value only under certain conditions, such as when impaired.

Fair value is defined as the price at which an asset could be exchanged in an orderly transaction between market participants at the balance sheet date. A liability's fair value is defined as the amount that would be paid to transfer the liability to a market participant, not the amount that would be paid to settle the liability with the creditor.

The Company's financial assets and liabilities carried at fair value have been classified based upon a hierarchy defined by GAAP. The hierarchy gives the highest ranking to fair values determined using unadjusted quoted prices in active markets for identical assets and liabilities (Level 1) and the lowest ranking to fair values determined using methodologies and models with unobservable inputs (Level 3). An asset's or a liability's

classification is based on the lowest level of input that is significant to its measurement. For example, a financial asset or liability carried at fair value would be classified in Level 3 if unobservable inputs were significant to the instrument's fair value, even though the measurement may be derived using inputs that are both observable (Levels 1 and 2) and unobservable (Level 3).

The Company estimates fair values using prices from third parties or internal pricing methods. Fair value estimates received from third-party pricing services are based on reported trade activity and quoted market prices when available, and other market information that a market participant may use to estimate fair value. The internal pricing methods are performed by the Company's investment professionals and generally involve using discounted cash flow analyses, incorporating current market inputs for similar financial instruments with comparable terms and credit quality, as well as other qualitative factors. In instances where there is little or no market activity for the same or similar instruments, fair value is estimated using methods, models and assumptions that the Company believes a hypothetical market participant would use to determine a current transaction price. These valuation techniques involve some level of estimation and judgment that becomes significant with increasingly complex instruments or pricing models.

The Company is responsible for determining fair value, as well as for assigning the appropriate level within the fair value hierarchy, based on the significance of unobservable inputs. The Company reviews methodologies, processes and controls of third-party pricing services and compares prices on a test basis to those obtained from other external pricing sources or internal estimates. The Company performs ongoing analyses of both prices received from third-party pricing services and those developed internally to determine that they represent appropriate estimates of fair value. The controls executed by the Company include evaluating changes in prices and monitoring for potentially stale valuations. The Company also performs sample testing of sales values to confirm the accuracy of prior fair value estimates. The minimal exceptions identified during these processes indicate that adjustments to prices are infrequent and do not significantly impact valuations. Annually, we conduct an on-site visit of the most significant pricing service to review their processes, methodologies and controls. This on-site review includes a walk-through of inputs for a sample of securities held across various asset types to validate the documented pricing process.

A. Financial Assets and Financial Liabilities Carried at Fair Value

The following table provides information as of December 31, 2018 and 2017 about the Company's financial assets and liabilities carried at fair value. Separate account assets that are also recorded at fair value on the Company's Consolidated Balance Sheets are reported separately in the Separate Accounts section as gains and losses related to these assets generally accrue directly to policyholders.

	Quoted Prices in Active Markets for Identical Assets (Level 1)		Significant Other Observable Inputs (Level 2)		Significant Unobservable Inputs (Level 3)		Total	
As of December 31, *(In millions)*	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**
Financial assets at fair value								
Fixed maturities								
Federal government and agency	**$ 209**	$ 253	**$ 501**	$ 526	**$ —**	$ —	**$ 710**	$ 779
State and local government	**—**	—	**985**	1,287	**—**	—	**985**	1,287
Foreign government	**—**	—	**2,356**	2,442	**6**	45	**2,362**	2,487
Corporate	**—**	—	**18,127**	17,658	**234**	430	**18,361**	18,088
Mortgage and other asset-backed	**—**	—	**372**	343	**138**	154	**510**	497
Total fixed maturities	**209**	253	**22,341**	22,256	**378**	629	**22,928**	23,138
Equity securities [1]	**384**	412	**43**	73	**32**	103	**459**	588
Short-term investments	**—**	—	**316**	199	**—**	—	**316**	199
Derivative assets	**—**	—	**53**	2	**—**	—	**53**	2
Real estate funds priced at NAV as a practical expedient [2]							**239**	N/A
Financial liabilities at fair value								
Derivative liabilities	**$ —**	$ —	**$ 10**	$ 25	**$ —**	$ —	**$ 10**	$ 25

(1) Certain private equity securities are no longer carried at fair value under the policy election of ASU 2016-01 (Recognition and Measurement of Financial Assets and Financial Liabilities) beginning in 2018. Such private equity securities of $70 million were included in the Level 3 amount as of December 31, 2017. See Note 9 for additional information on this accounting policy change.

(2) Certain real estate funds are carried at fair value (previously carried at cost) based on the Company's ownership share of the equity of the investee (Net Asset Value ("NAV")) as a practical expedient including changes in the fair value of its underlying investments upon adopting ASU 2016-01 beginning in 2018. The funds have a quarterly redemption frequency, 45-90 day redemption notice period and $57 million in unfunded commitments as of December 31, 2018. See Note 9 for additional information on this accounting change. Prior years are designated as not applicable ("N/A") in this table.

Level 1 Financial Assets

Inputs for instruments classified in Level 1 include unadjusted quoted prices for identical assets in active markets accessible at the measurement date. Active markets provide pricing data for trades occurring at least weekly and include exchanges and dealer markets.

Assets in Level 1 include actively-traded U.S. government bonds and exchange-listed equity securities. A relatively small portion of the Company's investment assets are classified in this category given the narrow definition of Level 1 and the Company's investment asset strategy to maximize investment returns.

Level 2 Financial Assets and Financial Liabilities

Inputs for instruments classified in Level 2 include quoted prices for similar assets or liabilities in active markets, quoted prices from those willing to trade in markets that are not active, or other inputs that are market observable or can be corroborated by market data for the term of the instrument. Such other inputs include market interest rates and volatilities, spreads and yield curves. An instrument is classified in Level 2 if the Company determines that unobservable inputs are insignificant.

Fixed maturities and equity securities. Approximately 96% of the Company's investments in fixed maturities and equity securities are classified in Level 2 including most public and private corporate debt and hybrid equity securities, federal agency and municipal bonds, non-government mortgage-backed securities and preferred stocks. Third-party pricing services and internal methods often use recent trades of securities with similar features and characteristics because many fixed maturities do not trade daily. Pricing models are used to determine these prices when recent trades are not available. These models calculate fair values by discounting future cash flows at estimated market interest rates. Such market rates are derived by calculating the appropriate spreads over comparable U.S. Treasury securities, based on the credit quality, industry and structure of the asset. Typical inputs and assumptions to pricing models include, but are not limited to, a combination of benchmark yields, reported trades, issuer spreads, liquidity, benchmark securities, bids, offers, reference data, and industry and economic events. For mortgage-backed securities, inputs and assumptions may also include characteristics of the issuer, collateral attributes, prepayment speeds and credit rating.

Nearly all of these instruments are valued using recent trades or pricing models. Less than 1% of the fair value of investments classified in Level 2 represents foreign bonds that are valued using a single unadjusted market-observable input derived by averaging multiple broker-dealer quotes, consistent with local market practice.

Short-term investments are carried at fair value which approximates cost. The Company compares market prices for these securities to recorded amounts on a regular basis to validate that current carrying amounts approximate exit prices. The short-term nature of the investments and corroboration of the reported amounts over the holding period support their classification in Level 2.

Derivative assets and liabilities classified in Level 2 represent over-the-counter instruments such as foreign currency forward and swap contracts. Fair values for these instruments are determined using market observable inputs including forward currency and interest rate curves and widely published market observable indices. Credit risk related to the counterparty and the Company is considered when estimating the fair values of these derivatives. However, the Company is largely protected by collateral arrangements with counterparties and determined that no adjustment for credit risk was required as of December 31, 2018 or 2017. The nature and use of these derivative financial instruments are described in Note 9.

Level 3 Financial Assets and Financial Liabilities

Certain inputs for instruments classified in Level 3 are unobservable (supported by little or no market activity) and significant to their resulting fair value measurement. Unobservable inputs reflect the Company's best estimate of what hypothetical market participants would use to determine a transaction price for the asset or liability at the reporting date.

The Company classifies certain newly issued, privately-placed, complex or illiquid securities in Level 3. Approximately 2% of fixed maturities and equity securities are priced using significant unobservable inputs and classified in this category.

Fair values of mortgage and other asset-backed securities as well as corporate and government fixed maturities are primarily determined using pricing models that incorporate the specific characteristics of each asset and related assumptions including the investment type and structure, credit quality, industry and maturity date in comparison to current market indices, spreads and liquidity of assets with similar characteristics. Inputs and assumptions for pricing may also include collateral attributes and prepayment speeds for mortgage and other asset-backed securities. Recent trades in the subject security or similar securities are assessed when available, and the Company may also review published research in its evaluation, as well as the issuer's financial statements.

Quantitative Information about Unobservable Inputs

The following table summarizes the fair value and significant unobservable inputs used in pricing the following fixed maturities that were developed directly by the Company as of December 31, 2018 and 2017. The range and weighted average basis point amounts ("bps") for liquidity and credit spreads (adjustment to discount rates) reflect the Company's best estimates of the unobservable adjustments a market participant would make to calculate these fair values.

Mortgage and other asset-backed securities. The significant unobservable inputs used to value the following mortgage and other asset-backed securities are liquidity and weighting of credit spreads. An adjustment for liquidity is made as of the measurement date that considers current market conditions, issuer circumstances and complexity of the security structure when there is limited trading activity for the security. An adjustment to weight credit spreads is needed to value a more complex bond structure with multiple underlying collateral and no standard market valuation technique. The weighting of credit spreads is primarily based on the underlying collateral's characteristics and their proportional cash flows supporting the bond obligations.

Corporate and government fixed maturities. The significant unobservable input used to value the following corporate and government fixed maturities is an adjustment for liquidity. An adjustment is needed to reflect current market conditions and issuer circumstances when there is limited trading activity for the security.

	Fair Value			Unobservable Adjustment Range (Weighted Average)	
As of December 31, *(Fair value in millions)*	**2018**	**2017**	**Unobservable Input**	**2018**	**2017**
Fixed maturities					
Mortgage and other asset-backed securities	**$ 138**	$ 154	**Liquidity**	**60 – 340 (70) bps**	60 – 370 (90) bps
			Weighting of credit spreads	**190 – 340 (260) bps**	180 – 290 (230) bps
Corporate and government fixed maturities	**229**	446	**Liquidity**	**50 – 930 (230) bps**	70 – 1,650 (300) bps
Securities not priced by the Company [1]	**11**	29			
Total Level 3 fixed maturities	**$ 378**	$ 629			

(1) The fair values for these securities use single, unadjusted non-binding broker quotes not developed directly by the Company.

Significant increases in liquidity or credit spreads would result in lower fair value measurements while decreases in these inputs would result in higher fair value measurements. The unobservable inputs are generally not interrelated and a change in the assumption used for one unobservable input is not accompanied by a change in the other unobservable input.

Changes in Level 3 Financial Assets and Financial Liabilities Carried at Fair Value

The following table summarizes the changes in financial assets and financial liabilities classified in Level 3 for the years ended December 31, 2018 and 2017. Gains and losses reported in this table may include net changes in fair value that are attributable to both observable and unobservable inputs.

	Fixed Maturities & Equity Securities	
(In millions)	**2018**	**2017**
Balance at January 1,	**$ 732**	$ 776
Total gains (losses) included in shareholders' net income	**(22)**	25
Losses included in other comprehensive income	**(8)**	(11)
Gains (losses) required to adjust future policy benefits for settlement annuities [1]	**(8)**	7
Purchases, sales, settlements		
Purchases	**22**	133
Sales	**(11)**	(95)
Settlements	**(70)**	(74)
Total purchases, sales and settlements	**(59)**	(36)
Transfers into/(out of) Level 3		
Transfers into Level 3	**44**	275
Transfers out of Level 3 [2]	**(269)**	(304)
Total transfers into/(out of) Level 3	**(225)**	(29)
Balance at December 31,	**$ 410**	$ 732
Total gains (losses) included in shareholders' net income attributable to instruments held at the reporting date	**$ (9)**	$ (9)

(1) Amounts do not accrue to shareholders.

(2) Beginning in 2018, certain private equity securities are no longer carried at fair value under the policy election of ASU 2016-01 (Recognition and Measurement of Financial Assets and Financial Liabilities). Private equity securities of $70 million as of December 31, 2017 are included in the 2018 Transfers out of Level 3 amount.

Total gains and losses included in shareholders' net income in the table above are reflected in the Consolidated Statements of Income as realized investment gains (losses) and net investment income.

Gains and losses included in other comprehensive income in the tables above are reflected in net unrealized appreciation (depreciation) on securities in the Consolidated Statements of Comprehensive Income.

Transfers into or out of the Level 3 category occur when unobservable inputs, such as the Company's best estimate of what a market participant would use to determine a current transaction price, become more or less significant to the fair value measurement. Transfers between Level 2 and Level 3 during 2018 and 2017 primarily reflected changes in liquidity and credit risk estimates for certain private placement issuers across several sectors. As noted above, transfers out of Level 3 during 2018 also include $70 million of private equity securities that are no longer carried at fair value.

Separate Accounts

Accounting policy. Separate account assets and liabilities are contractholder funds maintained in accounts with specific investment objectives. The assets of these accounts are legally segregated and are not subject to claims that arise out of any of the Company's other businesses. These separate account assets are carried at fair value with equal amounts recorded for related separate account liabilities. The investment income and fair value gains and losses of these accounts generally accrue directly to the contractholders and, together with their deposits and withdrawals, are excluded from the Company's Consolidated Statements of Income and Cash Flows. Fees and charges earned for

mortality risks, asset management or administrative services are reported in either premiums or fees and other revenues. Investments that are measured using the practical expedient of NAV are excluded from the fair value hierarchy.

Fair values of separate account assets at December 31 were as follows:

	Quoted Prices in Active Markets for Identical Assets (Level 1)		Significant Other Observable Inputs (Level 2)		Significant Unobservable Inputs (Level 3)		Total	
(In millions)	2018	2017	2018	2017	2018	2017	2018	2017
Guaranteed separate accounts (See Note 19)	**$ 187**	$ 215	**$ 267**	$ 308	**$ —**	$ —	**$ 454**	$ 523
Non-guaranteed separate accounts [1]	**1,204**	1,536	**5,216**	5,298	**233**	292	**6,653**	7,126
Subtotal	**$ 1,391**	$ 1,751	**$ 5,483**	$ 5,606	**$ 233**	$ 292	**7,107**	7,649
Non-guaranteed separate accounts priced at NAV as a practical expedient [1]							**732**	774
Total separate account assets							**$ 7,839**	$ 8,423

(1) Non-guaranteed separate accounts included $3.8 billion as of December 31, 2018 and $3.9 billion as of December 31, 2017 in assets supporting the Company's pension plans, including $0.2 billion classified in Level 3 as of December 31, 2018 and $0.3 billion classified in Level 3 as of December 31, 2017.

Separate account assets in Level 1 primarily include exchange-listed equity securities. Level 2 assets primarily include:

- corporate and structured bonds valued using recent trades of similar securities or pricing models that discount future cash flows at estimated market interest rates as described above; and
- actively-traded institutional and retail mutual fund investments.

Separate account assets classified in Level 3 primarily support Cigna's pension plans, and include commercial mortgage loans as well as certain newly issued, privately-placed, complex, or illiquid securities that are priced using methods discussed above. Activity, including transfers into and out of Level 3, was not material for 2018 or 2017.

Separate account investments in securities partnerships, real estate, and hedge funds are generally valued based on the separate account's ownership share of the equity of the investee (NAV as a practical expedient), including changes in the fair values of its underlying investments. Substantially all of these assets support the Cigna Pension Plans. The following table provides additional information on these investments.

	Fair Value as of		Unfunded Commitments as of		
(In millions)	December 31, 2018	December 31, 2017	December 31, 2018	Redemption Frequency (if currently eligible)	Redemption Notice Period
Securities partnerships	**$ 477**	$ 458	**$ 308**	Not applicable	Not applicable
Real estate funds	**237**	239	**—**	Quarterly	30-90 days
Hedge funds	**18**	77	**—**	Up to annually, varying by fund	30-90 days
Total	**$ 732**	$ 774	**$ 308**		

B. Assets and Liabilities Measured at Fair Value under Certain Conditions

Some financial assets and liabilities are not carried at fair value each reporting period, but may be measured using fair value only under certain conditions, such as investments when they become impaired including investment real estate and commercial mortgage loans, and certain equity securities with no readily determinable fair value. Recorded values for these asset types representing less than 1% of total investments, were written down to their fair values, resulting in immaterial realized investment losses in 2018 and 2017.

C. Fair Value Disclosures for Financial Instruments Not Carried at Fair Value

The following table includes the Company's financial instruments not recorded at fair value that are subject to fair value disclosure requirements at December 31, 2018 and 2017. In addition to universal life products and capital leases, financial instruments that are carried in the Company's Consolidated Financial Statements at amounts that approximate fair value are excluded from the following table.

	Classification in Fair Value Hierarchy	December 31, 2018		December 31, 2017	
(In millions)		Fair Value	Carrying Value	Fair Value	Carrying Value
Commercial mortgage loans	Level 3	**$ 1,832**	**$ 1,858**	$ 1,766	$ 1,761
Long-term debt, including current maturities, excluding capital leases	Level 2	**$ 40,819**	**$ 40,829**	$ 5,730	$ 5,321

Fair values of off-balance sheet financial instruments were not material as of December 31, 2018 and 2017.

Note 11 Variable Interest Entities

When the Company becomes involved with a variable interest entity, as well as when there is a change in the Company's involvement with an entity, the Company must determine if it is the primary beneficiary and must consolidate the entity. The Company would be considered the primary beneficiary if it has the power to direct the entity's most significant economic activities or has the right to receive benefits or obligation to absorb losses that could be significant to the entity. The Company evaluates the following criteria:

- the structure and purpose of the entity;
- the risks and rewards created by and shared through the entity; and
- the Company's ability to direct its activities, receive its benefits and absorb its losses relative to the other parties involved with the entity including its sponsors, equity holders, guarantors, creditors and servicers.

The Company determined it was not a primary beneficiary in any material variable interest entities as of December 31, 2018 and 2017. The Company's involvement in variable interest entities where it is not the primary beneficiary is described below.

Securities limited partnerships and real estate limited partnerships. The Company owns interests in securities limited partnerships and real estate limited partnerships that are defined as variable interest entities. These partnerships invest in the equity or mezzanine debt of privately held companies and real estate properties. General partners unaffiliated with the Company control decisions that most significantly impact the partnership's operations and the limited partners do not have substantive kick-out or participating rights. The Company's maximum exposure to these entities of $2.9 billion across approximately 130 limited partnerships as of December 31, 2018 includes $1.5 billion reported in long-term investments and commitments to contribute an additional $1.4 billion. The Company's non-controlling interest in each of these limited partnerships is generally less than 10% of the partnership ownership interests.

Other asset-backed and corporate securities. In the normal course of its investing activities, the Company also makes passive investments in certain asset-backed and corporate securities that are issued by variable interest entities whose sponsors or issuers are unaffiliated with the Company. The Company receives fixed-rate cash flows from these investments and the maximum potential exposure to loss is limited to the carrying amount of $0.6 billion as of December 31, 2018 that is reported in fixed maturities. The Company's combined ownership interests are insignificant relative to the total principal amounts issued by these entities.

The Company is also involved in real estate joint ventures, independent physician associations ("IPAs") and a joint venture in India that are variable interest entities. The carrying values and maximum exposures associated with these arrangements are immaterial.

The Company has not provided, and does not intend to provide, financial support to any of the above entities that it is not contractually required to provide. The Company performs ongoing qualitative analyses of its involvement with these variable interest entities to determine if consolidation is required.

Note 12 Accumulated Other Comprehensive Income (Loss) ("AOCI")

AOCI includes the Company's share from entities accounted for using the equity method. AOCI excludes amounts required to adjust future policy benefits for the run-off settlement annuity business and a portion of deferred acquisition costs associated with the corporate-owned life insurance business. Generally, tax effects in AOCI are established at the currently enacted tax rate and reclassified to net income in the same period that the related pre-tax AOCI reclassifications are recognized. As discussed in Note 2, the Company early adopted ASU 2018-02 effective January 1, 2018 and $229 million of stranded tax effects resulting from U.S. tax reform legislation enacted in 2017 were reclassified from AOCI to retained earnings. Changes in the components of accumulated other comprehensive income (loss) were as follows:

(In millions)	2018	2017	2016
Securities and Derivatives			
Beginning balance	**$ 328**	$ 365	$ 425
Reclassification adjustment to retained earnings related to U.S. tax reform legislation [1]	**65**	–	–
Reclassification adjustment to retained earnings related to new financial instruments guidance [1]	**(4)**	–	–
Reclassification adjustment from retained earnings related to new hedging guidance [1]	**(6)**	–	–
Adjusted beginning balance	**383**	365	425
(Depreciation) appreciation on securities and derivatives	**(512)**	34	(48)
Tax benefit (expense)	**100**	(19)	6
Net (depreciation) appreciation on securities and derivatives	**(412)**	15	(42)
Reclassification adjustment for losses (gains) included in shareholders' net income (net realized investment losses (gains))	**60**	(81)	(29)
Reclassification adjustment for losses included in shareholders' net income (selling, general and administrative expenses)	**–**	1	1
Tax (expense) benefit	**(13)**	28	10
Net losses (gains) reclassified from AOCI to net income	**47**	(52)	(18)
Other comprehensive (loss), net of tax	**(365)**	(37)	(60)
Ending balance	**$ 18**	$ 328	$ 365
Translation of foreign currencies			
Beginning balance	**$ (65)**	$ (369)	$ (274)
Reclassification adjustment to retained earnings related to U.S. tax reform legislation [1]	**(4)**	–	–
Adjusted beginning balance	**(69)**	(369)	(274)
Translation of foreign currencies	**(152)**	309	(95)
Tax (expense)	**–**	(5)	–
Net translation of foreign currencies	**(152)**	304	(95)
Ending balance	**$ (221)**	$ (65)	$ (369)
Postretirement benefits liability			
Beginning balance	**$ (1,345)**	$ (1,378)	$ (1,401)
Reclassification adjustment to retained earnings related to U.S. tax reform legislation [1]	**(290)**	–	–
Adjusted beginning balance	**(1,635)**	(1,378)	(1,401)
Reclassification adjustment for amortization of net losses from past experience and prior service costs (selling, general and administrative expenses)	**69**	64	64
Reclassification adjustment for settlement (selling, general and administrative expenses)	**–**	7	–
Tax (expense)	**(15)**	(24)	(22)
Net adjustments reclassified from AOCI to net income	**54**	47	42
Valuation update	**93**	(22)	(29)
Tax (expense) benefit	**(20)**	8	10
Net change due to valuation update	**73**	(14)	(19)
Other comprehensive income, net of tax	**127**	33	23
Ending balance	**$ (1,508)**	$ (1,345)	$ (1,378)

(1) See Note 2 for further information about adjustments resulting from the Company's adoption of new accounting standards in 2018.

Note 13 Pension and Other Postretirement Benefit Plans

A. About our Plans

Pension plans. We froze future benefit accruals for the Company's principal domestic defined benefit pension plans in 2009. The Company also has foreign pension and other postretirement benefit plans that are immaterial to our results of operations, liquidity and financial position. Additionally, in connection with the acquisition of Express Scripts on December 20, 2018, the Company assumed a frozen cash balance retirement plan, the results of which are immaterial to our results of operations, liquidity and financial position.

Other postretirement benefit plans. The Company's postretirement medical plan was frozen in 2013. The Company also offers certain postretirement life insurance benefits through various plans.

Accounting policy. The Company measures the assets and liabilities of its domestic pension and other postretirement benefit plans as of December 31. Benefit obligations are measured at the present value of estimated future payments based on actuarial assumptions. Changes in these assumptions are called net unrecognized actuarial gains (losses) because the Company uses the "corridor" method to account for changes in the benefit obligation when actual results differ from those assumed, or when assumptions change. Under the corridor method, net unrecognized actuarial gains (losses) are initially recorded in accumulated other comprehensive income. When the unrecognized gain (loss) exceeds 10% of the benefit obligation, that excess is amortized to expense over the expected remaining lives of plan participants. The net plan expense is reported in interest expense and other in the Consolidated Statements of Income.

For balance sheet purposes, we measure plan assets at fair value. When the actual return differs from the expected return, those differences are reflected in the net unrealized actuarial gain (loss) discussed above. However, to measure pension benefit costs, we use a "market-related" asset valuation that differs from the actual fair value for domestic pension plan assets invested in non-fixed income investments. The "market-related" value recognizes the difference between actual and expected long-term returns in the portfolio over five years, a method that reduces the short-term impact of market fluctuations on pension costs. The market-related asset value was approximately $4.0 billion, compared with a fair value of approximately $4.2 billion at December 31, 2018.

B. Funded Status and Amounts Included in Accumulated Other Comprehensive Income

The following table summarizes the projected benefit obligations and assets related to our domestic and international pension and other postretirement benefit plans as of, and for the years ended, December 31:

	Pension Benefits		Other Postretirement Benefits	
(In millions)	**2018**	**2017**	**2018**	**2017**
Change in benefit obligation				
Benefit obligation, January 1	**$ 4,969**	$ 4,888	**$ 258**	$ 277
Service cost	**3**	3	**–**	–
Interest cost	**169**	186	**8**	9
Assumed in acquisition	**137**	–	**–**	–
Partial litigation settlement-attorneys' fees	**32**	–	**–**	–
(Gain) loss from past experience	**(235)** [1]	181 [2]	**(31)**	1
Benefits paid from plan assets	**(314)**	(277)	**–**	(3)
Benefits paid – other	**(20)**	(12)	**(25)**	(26)
Benefit obligation, December 31	**4,741**	4,969	**210**	258
Change in plan assets				
Fair value of plan assets, January 1	**4,281**	3,977	**2**	5
Assumed in acquisition	**96**	–	**–**	–
Actual return on plan assets	**85**	418	**–**	–
Benefits paid	**(314)**	(277)	**(2)**	(3)
Contributions	**3**	163	**–**	–
Fair value of plan assets, December 31	**4,151**	4,281	**–**	2
Funded status	**$ (590)**	$ (688)	**$ (210)**	$ (256)
Liability in Consolidated Balance Sheets				
Accrued expenses and other liabilities	**$ (30)**	$ (25)	**$ (23)**	$ (27)
Other non-current liabilities	**$ (560)**	$ (663)	**$ (187)**	$ (229)

(1) Gain reflects an increase in the discount rate and a favorable change in the mortality assumption.

(2) Loss reflects a decrease in the discount rate, partially offset by a favorable change in the mortality assumption.

We fund our qualified pension plans at least at the minimum amount required by the Employee Retirement Income Security Act of 1974 and the Pension Protection Act of 2006. For 2019, contributions to the qualified pension plans are expected to be immaterial. Future years' contributions will ultimately be based on a wide range of factors including but not limited to asset returns, discount rates and funding targets. Non-qualified pension and other postretirement benefit plans are generally funded on a pay-as-you-go basis as there are no plan assets for these plans.

Benefit payments. The following benefit payments are expected to be paid in:

(In millions)	Pension Benefits	Other Postretirement Benefits
2019	**$ 324**	**$ 25**
2020	**$ 311**	**$ 23**
2021	**$ 313**	**$ 22**
2022	**$ 316**	**$ 20**
2023	**$ 318**	**$ 19**
2024-2028	**$ 1,549**	**$ 72**

Amounts reflected in the pension and other postretirement benefit liabilities shown above that have not yet been reported in net income and therefore are included in accumulated other comprehensive loss consisted of the following as of December 31:

	Pension Benefits		Other Postretirement Benefits	
(In millions)	**2018**	**2017**	**2018**	**2017**
Unrecognized net gains (losses)	**$ (1,980)**	$ (2,113)	**$ 32**	$ –
Unrecognized prior service cost	**(6)**	(6)	**44**	46
Postretirement benefits liability adjustment	**$ (1,986)**	$ (2,119)	**$ 76**	$ 46

C. Cost of Our Plans

Net pension and other postretirement benefits cost was as follows for the years ended December 31:

	Pension Benefits			Other Postretirement Benefits		
(In millions)	**2018**	**2017**	**2016**	**2018**	**2017**	**2016**
Service cost	**$ 3**	$ 3	$ 2	**$ –**	$ –	$ –
Interest cost	**169**	186	199	**8**	9	11
Expected long-term return on plan assets	**(257)**	(260)	(249)	**–**	–	–
Partial litigation settlement – attorneys' fees	**32**	–	–	**–**	–	–
Amortization of:						
Net loss from past experience	**70**	66	65	**1**	1	1
Prior service cost	**–**	–	1	**(2)**	(3)	(3)
Settlement loss	**–**	7	–	**–**	–	–
Net plan cost	**$ 17**	$ 2	$ 18	**$ 7**	$ 7	$ 9

As further discussed in Note 19, Old Cigna and the Cigna Pension Plan are defendants in a class action lawsuit related to the Plan's conversion of certain employees from an annuity to a cash balance benefit in 1997. In the fourth quarter of 2018, the Court ordered the Plan to pay $32 million representing the attorney fee portion of the settlement. This payment was recognized as an expense in 2018. An offsetting expense credit of $32 million was also recorded to reduce the litigation reserve held, resulting in no impact to net income in 2018 related to this matter. In 2019, barring any new order from the Court, it is expected that: 1) class participants will be notified of their increased benefits; 2) the plan will be amended; and 3) benefits will begin to be paid. However, the exact timing and amount of these actions remain uncertain. The Company's remaining litigation reserve is adequate to cover the expected benefits due to class participants.

D. Assumptions Used for Pension and Other Postretirement Benefit Plans

Management determined the present value of the projected benefit obligation and the accumulated other postretirement benefit obligation and related benefit costs based on the following weighted average assumptions as of and for the years ended December 31:

	2018	**2017**
Discount rate:		
Pension benefit obligation	**4.23%**	3.51%
Other postretirement benefit obligation	**4.09%**	3.37%
Pension benefit cost	**3.51%**	3.95%
Other postretirement benefit cost	**3.37%**	3.70%
Expected long-term return on plan assets:		
Pension benefit cost	**7.00%**	7.25%
Other postretirement benefit cost	**5.00%**	5.00%
Mortality table for pension and postretirement benefit obligations	**RP 2014 with MP 2018 projection scale**	RP 2014 with MP 2017 projection scale

The Company used the Society of Actuaries mortality table RP2014 and the updated improvement scales published in 2017 and 2018 to value its benefit obligations because the Company's mortality experience closely matched these tables based on internal studies. The updated improvement scales published in 2017 and 2018 both indicated that mortality improvement is expected to be lower than was originally projected when the study was first published in 2014, resulting in decreases to the benefit obligations in both years.

The Company sets discount rates by applying actual annualized yields for high quality bonds at various durations to the expected cash flows of the pension and other postretirement benefits liabilities. A discount rate curve is constructed using an array of bonds in various industries throughout the domestic market, but only selects those for the curve that have an above average return at each duration. Management believes that this curve is representative of the yields that the Company is able to achieve through its plan asset investment strategy.

Expected long-term rates of return on plan assets were developed considering actual long-term historical returns, expected long-term market conditions, plan asset mix and management's investment strategy that continues a significant allocation to domestic and foreign equity securities as well as securities partnerships, real estate and hedge funds. Expected long-term market conditions take into consideration certain key macroeconomic trends including expected domestic and foreign GDP growth, employment levels and inflation.

E. Pension Plan Assets

As of December 31, 2018, pension assets included $3.8 billion invested in the separate accounts of Connecticut General Life Insurance Company and Life Insurance Company of North America, subsidiaries of the Company, as well as an additional $265 million invested directly in funds offered by the buyer of the retirement benefits business, and $116 million invested by others.

The fair values of pension assets by category are as follows as of December 31, 2018 and 2017.

(In millions)	2018	2017
Fixed maturities:		
Federal government and agency	**$ –**	$ 1
Corporate	**1,446**	1,124
Asset-backed	**32**	22
Fund investments	**768**	884
Total fixed maturities	**2,246**	2,031
Equity securities:		
Domestic	**506**	689
International, including funds and pooled separate accounts [1]	**360**	476
Total equity securities	**866**	1,165
Securities partnerships	**477**	457
Real estate funds, including pooled separate accounts [1]	**250**	300
Commercial mortgage loans	**110**	140
Hedge funds	**36**	73
Guaranteed deposit account contract	**107**	63
Cash equivalents and other current assets, net	**59**	52
Total pension assets at fair value	**$ 4,151**	$ 4,281

(1) A pooled separate account has several participating benefit plans and each owns a share of the total pool of investments.

The Company's current target investment allocation percentages (55% fixed income, 25% public equity securities and 20% in other investments, including private equity (securities partnerships) and real estate, are developed by management as guidelines, although the fair values of each asset category are expected to vary as a result of changes in market conditions. The Company would expect to further reduce the allocation to equity securities and other investments and increase the allocation to fixed income investments as funding levels improve.

See Note 10 for further details regarding how fair value is determined, including the level within the fair value hierarchy and the procedures we use to validate fair value measurements. The Company classifies substantially all fixed maturities in Level 2 for pension plan assets. These assets are valued using recent trades of similar securities or are fund investments priced using their daily net asset value that is the exit price. A substantial portion of domestic equity securities within pension assets are classified as Level 1, while international equity funds within pension assets are predominantly classified in Level 2 using daily net asset value.

Securities partnerships, real estate and hedge funds are valued using NAV as a practical expedient and are excluded from the fair value hierarchy. See Note 10 for additional disclosures related to these assets invested in the separate accounts of the Company's subsidiaries. Certain securities as described in Note 10, as well as commercial mortgage loans and guaranteed deposit account contracts, are classified in Level 3 because unobservable inputs used in their valuation are significant.

F. 401(k) Plans

The Company sponsors a 401(k) plan in which the Company matches a portion of employees' pre-tax contributions. Participants in the plan may invest in various funds that invest in the Company's common stock, several diversified stock funds, a bond fund or a fixed-income fund.

The Company may elect to increase its matching contributions if the Company's annual performance meets certain targets. The Company's annual expense for these plans was as follows:

(In millions)	2018	2017	2016
Expense	**$ 196**	$ 122	$ 113

Note 14 Employee Incentive Plans

A. About Our Plans

The People Resources Committee (the "Committee") of the Board of Directors awards stock options, restricted stock, restricted stock units, deferred stock and strategic performance shares ("SPS") to certain employees. The Committee has issued common stock instead of cash compensation. Prior to the acquisition of Express Scripts, the Company issued shares from Treasury stock for these awards. Following the acquisition, original issues shares were used.

Awards of Express Scripts options and restricted stock units were rolled over to Cigna stock options and restricted stock units in connection with the Express Scripts acquisition on December 20, 2018 as explained further in Note 3. Information in this footnote includes the effect of the Express Scripts rollover awards unless otherwise indicated.

The Company records compensation expense for stock and option awards over their vesting periods primarily based on the estimated fair value at the grant date. Fair value is determined differently for each type of award as discussed below.

Shares of common stock available for award at December 31 were as follows:

(In millions)	2018	2017	2016
Common shares available for award	**25.7**	14.0	6.8

B. Stock Options

Accounting policy. The Company awards options to purchase Cigna common stock at the market price of the stock on the grant date except for rollover option awards issued to Express Scripts employees in connection with the acquisition (see Note 3). Options vest over periods ranging from one to three years and expire no later than 10 years from grant date. Fair value is estimated using the Black-Scholes option-pricing model by applying the assumptions presented below. That fair value is reduced by options expected to be forfeited during the vesting period. The Company estimates forfeitures at the grant date based on our experience and adjusts the expense to reflect actual forfeitures over the vesting period. The fair value of options, net of forfeitures, is recognized in selling, general and administrative expenses on a straight line basis over the vesting period.

Black-Scholes option-pricing model assumptions and the resulting fair value of options are presented in the following table. The average fair value of options, and the expected option life exclude the rollover options granted to Express Scripts employees in connection with the acquisition. See Note 3 for further information.

	2018	2017	2016
Dividend yield	**0.0%**	0.0%	0.0%
Expected volatility	**35.0%**	35.0%	35.0%
Risk-free interest rate	**2.5%**	1.8%	1.2%
Expected option life	**4.4 years**	4.3 years	4.3 years
Weighted average fair value of options	**$ 64.18**	$ 46.38	$ 42.01

The expected volatility reflects the past daily stock price volatility of Cigna stock. The Company does not consider volatility implied in the market prices of traded options to be a good indicator of future volatility because remaining traded options will expire within one year. The risk-free interest rate is derived using the four-year U.S. Treasury bond yield rate as of the award date for the primary annual grant. Expected option life reflects the Company's historical experience.

The following table shows the status of, and changes in, common stock options during the last three years.

	2018		2017		2016	
(Options in thousands)	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price
Outstanding – January 1	**6,156**	**$ 100.79**	7,097	$ 82.01	6,433	$ 68.86
Granted	**7,080**	**$ 143.62**	1,230	$ 149.17	1,336	$ 139.20
Exercised	**(771)**	**$ 88.35**	(2,072)	$ 63.41	(577)	$ 62.09
Expired or canceled	**(95)**	**$ 165.04**	(99)	$ 138.41	(95)	$ 117.18
Outstanding – December 31	**12,370**	**$ 125.46**	6,156	$ 100.79	7,097	$ 82.01
Options exercisable at year-end	**9,446**	**$ 114.22**	3,894	$ 77.36	4,409	$ 58.36

Compensation expense of $61 million related to unvested stock options at December 31, 2018 will be recognized over the next two years (weighted average period).

The table below summarizes information for stock options exercised during the last three years:

(In millions)	2018	2017	2016
Intrinsic value of options exercised	**$ 86**	$ 218	$ 41
Cash received for options exercised	**$ 68**	$ 131	$ 36
Tax benefit from options exercised	**$ 8**	$ 41	$ 11

The following table summarizes information for outstanding common stock options at December 31, 2018:

	Options Outstanding	Options Exercisable
Number (in thousands)	**12,370**	**9,446**
Total intrinsic value (in millions)	**$ 804**	**$ 715**
Weighted average exercise price	**$ 125.46**	**$ 114.22**
Weighted average remaining contractual life	**5.4 years**	**4.5 years**

C. Restricted Stock

The Company awards restricted stock to the Company's employees with vesting periods ranging from three to five years. Recipients of restricted stock awards accumulate dividends during the vesting period, but forfeit their awards and accumulated dividends if their employment terminates before the vesting date.

Accounting policy. Fair value of restricted stock awards is equal to the market price of Cigna's common stock on the date of grant. This fair value is reduced by awards that are expected to forfeit. At the grant date, the Company estimates forfeitures based on experience and adjusts the expense to reflect actual forfeitures over the vesting period. This fair value, net of forfeitures, is recognized in selling, general and administrative expenses over the vesting period on a straight-line basis.

The following table shows the status of, and changes in, restricted stock awards during the last three years.

	2018		2017		2016	
(Awards in thousands)	Grants/Units	Weighted Average Fair Value at Award Date	Grants/Units	Weighted Average Fair Value at Award Date	Grants/Units	Weighted Average Fair Value at Award Date
Outstanding – January 1	**1,295**	**$ 126.44**	1,309	$ 97.78	1,642	$ 72.58
Awarded	**1,451**	**$ 183.29**	451	$ 155.21	315	$ 138.61
Vested	**(560)**	**$ 112.53**	(409)	$ 67.09	(591)	$ 50.01
Forfeited	**(48)**	**$ 150.84**	(56)	$ 121.74	(57)	$ 92.51
Outstanding – December 31	**2,138**	**$ 168.12**	1,295	$ 126.44	1,309	$ 97.78

The fair value of vested restricted stock at the vesting date for the years ended December 31 was as follows:

(In millions)	2018	2017	2016
Fair value of vested restricted stock	**$ 107**	$ 62	$ 82

Approximately 10,400 employees held 2.1 million restricted stock awards at the end of 2018 with $174 million of related compensation expense to be recognized over the next two years (weighted average period).

D. Strategic Performance Shares ("SPS")

The Company awards SPSs to executives and certain other key employees generally with a performance period of three years. Half of these shares are subject to a market condition (total shareholder return relative to industry peer companies) and half are subject to a performance condition (cumulative adjusted net income). These targets are set by the Committee. Holders of these awards receive shares of Cigna common stock at the end of the performance period ranging anywhere from 0 to 200% of the original awards.

Accounting policy. Compensation expense for SPSs is recorded over the performance period. Fair value is determined at the grant date for "market condition" SPSs using a Monte Carlo simulation model and not subsequently adjusted regardless of the final outcome. Expense is initially accrued for "performance condition" SPSs based on the most likely outcome, but evaluated for adjustment each period for updates in the expected outcome. Expense is adjusted to the actual outcome (number of shares awarded times the share price at the grant date) at the end of the performance period. The Company estimates forfeitures at the grant date based on experience and adjusts the expense to reflect actual forfeitures over the vesting period.

The following table shows the status of, and changes in, SPSs during the last three years:

	2018		2017		2016	
(Awards in thousands)	Shares	Weighted Average Fair Value at Award Date	Shares	Weighted Average Fair Value at Award Date	Shares	Weighted Average Fair Value at Award Date
Outstanding – January 1	**778**	**$ 136.57**	942	$ 109.14	1,188	$ 81.68
Awarded	**221**	**$ 197.51**	275	$ 150.06	286	$ 139.05
Vested	**(269)**	**$ 121.57**	(386)	$ 78.91	(494)	$ 60.15
Forfeited	**(23)**	**$ 158.16**	(53)	$ 138.19	(38)	$ 112.70
Outstanding – December 31	**707**	**$ 160.74**	778	$ 136.57	942	$ 109.14

The fair value of vested SPSs at the vesting date for the years ended December 31 was as follows:

	2018		2017		2016	
(Shares in thousands; $ in millions)	Shares	Fair Value	Shares	Fair Value	Shares	Fair Value
Shares of Cigna common stock distributed upon SPS vesting	**380**	**$ 73**	476	$ 70	768	$ 109

Approximately 1,500 employees held 707,000 SPSs at the end of 2018 and $51 million of related compensation expense is expected to be recognized over the next two years. The amount of expense for "performance condition" SPSs may vary based on actual performance in 2019 and 2020.

E. One-Time Employee Stock Award

The Company granted most employees a one-time stock award in 2017 of five shares that immediately vested. Approximately 205,000 shares were issued in connection with this program at a price of $162.96, resulting in a pre-tax cost of $33 million.

F. Compensation Cost and Tax Effects of Share-based Compensation

The Company records tax benefits in shareholders' net income during the vesting period based on the amount of expense being recognized. The difference between tax benefits based on the expense and the actual tax benefit realized are also recorded in net income when stock options are exercised, or when restricted stock and SPSs vest.

(In millions)	2018	2017	2016
Total compensation cost for shared-based awards	**$ 180**	$ 178	$ 128
Tax benefits recognized	**$ 36**	$ 79	$ 57

Note 15 Goodwill, Other Intangibles and Property and Equipment

A. Goodwill

Accounting policy. Goodwill represents the excess of the cost of businesses acquired over the fair value of their net assets. The resulting goodwill is assigned to those reporting units expected to realize cash flows from the acquisition, allocated to reporting units based on relative fair values, primarily reported in the Health Services segment ($33.7 billion), the Integrated Medical segment ($10.5 billion) and, to a lesser extent, the International Markets segment ($0.3 billion)

The Company evaluates goodwill for impairment at least annually during the third quarter at the reporting unit level and writes it down through shareholders' net income if impaired. Fair value of a reporting unit is generally estimated based on either market data or a discounted cash flow analysis using assumptions that the Company believes a hypothetical market participant would use to determine a current transaction price. The significant assumptions and estimates used in determining fair value include the discount rate and future cash flows. A discount rate is selected to correspond with each reporting unit's weighted average cost of capital, consistent with that used for investment decisions considering the specific and detailed operating plans and strategies within that reporting unit. Projections of future cash flows for each reporting unit are consistent with our annual planning process for revenues, claims, operating expenses, taxes, capital levels and long-term growth rates.

Goodwill activity. Goodwill activity during 2018 and 2017 was as follows:

(In millions)	2018	2017
Balance at January 1,	**$ 6,164**	$ 5,980
Goodwill acquired, net	**38,371**	154
Impact of foreign currency translation	**(30)**	30
Balance at December 31,	**$ 44,505**	$ 6,164

The significant increase in goodwill during 2018 reflects the Company's acquisition of Express Scripts as further discussed in Note 3.

B. Other Intangibles

Accounting policy. The Company's other intangible assets include purchased customer and producer relationships, provider networks and trademarks. The fair value of purchased customer relationships and the amortization method were determined as of the dates of purchase using an income approach that relies on projected future net cash flows including key assumptions for customer attrition and discount rates. The Company amortizes other intangibles on an accelerated or straight-line basis over periods from one to 39 years. Management revises amortization periods if it believes there has been a change in the length of time that an intangible asset will continue to have value. Costs incurred to renew or extend the terms of these intangible assets are generally expensed as incurred.

Components of other assets, including other intangibles. Other intangible assets were comprised of the following at December 31:

(In millions)	Cost	Accumulated Amortization	Net Carrying Value
2018			
Customer relationships	**$ 31,451**	**1,213**	**30,238**
Trade Name – Express Scripts	**8,400**	**–**	**8,400**
Other	**560**	**195**	**365**
Other intangible assets	**40,411**	**1,408**	**39,003**
Value of business acquired (reported in deferred policy acquisition costs)	**665**	**102**	**563**
Total	**$ 41,076**	**1,510**	**39,566**
2017			
Customer relationships	$ 1,280	1,056	224
Other	291	170	121
Other intangible assets	1,571	1,226	345
Value of business acquired (reported in deferred policy acquisition costs)	232	86	146
Total	$ 1,803	1,312	491

The significant increase reflects the intangible assets acquired from Express Scripts as discussed further in Note 3.

C. Property and Equipment

Accounting policy. Property and equipment is carried at cost less accumulated depreciation. Cost includes interest, real estate taxes and other costs incurred during construction when applicable. Internal-use software that is acquired, developed or modified solely to meet the Company's internal needs, with no plan to market externally, is also included in this category. Costs directly related to acquiring, developing or modifying internal-use software are capitalized.

The Company calculates depreciation and amortization principally using the straight-line method generally based on the estimated useful life of each asset as follows: buildings and improvements, 10 to 40 years; purchased software, three to five years; internally developed software, three to seven years; and furniture and equipment (including computer equipment), three to 10 years. Improvements to leased facilities are depreciated over the lesser of the remaining lease term or the estimated life of the improvement. The Company considers events and circumstances that would indicate the carrying value of property, equipment or capitalized software might not be recoverable. An impairment charge is recorded if the Company determines the carrying value of any of these assets is not recoverable. The Company also reviews and shortens the estimated useful lives of these assets, if necessary.

Components of property and equipment. Property and equipment was comprised of the following as of December 31:

(In millions)	Cost	Accumulated Amortization	Net Carrying Value
2018			
Internal-use software	**$ 5,694**	**$ 2,415**	**$ 3,279**
Other property and equipment			
Assets recorded under capital leases [1]	**56**	**4**	**52**
Other property and equipment not recorded under capital leases	**2,208**	**977**	**1,231**
Total other property and equipment	**2,264**	**981**	**1,283**
Total property and equipment	**$ 7,958**	**$ 3,396**	**$ 4,562**
2017			
Internal-use software	$ 2,991	$ 2,184	$ 807
Other property and equipment			
Assets recorded under capital leases [1]	49	31	18
Other property and equipment not recorded under capital leases	1,573	835	738
Total other property and equipment	1,622	866	756
Total property and equipment	$ 4,613	$ 3,050	$ 1,563

(1) Current capital lease agreements are for equipment and generally have a term of 48 months with the equipment expected to be returned to the lessor at termination.

Components of depreciation and amortization. Depreciation and amortization was comprised of the following for the years ended December 31:

(In millions)	2018	2017	2016
Internal-use software	**$ 323**	$ 298	$ 303
Other property and equipment [1]	**146**	153	158
Value of business acquired (reported in deferred policy acquisition costs)	**16**	18	20
Other intangibles	**210**	97	129
Total depreciation and amortization	**$ 695**	$ 566	$ 610

(1) Other property and equipment includes amortization on assets recorded under capital leases of $9 million in 2018, $14 million in 2017 and $20 million in 2016.

The Company estimates annual pre-tax amortization for intangible assets, including internal-use software, over the next five calendar years to be as follows:

(In millions)	Pre-tax Amortization
2019	**$ 3,169**
2020	**$ 2,164**
2021	**$ 2,062**
2022	**$ 1,844**
2023	**$ 1,777**

Note 16 Leases and Rentals

Description of operating leases. The Company's operating leases are primarily for office space and certain computer and other equipment. Some of these leases include renewal options and other incentives that are amortized over the life of the lease. Leases active in 2018 had terms ranging from one month to 18 years.

Rental expense and payments. For the years ended December 31, net rental expenses for operating leases were approximately:

(In millions)	2018	2017	2016
Net rental expense for operating leases	**$ 162**	$ 162	$ 151

Future net minimum rental payments under non-cancelable operating leases were approximately $860 million as of December 31, 2018, payable as follows:

(In millions)	Operating Lease Payments
2019	**$ 199**
2020	**$ 182**
2021	**$ 148**
2022	**$ 116**
2023	**$ 84**
2024 and thereafter	**$ 132**

The Company also has capital lease arrangements. See Note 15 and Note 5 for further information on assets recorded under capital leases and our related obligations.

Note 17 Shareholders' Equity and Dividend Restrictions

State insurance departments and foreign jurisdictions that regulate certain of the Company's subsidiaries prescribe accounting practices (differing in some respects from GAAP) to determine statutory net income and surplus. The Company's life, accident and health insurance and Health Maintenance Organization ("HMO") subsidiaries are regulated by such statutory requirements. Regulatory changes in the jurisdiction of one of our foreign insurance affiliates caused a significant increase in surplus in 2017, primarily from beginning to include deferred policy acquisition costs as an admitted asset. The statutory net income of the Company's life, accident and health insurance and HMO subsidiaries for the years ended, and their statutory surplus as of December 31, were as follows:

(In billions)	2018	2017	2016
Net income	**$ 3.4**	$ 2.5	$ 2.0
Surplus	**$ 12.2**	$ 10.4	$ 8.5

The Company's HMO and life, accident and health insurance subsidiaries are also subject to minimum statutory surplus requirements and may be required to maintain investments on deposit with state departments of insurance or other regulatory bodies. Additionally, these subsidiaries may be subject to regulatory restrictions on the amount of annual dividends or other distributions (such as loans or cash advances) that

insurance companies may extend to their parent companies without prior approval. As of December 31, 2018, these amounts, including restricted GAAP net assets of the Company's subsidiaries, were as follows:

(In billions)	2018
Minimum statutory surplus required by regulators	**$ 3.9**
Investments on deposit with regulatory bodies	**$ 0.6**
Maximum dividend distributions permitted in 2019 without regulatory approval	**$ 2.1**
Maximum loans to the parent company permitted without regulatory approval	**$ 1.3**
Restricted GAAP net assets of Cigna Corporation's subsidiaries	**$ 15.5**

Permitted practices used by the Company's insurance subsidiaries in 2018 that differed from prescribed regulatory accounting had an immaterial impact on statutory net income and surplus.

Note 18 Income Taxes

Accounting policy. Deferred income taxes are reflected in the balance sheet for differences between the financial and income tax reporting bases of the underlying assets and liabilities, and established based upon enacted tax rates and laws. Deferred income tax assets are recognized when available evidence indicates that realization is more likely than not, and to the extent this standard is not met a valuation allowance is established. The deferred income tax provision generally represents the net change in deferred income tax assets and liabilities during the reporting period excluding adjustments to accumulated other comprehensive income or amounts recorded in connection with a business combination. The current income tax provision generally represents estimated amounts due on income tax returns for the year reported to various jurisdictions plus the effect of any uncertain tax positions. The Company recognizes a liability for uncertain tax positions if management believes the probability that the positions will be sustained is less than 50 percent.

Income taxes attributable to the Company's foreign operations are generally provided using the respective foreign jurisdictions' tax rate.

The Company's foreign operations continue to retain a significant portion of their earnings overseas. These undistributed earnings are deployed outside of the United States in support of the liquidity and capital needs of our foreign operations as well as to support growth initiatives overseas. The Company generally does not intend to repatriate these earnings.

A. Income Tax Expense

The federal corporate income tax rate declined to 21% effective January 1, 2018 because of U.S. tax reform legislation enacted in late 2017. As a result, the Company's U.S. income tax expense and effective tax rate were notably lower in 2018. Prior year consolidated tax expense included a $232 million charge due to U.S. tax reform, driven by revaluation of deferred tax balances and the deemed repatriation tax on accumulated foreign earnings. The Company has continued to evaluate the provisional tax reform adjustments first recorded in 2017. The one-year measurement period under SEC requirements has expired with only minor adjustments to the initial amounts recorded.

The components of income taxes for the years ended December 31 were as follows:

(In millions)	2018	2017	2016
Current taxes			
U.S. income taxes	**$ 804**	$ 974	$ 935
Foreign income taxes	**185**	122	95
State income taxes	**47**	36	32
Total current taxes	**1,036**	1,132	1,062
Deferred taxes (benefits)			
U.S. income taxes (benefits)	**(75)**	204	69
Foreign income taxes	**8**	39	9
State income tax (benefits)	**(34)**	(1)	(4)
Total deferred taxes (benefits)	**(101)**	242	74
Total income taxes	**$ 935**	$ 1,374	$ 1,136

Total income taxes for the years ended December 31 were different from the amount computed using the nominal federal income tax rate for the following reasons:

	2018		2017		2016	
(In millions)	**$**	**%**	**$**	**%**	**$**	**%**
Tax expense at nominal rate	**$ 752**	**21.0%**	$ 1,262	35.0%	$ 1,043	35.0%
Effect of U.S. tax reform legislation	**(4)**	**(0.1)**	232	6.4	–	0.0
Effect of foreign earnings	**74**	**2.1**	(70)	(1.9)	(57)	(1.9)
Health insurance industry tax	**78**	**2.2**	–	0.0	108	3.6
State income tax (net of federal income tax benefit)	**10**	**0.3**	23	0.6	18	0.6
Other	**25**	**0.6**	(73)	(2.0)	24	0.8
Total income taxes	**$ 935**	**26.1%**	$ 1,374	38.1%	$ 1,136	38.1%

Consolidated pre-tax income from the Company's foreign operations was approximately 15% of the Company's pre-tax income in 2018. The comparable amount in prior years was 14% in 2017 and 11% in 2016. South Korean operations produced a majority of the Company's foreign pre-tax earnings.

The effective tax rate for 2018 of 26.1% was considerably lower than the 38.1% rate for 2017. The decline was due to the reduction in the U.S. tax rate, and was partially offset by reinstatement of the non-deductible health insurance industry tax. The health insurance industry tax will again be suspended for 2019.

The Company continues to retain a significant portion of its foreign earnings overseas, where they are generally subject to a higher tax rate than that imposed in the U.S. Additional deferred tax liabilities of approximately $135 million for foreign withholding taxes would have been recorded if these earnings were intended to be remitted. A portion of these withholding taxes may be eligible for credit against the Company's U.S. tax liability.

B. Deferred Income Taxes

Deferred income tax assets and liabilities as of December 31 were as follows:

(In millions)	2018	2017
Deferred tax assets		
Employee and retiree benefit plans	**$ 411**	$ 279
Other insurance and contractholder liabilities	**402**	358
Loss carryforwards	**255**	105
Other accrued liabilities	**340**	101
Other	**205**	91
Deferred tax assets before valuation allowance	**1,613**	934
Valuation allowance for deferred tax assets	**(199)**	(72)
Deferred tax assets, net of valuation allowance	**1,414**	862
Deferred tax liabilities		
Depreciation and amortization	**838**	176
Acquisition-related basis differences	**9,792**	320
Policy acquisition expenses	**211**	190
Unrealized appreciation on investments and foreign currency translation	**(29)**	102
Other	**55**	35
Total deferred tax liabilities	**10,867**	823
Net deferred income tax (liabilities) assets	**$ (9,453)**	$ 39

The net deferred tax balance changed significantly due to the Company's acquisition of Express Scripts, primarily representing deferred tax liabilities on the intangible assets recognized in purchase accounting. No deferred tax liability has been recognized for goodwill that is nondeductible for tax purposes. Also certain prior year balances have been reclassified to align with our presentation as of December 31, 2018.

Management believes that future results will generally be sufficient to realize the Company's gross deferred tax assets. The Company establishes a valuation allowance when it determines that it is not at least more likely than not the asset will be recognized. The Company has recognized deferred tax assets related to federal, state and foreign losses, a portion of which have been offset by a valuation allowance. There are multiple expiration dates associated with these losses, though a significant portion expires in 2021.

C. Uncertain Tax Positions

A reconciliation of unrecognized tax benefits for the years ended December 31 was as follows:

(In millions)	2018	2017	2016
Balance at January 1,	**$ 35**	$ 31	$ 31
Increase due to prior year positions	**40**	–	–
Increase due to business combinations	**860**	–	–
Increase due to current year positions	**6**	7	10
Reduction related to settlements with taxing authorities	**(1)**	(1)	(2)
Reduction related to lapse of applicable statute of limitations	**(12)**	(2)	(8)
Balance at December 31,	**$ 928**	$ 35	$ 31

The liability for uncertain tax positions has increased significantly due to the Company's acquisition of Express Scripts, the majority of which would impact shareholder's net income, if recognized. It is reasonably possible that the liability for uncertain tax positions could decline over the intervening twelve months.

The Company classifies net interest expense on uncertain tax positions as a component of income tax expense, but excludes this amount from the disclosed liability for uncertain tax positions. The liability for net interest expense was not material as of December 31, 2018 or 2017.

D. Other Tax Matters

The statute of limitations for Cigna's consolidated income tax returns through 2014 has closed, and there are no pending examinations. The Company has filed an amended 2014 consolidated tax return and the claim is subject to Internal Revenue Service ("IRS") review. The IRS has examined Express Scripts' tax returns for 2010 through 2012, for which there is a significant disputed tax matter, and is currently examining returns for 2013 through 2015. The Company conducts business in a number of state and foreign jurisdictions, and may be engaged in multiple audit proceedings at any given time. Generally, no further state or foreign audit activity is expected for tax years prior to 2011 for Cigna's entities and 2006 for Express Scripts' entities.

Note 19 Contingencies and Other Matters

The Company, through its subsidiaries, is contingently liable for various guarantees provided in the ordinary course of business.

A. Financial Guarantees: Retiree and Life Insurance Benefits

The Company guarantees that separate account assets will be sufficient to pay certain life insurance or retiree benefits. For the majority of these benefits, the sponsoring employers are primarily responsible for ensuring that assets are sufficient to pay these benefits and are required to maintain assets that exceed a certain percentage of benefit obligations. If employers fail to do so, the Company or an affiliate of the buyer of the retirement benefits business (Prudential Retirement Insurance and Annuity Company or "Prudential") has the right to redirect the management of the related assets to provide for benefit payments. As of December 31, 2018, employers maintained assets that exceeded the benefit obligations under these arrangements of approximately $455 million. Approximately 11% of these are reinsured by Prudential. The remaining guarantees are provided by the Company with minimal reinsurance from third parties. The Company establishes an additional liability if management believes that the Company will be required to make payment under the guarantees; there were no additional liabilities required for these guarantees, net of reinsurance, as of December 31, 2018. Separate account assets supporting these guarantees are classified in Levels 1 and 2 of the GAAP fair value hierarchy (see Note 10).

The Company does not expect that these financial guarantees will have a material effect on the Company's consolidated results of operations, liquidity or financial condition.

B. Certain Other Guarantees

The Company had indemnification obligations as of December 31, 2018 in connection with acquisition and disposition transactions. These indemnification obligations are triggered by the breach of representations or covenants provided by the Company, such as representations for the presentation of financial statements, the filing of tax returns, compliance with law or the identification of outstanding litigation. These obligations are typically subject to various time limitations, defined by the contract or by operation of law, such as statutes of limitation. In some cases, the maximum potential amount due is subject to contractual limitations based on a percentage of the transaction purchase price, while in other cases limitations are not specified or applicable. The Company does not believe that it is possible to determine the maximum potential amount due under these obligations because not all amounts due under these indemnification obligations are subject to limitation. There were no liabilities for these indemnification obligations as of December 31, 2018.

C. Guaranty Fund Assessments

The Company operates in a regulatory environment that may require its participation in assessments under state insurance guaranty association laws. The Company's exposure to assessments for certain obligations of insolvent insurance companies to policyholders and claimants is based on its share of business written in the relevant jurisdictions.

In first quarter 2017, the Commonwealth Court of Pennsylvania entered an order of liquidation of Penn Treaty Network America Insurance Company, together with its subsidiary American Network Insurance Company (collectively "Penn Treaty," a long-term care insurance carrier), triggering guaranty fund coverage and a charge of approximately $130 million before-tax ($85 million after-tax). As of December 31, 2018, the recorded liability for this assessment was approximately $42 million. Updates to the amount of the Penn Treaty assessment were not material in 2018. A portion of this assessment is expected to be offset in the future by premium tax credits that will be recognized in the period received.

D. Legal and Regulatory Matters

The Company is routinely involved in numerous claims, lawsuits, regulatory inquiries and audits, government investigations, including under the federal False Claims Act and state false claims acts initiated by a government investigating body or by a qui tam relator's filing of a complaint under court seal, and other legal matters arising, for the most part, in the ordinary course of managing a global health services business. Additionally, the Company has received and is cooperating with subpoenas or similar processes from various governmental agencies requesting information, all arising in the normal course of its business. Except for the specific matters noted below, the Company believes that the legal actions, regulatory matters, proceedings and investigations currently pending against it should not have a material adverse effect on the Company's results of operations, financial condition or liquidity based upon our current knowledge and taking into consideration current accruals. This includes certain matters previously discussed in Express Scripts' annual and quarterly reports that are no longer disclosed because they are not considered material legal proceedings for the combined company. Disputed tax matters arising from audits by the IRS or other state and foreign jurisdictions, including those resulting in litigation, are accounted for under GAAP guidance for uncertain tax positions. Further information on income tax matters can be found in Note 18.

Pending litigation and legal or regulatory matters that the Company has identified with a reasonably possible material loss are described below. When litigation and regulatory matters present loss contingencies that are both probable and estimable, the Company accrues the estimated loss by a charge to shareholders' net income. The estimated loss is the Company's best estimate of the probable loss at the time or an amount within a range of estimated losses reflecting the most likely outcome or the minimum amount of the range (if no amount is better than any other estimated amount in the range.) For material pending litigation and legal or regulatory matters discussed below, the Company provides disclosure in the aggregate of accruals and range of loss, or a statement that such information cannot be estimated. In light of the uncertainties involved in these matters, there is no assurance that their ultimate resolution will not exceed the amounts currently accrued by the Company. The Company has accrued approximately $190 million ($150 million after-tax) as of December 31, 2018 for the matters discussed below under "Litigation Matters" as well as litigation related to certain of the Company's claim operating practices and disputes around reimbursement rates to providers. Due to numerous uncertain factors presented in these cases, it is not possible to estimate an aggregate range of loss (if any) for these matters at this time. In light of the uncertainties involved in these matters, there is no assurance that their ultimate resolution will not exceed the amounts currently accrued by the Company. An adverse outcome in one or more of these matters could be material to the Company's results of operations, financial condition or liquidity for any particular period.

Litigation Matters

Amara cash balance pension plan litigation. In December 2001, Janice Amara filed a class action lawsuit in the U.S. District Court for the District of Connecticut against Cigna Corporation and the Cigna Pension Plan (the "Plan") on behalf of herself and other similarly situated Plan participants affected by the 1998 conversion to a cash balance formula. The plaintiffs allege various violations of the Employee Retirement Income Security Act of 1974 ("ERISA"), including that the Plan's cash balance formula discriminates against older employees; that the conversion resulted in a wear-away period (when the pre-conversion accrued benefit exceeded the post-conversion benefit); and that the Plan communications contained inaccurate or inadequate disclosures about these conditions.

In 2008, the District Court (1) affirmed the Company's right to convert to a cash balance plan prospectively beginning in 1998; (2) found for plaintiffs on the disclosure claim only; and (3) required the Company to pay pre-1998 benefits under the pre-conversion traditional annuity formula and post-1997 benefits under the post-conversion cash balance formula. From 2008 through 2015, this case has undergone a series of court proceedings that resulted in the original District Court order being largely upheld. In 2015, the Company submitted to the District Court its proposed method for calculating the additional pension benefits due to class members and plaintiffs responded in August 2015.

Since then, there has been continued litigation regarding the calculation of benefits, attorneys' fees, and the administration of the remedy payments. On November 29, 2018, the Court ordered the Pension Plan to pay attorneys' and incentive fees of $32 million, and that the Plan must pay any past due lump sums and back benefits within 90 days of the Order. These payments were made as ordered in December 2018. Barring any new Order by the Court impacting the timing, the Company expects to amend the Plan and commence remedy benefit payments in 2019. Once these events occur, the Plan will reflect the additional remedy benefits ordered by the Court as an increase to the pension liability (see Note 13) and the Company will reduce the remaining litigation reserve accordingly. Management believes that the Company's remaining reserve is adequate as of December 31, 2018.

Litigation related to the Merger. Following announcement of the Company's Merger Agreement with Express Scripts as discussed in Note 3, putative class action complaints (collectively the "complaints") have been filed against Express Scripts and the Express Scripts board of directors. Certain of these complaints also include Cigna, Old Cigna, Cigna Merger Sub and Express Scripts Merger Sub as defendants. The complaints alleged that the registration statement filed in connection with the Merger (and certain amendments thereto) omitted material information in violation of Sections 14(a) and 20(a) of the Exchange Act, rendering the registration statement false and misleading. The parties entered into a settlement agreement in November 2018 and notices of voluntary dismissal have been filed.

Cigna Litigation with Anthem. In February 2017, the Company delivered a notice to Anthem terminating the 2015 merger agreement, and notifying Anthem that it must pay the Company the $1.85 billion reverse termination fee pursuant to the terms of the merger agreement. Also in February 2017, the Company filed suit against Anthem in the Delaware Court of Chancery (the "Chancery Court") seeking declaratory judgments that the Company's termination of the merger agreement was valid and that Anthem was not permitted to extend the termination date. The complaint also sought payment of the reverse termination fee and additional damages in an amount exceeding $13 billion, including the lost premium value to the Company's shareholders caused by Anthem's willful breaches of the merger agreement.

On February 15, 2017, the Chancery Court granted Anthem's motion for a temporary restraining order and temporarily enjoined the Company from terminating the merger agreement. In May 2017, the Chancery Court denied Anthem's motion for a preliminary injunction to enjoin Cigna from terminating the merger agreement but stayed its ruling pending Anthem's determination as to whether to seek an appeal. Anthem subsequently notified Cigna and the Chancery Court that it did not intend to appeal the Chancery Court's decision. As a result, the merger agreement was terminated.

The litigation between the parties remains pending. Trial commenced on February 25, 2019 and we await the outcome. We believe in the merits of our claims and dispute Anthem's claims, and we intend to vigorously defend ourselves and pursue our claims. The outcomes of lawsuits are inherently unpredictable, and we may be unsuccessful in the ongoing litigation or any future claims or litigation.

Express Scripts Litigation with Anthem. In March 2016, Anthem filed a lawsuit in the United States District Court for the Southern District of New York alleging various breach of contract claims against Express Scripts relating to the parties' rights and obligations under the periodic pricing review section of the pharmacy benefit management agreement between the parties, including allegations that Express Scripts failed to negotiate new pricing concessions in good faith, as well as various alleged service issues. Anthem requests the court enter declaratory judgment that Express Scripts is required to provide Anthem competitive benchmark pricing, that Anthem can terminate the agreement, and that Express Scripts is required to provide Anthem with post-termination services at competitive benchmark pricing for one year following any termination by Anthem. Anthem claims it is entitled to $13.0 billion in additional pricing concessions over the remaining term of the agreement as well as $1.8 billion for one year following any contract termination by Anthem, and $150 million in damages for service issues ("Anthem's Allegations"). On April 19, 2016, in response to Anthem's complaint, Express Scripts filed its answer denying Anthem's Allegations in their entirety and asserting affirmative defenses and counterclaims against Anthem. The court subsequently granted Anthem's motion to dismiss

two of six counts of Express Scripts' amended counterclaims. The current scheduling order runs through the completion of summary judgment briefing in December 2019. There is no tentative trial date.

Regulatory Matters

Civil Investigative Demand. The U.S. Department of Justice ("DOJ") is conducting an industry review of Medicare Advantage organizations' risk adjustment practices under Medicare Parts C and D, including medical chart reviews and health exams. The Company is currently responding to information requests (civil investigative demands) received from the DOJ (U.S. Attorney's Offices for the Eastern District of Pennsylvania and the Southern District of New York). We will continue to cooperate with the DOJ's investigation.

Disability claims regulatory matter. During the second quarter of 2013, the Company finalized an agreement with the Departments of Insurance for Maine, Massachusetts, Pennsylvania, Connecticut and California (together, the "monitoring states") related to the Company's long-term disability claims handling practices. The agreement requires primarily: (1) enhanced procedures related to documentation and disposition and (2) a two-year monitoring period followed by a re-examination that began in the second quarter of 2016. Management believes the Company has addressed the requirements of the agreement. If the monitoring states find material non-compliance with the agreement upon re-examination, the Company may be subject to additional costs and penalties or requests to change its business practices that could negatively impact future earnings for this business.

Note 20 Condensed Consolidating Financial Information

Effective with the Merger that closed on December 20, 2018 (see Note 3 for further information) the senior notes issued by Cigna, Old Cigna, Express Scripts, Inc. ("ESI"), Medco Health Solutions, Inc. ("Medco"), and Express Scripts became jointly and severally and fully and unconditionally (subject to certain customary release provisions, including sale, exchange, transfer or liquidation of the guarantor subsidiary) guaranteed by Cigna, Old Cigna, ESI, Medco and Express Scripts, as applicable. Details of these debt obligations are presented in Note 5. The following condensed consolidating financial information has been prepared in accordance with the requirements as prescribed by the SEC in Regulation S-X. The condensed consolidating financial information presented below is not indicative of what the financial position, results of operations or cash flows would have been had each of the entities operated as an independent company during the periods for various reasons, including, but not limited to, intercompany transactions and integration of systems.

The condensed consolidating financial information is presented separately for:

(i) Cigna (the Parent Company), guarantor, the issuer of additional guaranteed obligations;

(ii) Old Cigna (former Parent Company for the fiscal years ended 2017 and 2016), guarantor, the issuer of additional guaranteed obligations;

(iii) Express Scripts, guarantor, the issuer of additional guaranteed obligations;

(iv) ESI, guarantor, the issuer of additional guaranteed obligations;

(v) Medco, guarantor, the issuer of additional guaranteed obligations;

(vi) Non-guarantor subsidiaries, on a combined basis;

(vii) Consolidating entries and eliminations representing adjustments to (a) eliminate intercompany transactions between or among Cigna, Old Cigna, Express Scripts, ESI, Medco and the non-guarantor subsidiaries, (b) eliminate the investments in our subsidiaries and (c) record consolidating entries; and

(viii) Cigna and subsidiaries on a consolidated basis.

Condensed Consolidating Statements of Income

	For the year ended December 31, 2018							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Revenues								
Premiums	$ —	$ —	$ —	$ —	$ —	$ 36,113	$ —	$ 36,113
Fees and other revenues	—	—	—	23	7	5,596	(48)	5,578
Pharmacy revenues	—	—	—	1,866	418	4,165	(970)	5,479
Net investment income	123	1	2	—	—	1,354	—	1,480
Total revenues	123	1	2	1,889	425	47,228	(1,018)	48,650
Benefits and expenses								
Medical costs and other benefit expenses	—	—	—	—	—	27,528	—	27,528
Pharmacy and other service costs	—	—	—	1,763	417	3,583	(970)	4,793
Selling, general and administrative expenses	200	535	—	44	8	11,195	(48)	11,934
Amortization of acquired intangible assets	—	—	—	94	13	128	—	235
Total benefits and expenses	200	535	—	1,901	438	42,434	(1,018)	44,490
Income (loss) from operations	(77)	(534)	2	(12)	(13)	4,794	—	4,160
Interest and other income (expense)	(244)	(264)	15	(17)	(10)	22	—	(498)
Intercompany interest income (expense)	(5)	(58)	(15)	7	5	66	—	—
Net realized investment (losses)	(1)	—	—	—	—	(80)	—	(81)
Income (loss) before income taxes	(327)	(856)	2	(22)	(18)	4,802	—	3,581
Total income tax (benefit) expense	(74)	(163)	—	(4)	(4)	1,180	—	935
Income (loss) before equity in earnings of subsidiaries	(253)	(693)	2	(18)	(14)	3,622	—	2,646
Equity in earnings (loss) of subsidiaries	2,890	3,613	(32)	(33)	29	—	(6,467)	—
Net income (loss)	2,637	2,920	(30)	(51)	15	3,622	(6,467)	2,646
Less: Net income attributable to noncontrolling interests	—	—	—	—	—	9	—	9
Shareholders' net income (loss)	$ 2,637	$ 2,920	$ (30)	$ (51)	$ 15	$ 3,613	$ (6,467)	$ 2,637
Other comprehensive (loss), net of tax	(390)	(390)	—	—	—	(536)	926	(390)
Shareholders' comprehensive income (loss)	$ 2,247	$ 2,530	$ (30)	$ (51)	$ 15	$ 3,077	$ (5,541)	$ 2,247

Condensed Consolidating Statements of Income

	For the year ended December 31, 2017							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Revenues								
Premiums	$ —	$ —	$ —	$ —	$ —	$ 32,491	$ —	$ 32,491
Fees and other revenues	—	—	—	—	—	5,110	—	5,110
Pharmacy revenues	—	—	—	—	—	2,979	—	2,979
Net investment income	—	—	—	—	—	1,226	—	1,226
Total revenues	—	—	—	—	—	41,806	—	41,806
Benefits and expenses								
Medical costs and other benefit expenses	—	—	—	—	—	25,263	—	25,263
Pharmacy and other service costs	—	—	—	—	—	2,456	—	2,456
Selling, general and administrative expenses	—	195	—	—	—	9,835	—	10,030
Amortization of acquired intangible assets	—	—	—	—	—	115	—	115
Total benefits and expenses	—	195	—	—	—	37,669	—	37,864
Income (loss) from operations	—	(195)	—	—	—	4,137	—	3,942
Interest and other (expense)	—	(246)	—	—	—	(6)	—	(252)
Intercompany interest income (expense)	—	(18)	—	—	—	18	—	—
Debt extinguishment (costs)	—	(321)	—	—	—	—	—	(321)
Net realized investment gains	—	—	—	—	—	237	—	237
Income (loss) before income taxes	—	(780)	—	—	—	4,386	—	3,606
Total income tax (benefit) expense	—	(194)	—	—	—	1,568	—	1,374
Income (loss) before equity in earnings of subsidiaries	—	(586)	—	—	—	2,818	—	2,232
Equity in earnings of subsidiaries	—	2,823	—	—	—	—	(2,823)	—
Net income	—	2,237	—	—	—	2,818	(2,823)	2,232
Less: Net (loss) attributable to noncontrolling interests	—	—	—	—	—	(5)	—	(5)
Shareholders' net income	$ —	$ 2,237	$ —	$ —	$ —	$ 2,823	$ (2,823)	$ 2,237
Other comprehensive income, net of tax	—	300	—	—	—	269	(269)	300
Shareholders' comprehensive income	$ —	$ 2,537	$ —	$ —	$ —	$ 3,092	$ (3,092)	$ 2,537

Condensed Consolidating Statements of Income

	For the year ended December 31, 2016							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Revenues								
Premiums	$ —	$ —	$ —	$ —	$ —	$ 30,824	$ —	$ 30,824
Fees and other revenues	—	—	—	—	—	4,901	—	4,901
Pharmacy revenues	—	—	—	—	—	2,966	—	2,966
Net investment income	—	—	—	—	—	1,147	—	1,147
Total revenues	—	—	—	—	—	39,838	—	39,838
Benefits and expenses								
Medical costs and other benefit expenses	—	—	—	—	—	24,341	—	24,341
Pharmacy and other service costs	—	—	—	—	—	2,468	—	2,468
Selling, general and administrative expenses	—	281	—	—	—	9,509	—	9,790
Amortization of acquired intangible assets	—	—	—	—	—	151	—	151
Total benefits and expenses	—	281	—	—	—	36,469	—	36,750
Income (loss) from operations	—	(281)	—	—	—	3,369	—	3,088
Interest and other (expense)	—	(244)	—	—	—	(34)	—	(278)
Intercompany interest income (expense)	—	(3)	—	—	—	3	—	—
Net realized investment gains	—	—	—	—	—	169	—	169
Income (loss) before income taxes	—	(528)	—	—	—	3,507	—	2,979
Total income tax (benefit) expense	—	(146)	—	—	—	1,282	—	1,136
Income (loss) before equity in earnings of subsidiaries	—	(382)	—	—	—	2,225	—	1,843
Equity in earnings of subsidiaries	—	2,249	—	—	—	—	(2,249)	—
Net income	—	1,867	—	—	—	2,225	(2,249)	1,843
Less: Net (loss) attributable to noncontrolling interests	—	—	—	—	—	(24)	—	(24)
Shareholders' net income	$ —	$ 1,867	$ —	$ —	$ —	$ 2,249	$ (2,249)	$ 1,867
Other comprehensive (loss), net of tax	—	(132)	—	—	—	(154)	154	(132)
Shareholders' comprehensive income	$ —	$ 1,735	$ —	$ —	$ —	$ 2,095	$ (2,095)	$ 1,735

Condensed Consolidating Balance Sheets

	As of December 31, 2018							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Assets								
Cash and cash equivalents	$ 243	$ —	$ 633	$ 43	$ —	$ 2,936	$ —	$ 3,855
Investments	—	—	—	—	—	2,045	—	2,045
Accounts receivable, net	—	—	—	4,206	748	5,519	—	10,473
Inventories	—	—	—	—	—	2,821	—	2,821
Other current assets	14	59	—	310	—	1,063	(210)	1,236
Total current assets	257	59	633	4,559	748	14,384	(210)	20,430
Long-term investments	—	10	—	—	—	26,919	—	26,929
Reinsurance recoverables	—	—	—	—	—	5,507	—	5,507
Deferred policy acquisition costs	—	—	—	—	—	2,821	—	2,821
Property and equipment	—	—	—	2,432	—	2,130	—	4,562
Investments in subsidiaries	68,969	27,544	52,035	17,115	8,117	—	(173,780)	—
Intercompany receivables	—	4,505	—	7,425	2,335	24,882	(39,147)	—
Goodwill	—	—	31,049	—	—	13,456	—	44,505
Other intangible assets	—	—	8,400	18,962	7,040	4,601	—	39,003
Other assets	48	198	—	68	74	1,488	(246)	1,630
Separate account assets	—	—	—	—	—	7,839	—	7,839
TOTAL ASSETS	$ 69,274	$ 32,316	$ 92,117	$ 50,561	$ 18,314	$ 104,027	$ (213,383)	$ 153,226
Liabilities								
Current insurance and contractholder liabilities	$ —	$ —	$ —	$ —	$ —	$ 6,801	$ —	$ 6,801
Pharmacy and service costs payable	—	—	—	8,422	1,579	701	—	10,702
Accounts payable	22	—	—	834	4	3,506	—	4,366
Accrued expenses and other liabilities	396	182	129	1,387	189	4,998	(210)	7,071
Short-term debt	—	1,500	995	353	—	107	—	2,955
Total current liabilities	418	1,682	1,124	10,996	1,772	16,113	(210)	31,895
Non-current insurance and contractholder liabilities	—	—	—	—	—	19,974	—	19,974
Deferred tax liabilities, net	—	—	2,001	5,012	1,685	1,001	(246)	9,453
Other non-current liabilities	—	685	—	497	290	1,998	—	3,470
Intercompany payables	4,965	4,361	29,569	—	—	252	(39,147)	—
Long-term debt	22,863	5,110	10,932	24	506	88	—	39,523
Separate account liabilities	—	—	—	—	—	7,839	—	7,839
TOTAL LIABILITIES	28,246	11,838	43,626	16,529	4,253	47,265	(39,603)	112,154
Redeemable noncontrolling interests	—	—	—	—	—	37	—	37
TOTAL SHAREHOLDERS' EQUITY	41,028	20,478	48,491	34,032	14,061	56,718	(173,780)	41,028
Noncontrolling interests	—	—	—	—	—	7	—	7
TOTAL EQUITY	41,028	20,478	48,491	34,032	14,061	56,725	(173,780)	41,035
TOTAL LIABILITIES AND EQUITY	$ 69,274	$ 32,316	$ 92,117	$ 50,561	$ 18,314	$ 104,027	$ (213,383)	$ 153,226

Condensed Consolidating Balance Sheets

	As of December 31, 2017							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Assets								
Cash and cash equivalents	$ –	$ 9	$ –	$ –	$ –	$ 2,963	$ –	$ 2,972
Investments	–	63	–	–	–	2,073	–	2,136
Accounts receivable, net	–	–	–	–	–	3,155	–	3,155
Inventories	–	–	–	–	–	228	–	228
Other current assets	–	31	–	–	–	789	–	820
Total current assets	–	103	–	–	–	9,208	–	9,311
Long-term investments	–	–	–	–	–	26,483	–	26,483
Reinsurance recoverables	–	–	–	–	–	5,763	–	5,763
Deferred policy acquisition costs	–	–	–	–	–	2,237	–	2,237
Property and equipment	–	–	–	–	–	1,563	–	1,563
Investments in subsidiaries	–	22,631	–	–	–	–	(22,631)	–
Intercompany receivables	–	200	–	–	–	2,980	(3,180)	–
Deferred tax assets, net	–	221	–	–	–	(182)	–	39
Goodwill	–	–	–	–	–	6,164	–	6,164
Other intangible assets	–	–	–	–	–	345	–	345
Other assets	–	–	–	–	–	1,431	–	1,431
Separate account assets	–	–	–	–	–	8,423	–	8,423
TOTAL ASSETS	$ –	$ 23,155	$ –	$ –	$ –	$ 64,415	$ (25,811)	$ 61,759
Liabilities								
Current insurance and contractholder liabilities	–	–	–	–	–	6,317	–	6,317
Pharmacy and service costs payable	–	–	–	–	–	305	–	305
Accounts payable, accrued expenses and other liabilities	–	270	–	–	–	3,877	–	4,147
Short-term debt	–	231	–	–	–	9	–	240
Total current liabilities	–	501	–	–	–	10,508	–	11,009
Non-current insurance and contractholder liabilities	–	–	–	–	–	20,530	–	20,530
Intercompany payables	–	2,980	–	–	–	200	(3,180)	–
Other non-current liabilities	–	851	–	–	–	1,987	–	2,838
Long-term debt	–	5,112	–	–	–	87	–	5,199
Separate account liabilities	–	–	–	–	–	8,423	–	8,423
TOTAL LIABILITIES	–	9,444	–	–	–	41,735	(3,180)	47,999
Redeemable noncontrolling interests	–	–	–	–	–	49	–	49
SHAREHOLDERS' EQUITY	–	13,711	–	–	–	22,631	(22,631)	13,711
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	$ –	$ 23,155	$ –	$ –	$ –	$ 64,415	$ (25,811)	$ 61,759

Condensed Consolidating Cash Flow Statements

	For the year ended December 31, 2018							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Net cash provided by (used in) operating activities	$ 145	$ 2,416	$ (36)	$ 80	$ (304)	$ 3,987	$ (2,518)	$ 3,770
Cash Flows from Investing Activities								
Net change in loans due (from) affiliates	—	(4,412)	(200)	—	—	(1,121)	5,733	—
Proceeds from investments sold:								
Fixed maturities and equity securities	—	—	—	—	—	2,655	—	2,655
Investment maturities and repayments:								
Fixed maturities and equity securities	—	—	—	—	—	2,151	—	2,151
Commercial mortgage loans	—	—	—	—	—	215	—	215
Other sales, maturities and repayments (primarily short-term and other long-term investments)	—	63	—	—	—	671	—	734
Investments purchased or originated:								
Fixed maturities and equity securities	—	(10)	—	—	—	(5,627)	—	(5,637)
Commercial mortgage loans	—	—	—	—	—	(312)	—	(312)
Other sales, maturities and repayments (primarily short-term and other long-term investments)	—	—	—	—	—	(1,189)	—	(1,189)
Property and equipment purchases, net	—	—	—	(6)	—	(522)	—	(528)
Acquisitions, net of cash acquired	(27,115)	—	1,676	23	—	961	—	(24,455)
Other, net	—	—	—	—	—	(12)	—	(12)
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	(27,115)	(4,359)	1,476	17	—	(2,130)	5,733	(26,378)
Cash Flows from Financing Activities								
Net change in amounts due to (from) affiliates	4,437	1,121	(807)	(54)	304	732	(5,733)	—
Intercompany dividends paid	—	—	—	—	—	(2,518)	2,518	—
Deposits and interest credited to contractholder deposit funds	—	—	—	—	—	1,040	—	1,040
Withdrawals and benefit payments from contractholder deposit funds	—	—	—	—	—	(1,151)	—	(1,151)
Net change in short-term debt	—	1,400	—	—	—	87	—	1,487
Payments for debt extinguishment	—	—	—	—	—	—	—	—
Repayment of long-term debt	—	(131)	—	—	—	—	—	(131)
Net proceeds on issuance of long-term debt	22,856	—	—	—	—	—	—	22,856
Repurchase of common stock	(32)	(310)	—	—	—	—	—	(342)
Issuance of common stock	1	67	—	—	—	—	—	68
Other, net	(49)	(213)	—	—	—	(50)	—	(312)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	27,213	1,934	(807)	(54)	304	(1,860)	(3,215)	23,515
Effect of foreign currency rate changes on cash and cash equivalents	—	—	—	—	—	(24)	—	(24)
Net increase (decrease) in cash and cash equivalents	243	(9)	633	43	—	(27)	—	883
Cash and cash equivalents, January 1,	—	9	—	—	—	2,963	—	2,972
Cash and cash equivalents, December 31,	$ 243	$ —	$ 633	$ 43	$ —	$ 2,936	$ —	$ 3,855

Condensed Consolidating Cash Flow Statements

	For the year ended December 31, 2017							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Net cash provided by operating activities	$ –	$ 602	$ –	$ –	$ –	$ 4,242	$ (758)	$ 4,086
Cash Flows from Investing Activities								
Net change in loans due (from) affiliates	–	–	–	–	–	(1,955)	1,955	–
Proceeds from investments sold:								
Fixed maturities and equity securities	–	–	–	–	–	2,012	–	2,012
Investment maturities and repayments:								
Fixed maturities and equity securities	–	–	–	–	–	2,051	–	2,051
Commercial mortgage loans	–	–	–	–	–	335	–	335
Other sales, maturities and repayments (primarily short-term and other long-term investments)	–	–	–	–	–	1,702	–	1,702
Investments purchased or originated:								
Fixed maturities and equity securities	–	–	–	–	–	(5,628)	–	(5,628)
Commercial mortgage loans	–	–	–	–	–	(430)	–	(430)
Other sales, maturities and repayments (primarily short-term and other long-term investments)	–	(6)	–	–	–	(1,059)	–	(1,065)
Property and equipment purchases, net	–	–	–	–	–	(471)	–	(471)
Acquisitions, net of cash acquired	–	–	–	–	–	(209)	–	(209)
Other, net	–	(11)	–	–	–	11	–	–
NET CASH (USED IN) INVESTING ACTIVITIES	–	(17)	–	–	–	(3,641)	1,955	(1,703)
Cash Flows from Financing Activities								
Net change in amounts due to affiliates	–	1,955	–	–	–	–	(1,955)	–
Intercompany dividends paid	–	–	–	–	–	(758)	758	–
Deposits and interest credited to contractholder deposit funds	–	–	–	–	–	1,230	–	1,230
Withdrawals and benefit payments from contractholder deposit funds	–	–	–	–	–	(1,363)	–	(1,363)
Net change in short-term debt	–	100	–	–	–	(20)	–	80
Payments for debt extinguishment	–	(313)	–	–	–	–	–	(313)
Repayment of long-term debt	–	(1,250)	–	–	–	–	–	(1,250)
Net proceeds on issuance of long-term debt	–	1,581	–	–	–	–	–	1,581
Repurchase of common stock	–	(2,725)	–	–	–	–	–	(2,725)
Issuance of common stock	–	131	–	–	–	–	–	131
Other, net	–	(73)	–	–	–	51	–	(22)
NET CASH (USED IN) FINANCING ACTIVITIES	–	(594)	–	–	–	(860)	(1,197)	(2,651)
Effect of foreign currency rate changes on cash and cash equivalents	–	–	–	–	–	55	–	55
Net decrease in cash and cash equivalents	–	(9)	–	–	–	(204)	–	(213)
Cash and cash equivalents, January 1,	–	18	–	–	–	3,167	–	3,185
Cash and cash equivalents, December 31,	$ –	$ 9	$ –	$ –	$ –	$ 2,963	$ –	$ 2,972

Condensed Consolidating Cash Flow Statements

	For the year ended December 31, 2016							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Net cash provided by operating activities	$ –	$ 376	$ –	$ –	$ –	$ 4,230	$ (580)	$ 4,026
Cash Flows from Investing Activities								
Net change in loans due to affiliates	–	–	–	–	–	78	(78)	–
Proceeds from investments sold:								
Fixed maturities and equity securities	–	–	–	–	–	1,544	–	1,544
Investment maturities and repayments:								
Fixed maturities and equity securities	–	–	–	–	–	1,755	–	1,755
Commercial mortgage loans	–	–	–	–	–	316	–	316
Other sales, maturities and repayments (primarily short-term and other long-term investments)	–	–	–	–	–	1,431	–	1,431
Investments purchased or originated:								
Fixed maturities and equity securities	–	–	–	–	–	(5,191)	–	(5,191)
Commercial mortgage loans	–	–	–	–	–	(165)	–	(165)
Other sales, maturities and repayments (primarily short-term and other long-term investments)	–	(3)	–	–	–	(1,695)	–	(1,698)
Property and equipment purchases, net	–	–	–	–	–	(461)	–	(461)
Acquisitions, net of cash acquired	–	–	–	–	–	(4)	–	(4)
Other, net	–	(8)	–	–	–	(93)	–	(101)
NET CASH (USED IN) INVESTING ACTIVITIES	–	(11)	–	–	–	(2,485)	(78)	(2,574)
Cash Flows from Financing Activities								
Net change in amounts due (from) affiliates	–	(78)	–	–	–	–	78	–
Intercompany dividends paid	–	–	–	–	–	(580)	580	–
Deposits and interest credited to contractholder deposit funds	–	–	–	–	–	1,460	–	1,460
Withdrawals and benefit payments from contractholder deposit funds	–	–	–	–	–	(1,362)	–	(1,362)
Net change in short-term debt	–	(100)	–	–	–	(48)	–	(148)
Payments for debt extinguishment	–	–	–	–	–	–	–	–
Repayment of long-term debt	–	–	–	–	–	–	–	–
Net proceeds on issuance of long-term debt	–	–	–	–	–	–	–	–
Repurchase of common stock	–	(139)	–	–	–	–	–	(139)
Issuance of common stock	–	36	–	–	–	–	–	36
Other, net	–	(82)	–	–	–	10	–	(72)
NET CASH (USED IN) FINANCING ACTIVITIES	–	(363)	–	–	–	(520)	658	(225)
Effect of foreign currency rate changes on cash and cash equivalents	–	–	–	–	–	(10)	–	(10)
Net increase in cash and cash equivalents	–	2	–	–	–	1,215	–	1,217
Cash and cash equivalents, January 1,	–	16	–	–	–	1,952	–	1,968
Cash and cash equivalents, December 31,	$ –	$ 18	$ –	$ –	$ –	$ 3,167	$ –	$ 3,185

Note 21 Segment Information

See Note 1 for a description of our segments. Effective with the fourth quarter of 2018, the Company uses adjusted income from operations on a before-tax basis as its principal financial measure of segment operating performance. Prior year segment information has been adjusted to reflect this change and a description of our basis for reporting segment operating results is outlined below. Intersegment transactions primarily reflect home delivery pharmacy sales to insured customers of the Integrated Medical segment. These transactions are eliminated in consolidation.

The Company uses "pre-tax adjusted income from operations" as its principal financial measure of segment operating performance because management believes it best reflects the underlying results of business operations and permits analysis of trends in underlying revenue, expenses and profitability. Pre-tax adjusted income from operations is defined as income before taxes excluding realized investment results, amortization of acquired intangible assets, results of transitioning clients and special items. Income or expense amounts that are excluded from adjusted income from operations because they are not indicative of underlying performance or the responsibility of operating segment management include:

- Realized investment gains (losses), including changes in market values of certain financial instruments between balance sheet dates, as well as gains and losses associated with invested asset sales
- Amortization of acquired intangible assets, because these relate to costs incurred for acquisitions
- Results of transitioning clients, because those results are not indicative of ongoing results
- Special items, if any, that management believes are not representative of the underlying results of operations due to the nature or size of these matters. Further context about these items is provided in the footnotes listed in the table below.

The following table presents the special items recorded by the Company for the years ended December 31, 2018, 2017 and 2016.

(In millions)

Description of Special Item Charges (Benefits) and Financial Statement Line Item(s)	After-tax	Before-tax
Year ended December 31, 2018		
Transaction-related costs		
– Selling, general and administrative expenses (see Note 3)	**$ 587**	**$ 748**
– Interest expense and other (see Note 3)	**179**	**227**
– Net investment income (see Note 3)	**(97)**	**(123)**
Total transaction-related costs	**$ 669**	**$ 852**
Charges associated with litigation matters (Selling, general and adminstrative expenses, see Note 19D.)	**$ 19**	**$ 25**
Charges associated with U.S. tax reform		
– Selling, general and administrative expenses	**$ 1**	**$ 2**
– Tax expense (see Note 18)	**(3)**	**—**
Total charges associated with U.S. tax reform	**$ (2)**	**$ 2**
Year ended December 31, 2017		
Transaction-related costs (see Note 3)	$ 33	$ 126
Charges associated with U.S. tax reform		
– Selling, general and administrative expenses	$ (36)	$ (56)
– Tax expense (see Note 18)	232	–
Total charges associated with U.S. tax reform	$ 196	$ (56)
Debt extinguishment costs (see Note 5)	$ 209	$ 321
Long-term care guaranty fund assessment (Selling, general and administrative expenses, see Note 19D. for details)	$ 83	$ 129
Year ended December 31, 2016		
Transaction-related costs (see Note 3)	$ 147	$ 166
Charges associated with litigation matters (Selling, general and administrative expenses, see Note 19D. for details)	$ 25	$ 40
Risk corridor allowance (Selling, general and administrative expenses)	$ 80	$ 124

Summarized segment financial information for the years ended December 31, was as follows:

(In millions)	Integrated Medical	Health Services	International Markets	Group Disability and Other	Corporate and Eliminations	Total
2018						
Revenues from external customers [1]	**$ 31,759**	**$ 5,902**	**$ 5,174**	**$ 4,335**	**$ –**	**$ 47,170**
Inter-segment revenues	**573**	**1,154**	**–**	**14**	**(1,741)**	**–**
Net investment income	**459**	**9**	**149**	**712**	**151**	**1,480**
Total revenues	**32,791**	**7,065**	**5,323**	**5,061**	**(1,590)**	**48,650**
Revenue contributions from transitioning clients	**–**	**(459)**	**–**	**–**	**–**	**(459)**
Net realized investment results from equity method subsidiaries [2]	**–**	**–**	**43**	**–**	**–**	**43**
Special items reported in transaction-related costs	**–**	**–**	**–**	**–**	**(123)**	**(123)**
Adjusted revenues	**$ 32,791**	**$ 6,606**	**$ 5,366**	**$ 5,061**	**$ (1,713)**	**$ 48,111**
Depreciation and amortization	**$ 466**	**$ 120**	**$ 55**	**$ 53**	**$ 1**	**$ 695**
Income (loss) before taxes	**$ 3,342**	**$ 329**	**$ 670**	**$ 497**	**$ (1,257)**	**$ 3,581**
Pre-tax adjustments to reconcile to adjusted income from operations						
Adjustment for transitioning clients	**–**	**(62)**	**–**	**–**	**–**	**(62)**
(Income) loss attributable to noncontrolling interests	**–**	**–**	**(14)**	**–**	**–**	**(14)**
Net realized investment (gains) losses	**36**	**–**	**61**	**25**	**2**	**124**
Amortization of acquired intangible assets	**99**	**113**	**18**	**5**	**–**	**235**
Special items						
Transaction-related costs	**–**	**–**	**–**	**–**	**852**	**852**
Charges associated with litigation matters	**25**	**–**	**–**	**–**	**–**	**25**
U.S. tax reform	**–**	**–**	**–**	**2**	**–**	**2**
Pre-tax adjusted income (loss) from operations	**$ 3,502**	**$ 380**	**$ 735**	**$ 529**	**$ (403)**	**$ 4,743**

(In millions)	Integrated Medical	Health Services	International Markets	Group Disability and Other	Corporate and Eliminations	Total
2017						
Revenues from external customers [1]	$ 28,193	$ 3,250	$ 4,774	$ 4,363	$ –	$ 40,580
Inter-segment revenues	476	988	–	12	(1,476)	–
Net investment income	366	3	127	700	30	1,226
Total revenues	$ 29,035	$ 4,241	$ 4,901	$ 5,075	$ (1,446)	$ 41,806
Adjusted revenues	$ 29,035	$ 4,241	$ 4,901	$ 5,075	$ (1,446)	$ 41,806
Depreciation and amortization	$ 470	$ –	$ 61	$ 31	$ 4	$ 566
Income (loss) before taxes	$ 2,859	$ 288	$ 667	$ 614	$ (822)	$ 3,606
Pre-tax adjustments to reconcile to adjusted income from operations						
(Income) loss attributable to noncontrolling interests	1	–	1	–	–	2
Net realized investment (gains) losses	(137)	–	(31)	(69)	–	(237)
Amortization of acquired intangible assets	93	–	17	5	–	115
Special items						
Transaction-related costs	–	–	–	–	126	126
U.S. tax reform	–	–	–	(56)	–	(56)
Debt extinguishment costs	–	–	–	–	321	321
Long-term care guaranty fund assessment	106	–	–	23	–	129
Pre-tax adjusted income (loss) from operations	$ 2,922	$ 288	$ 654	$ 517	$ (375)	$ 4,006

(1) Includes the Company's share of the earnings of its joint ventures reported in the International Markets segment using the equity method of accounting.

(2) Beginning in 2018, includes the Company's share of the realized investment gains (losses) of its joint ventures reported using the equity method of accounting.

(In millions)	Integrated Medical	Health Services	International Markets	Group Disability and Other	Corporate and Eliminations	Total
2016						
Revenues from external customers [1]	$ 26,695	$ 3,169	$ 4,424	$ 4,403	$ –	$ 38,691
Inter-segment revenues	395	894	–	–	(1,289)	–
Net investment income	305	3	113	705	21	1,147
Total revenues	$ 27,395	$ 4,066	$ 4,537	$ 5,108	$ (1,268)	$ 39,838
Adjusted revenues	$ 27,395	$ 4,066	$ 4,537	$ 5,108	$ (1,268)	$ 39,838
Depreciation and amortization	$ 519	$ –	$ 61	$ 29	$ 1	$ 610
Income (loss) before taxes	$ 2,417	$ 268	$ 497	$ 324	$ (527)	$ 2,979
Pre-tax adjustments to reconcile to adjusted income from operations						
(Income) loss attributable to noncontrolling interests	2	–	18	–	–	20
Net realized investment (gains) losses	(116)	–	2	(54)	(1)	(169)
Amortization of acquired intangible assets	125	–	21	5	–	151
Special items						
Transaction-related costs	–	–	–	–	166	166
Risk corridor allowance	124	–	–	–	–	124
Charges associated with litigation matters	40	–	–	–	–	40
Pre-tax adjusted income (loss) from operations	$ 2,592	$ 268	$ 538	$ 275	$ (362)	$ 3,311

(1) Includes the Company's share of the earnings of its joint ventures reported in the International Markets segment using the equity method of accounting.

Revenue from external customers includes premiums, pharmacy revenues, and fees and other revenues. The following table presents these revenues by premium, service and product type for the years ended December 31:

(In millions)	2018	2017	2016
Insurance premiums			
Integrated Medical premiums (ASC 944)			
Commercial Premiums			
Risk	**$ 10,710**	$ 9,439	$ 7,911
Stop loss	**4,008**	3,483	3,082
Other	**1,038**	917	886
Government			
Medicare Advantage	**5,832**	5,534	6,621
Medicare Part D	**764**	764	1,122
Other	**4,496**	3,494	2,640
Total Integrated Medical premiums	**26,848**	23,631	22,262
International Markets premiums	**5,043**	4,619	4,273
Domestic disability, life and accident premiums	**4,000**	3,973	4,002
Other premiums	**222**	268	287
Total premiums	**36,113**	32,491	30,824
Services (ASC 606)			
Fees	**5,588**	5,053	4,844
Other external revenues	**20**	57	57
Total services	**5,578**	5,110	4,901
Products (Pharmacy revenues) (ASC 606)			
Home delivery and specialty revenues	**3,997**	2,979	2,966
Network revenues	**1,415**	–	–
Other	**67**	–	–
Total pharmacy revenues	**5,479**	2,979	2,966
Total revenues from external customers	**$ 47,170**	$ 40,580	$ 38,691

Foreign and U.S. revenues from external customers for the three years ended December 31 are shown below. The Company's foreign revenues are generated by its foreign operating entities. In the periods shown, no foreign country contributed more than 5% of consolidated revenues from external customers.

(In millions)	2018	2017	2016
United States	**$ 42,773**	$ 36,555	$ 35,011
South Korea	**2,093**	1,892	1,666
All other foreign countries	**2,304**	2,133	2,014
Total	**$ 47,170**	$ 40,580	$ 38,691

Revenues from CMS were 16% of consolidated revenues in 2018 and 2017, compared with 19% in 2016. These amounts were reported in the Integrated Medical segment.

Quarterly Financial Data *(unaudited)*

The following unaudited quarterly financial data is presented on a consolidated basis for each of the years ended December 31, 2018 and December 31, 2017. Quarterly financial results necessarily rely heavily on estimates. This and certain other factors, such as the seasonal nature of portions of the insurance business, suggest the need to exercise caution in drawing specific conclusions from quarterly consolidated results.

	Three Months Ended			
(In millions, except per share amounts)	March 31,	June 30,	September 30,	December 31,
Consolidated Results				
2018				
Total revenues	**$ 11,413**	**$ 11,480**	**$ 11,457**	**$ 14,300**
Income before income taxes	**1,218**	**1,102**	**1,033**	**228**
Shareholders' net income	**915**[1]	**806**[1]	**772**[1]	**144**[1]
Shareholders' net income per share				
Basic	**3.78**	**3.32**	**3.18**	**0.56**
Diluted	**3.72**	**3.29**	**3.14**	**0.55**
2017				
Total revenues	$ 10,428	$ 10,374	$ 10,372	$ 10,632
Income before income taxes	890	1,134	824	758
Shareholders' net income	598[1]	813[1]	560[1]	266[1]
Shareholders' net income per share				
Basic	2.34	3.20	2.25	1.09
Diluted	2.30	3.15	2.21	1.07
Stock and dividend data				
2018				
Price range of common stock – high	**$ 227.13**	**$ 182.10**	**$ 208.73**	**$ 226.61**
– low	**$ 163.02**	**$ 163.80**	**$ 166.88**	**$ 176.52**
Dividends declared per common share	**$ 0.04**	**$ –**	**$ –**	**$ –**
2017				
Price range of common stock – high	$ 154.83	$ 173.21	$ 188.36	$ 212.46
– low	$ 133.52	$ 146.70	$ 166.81	$ 183.08
Dividends declared per common share	$ 0.04	$ –	$ –	$ –

(1) Shareholders' net income includes the following after-tax charges (benefits), described in Note 21 to the Consolidated Financial Statements:

	March 31,	June 30,	September 30,	December 31,
2018 Transaction-related costs	***$ 50***	***$ 109***	***$ 108***	***$ 402***
2018 Charges associated with litigation matters	***–***	***–***	***35***	***(16)***
2018 U.S. tax reform	***–***	***–***	***(5)***	***3***
Total 2018 charges	***$ 50***	***$ 109***	***$ 138***	***$ 389***

	March 31,	June 30,	September 30,	December 31,
2017 U.S. tax reform	*$ –*	*$ –*	*$ –*	*$ 196*
2017 Debt extinguishment costs	*–*	*–*	*209*	*–*
2017 Long-term care guaranty fund assessment	*83*	*–*	*–*	*–*
2017 Transaction-related costs	*49*	*(47)*	*6*	*25*
Total 2017 charges (benefits)	*$ 132*	*$ (47)*	*$ 215*	*$ 221*

ITEM 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

ITEM 9A. Controls and Procedures

A. Disclosure Controls and Procedures

Based on an evaluation of the effectiveness of Cigna's disclosure controls and procedures conducted under the supervision and with the participation of Cigna's management, Cigna's Chief Executive Officer and Chief Financial Officer concluded that, as of the end of the period covered by this report, Cigna's disclosure controls and procedures are effective to ensure that information required to be disclosed by Cigna in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms.

B. Internal Control Over Financial Reporting

Management's Annual Report on Internal Control over Financial Reporting

Management of Cigna Corporation is responsible for establishing and maintaining adequate internal controls over financial reporting. The Company's internal controls were designed to provide reasonable assurance to the Company's management and Board of Directors that the Company's consolidated published financial statements for external purposes were prepared in accordance with accounting principles generally accepted in the United States. The Company's internal control over financial reporting includes those policies and procedures that:

(i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets and liabilities of the Company;

(ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with accounting principles generally accepted in the United States, and that receipts and expenditures of the Company are being made only in accordance with authorization of management and directors of the Company; and

(iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisitions, use or disposition of the Company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements.

Management assessed the effectiveness of the Company's internal controls over financial reporting as of December 31, 2018. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework (2013).* Based on management's assessment and the criteria set forth by COSO, it was determined that the Company's internal controls over financial reporting are effective as of December 31, 2018.

Management's assessment of the effectiveness of internal controls over financial reporting excludes Express Scripts, which was acquired on December 20, 2018 (See Note 3 in the accompanying consolidated financial statements for additional information).

Express Scripts' total assets (excluding goodwill and intangible assets recorded in connection with the acquisition) and total revenues excluded from our assessment of internal control over financial reporting represent approximately 10% and 5%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2018.

The Company's independent registered public accounting firm, PricewaterhouseCoopers LLP, has audited the effectiveness of the Company's internal control over financial reporting, as stated in their report located on page 65 in this Form 10-K.

Change in Internal Control over Financial Reporting

As of December 31, 2018, management is in the process of evaluating and integrating the internal controls of the acquired Express Scripts business into the Company's existing operations. Other than the controls enhanced or implemented to integrate the Express Scripts business, there has been no change in Cigna's internal controls over financial reporting during the year ended December 31, 2018 that has materially affected, or is reasonably likely to affect, Cigna's internal controls over financial reporting.

ITEM 9B. Other Information

None.

PART III

ITEM 10. Directors, Executive Officers and Corporate Governance

A. Directors of the Registrant

The information under the captions "Corporate Governance Matters – Process for Director Elections," " – Board of Directors' Nominees" and " – Board Meetings and Committees" (as it relates to Audit Committee disclosure) in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

B. Executive Officers of the Registrant

See PART I – "Executive Officers of the Registrant" on page 38 in this Form 10-K.

C. Code of Ethics and Other Corporate Governance Disclosures

The information under the caption "Corporate Governance Matters – Codes of Ethics" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

D. Section 16(a) Beneficial Ownership Reporting Compliance

The information under the caption "Ownership of Cigna Common Stock – Section 16(a) Beneficial Ownership Reporting Compliance" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

ITEM 11. Executive Compensation

The information under the captions "Corporate Governance Matters – Non-Employee Director Compensation," "Compensation Matters – Compensation Discussion and Analysis," " – Report of the People Resources Committee" and " – Executive Compensation Tables" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

ITEM 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The following table presents information regarding Cigna's equity compensation plans as of December 31, 2018:

Plan Category	(a) [1] Securities To Be Issued Upon Exercise Of Outstanding Options, Warrants And Rights	(b) [2] Weighted Average Exercise Price Per Share Of Outstanding Options, Warrants And Rights	(c) [3] Securities Remaining Available For Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected In Column (a))
Equity Compensation Plans Approved by Security Holders	**15,099,184**	**$ 125.46**	**28,891,766**
Equity Compensation Plans Not Approved by Security Holders	**-**	**-**	**-**
Total	**15,099,184**	**$ 125.46**	**28,891,766**

(1) Includes, in addition to outstanding stock options:
(i) 103,322 restricted stock units, 111,315 deferred shares, and 1,401,071 strategic performance shares that are reported at the maximum 200% payout rate granted under the Cigna Long-Term Incentive Plan, the Corporation Stock Plan, and the Cigna Corporation Director Equity Plan;
(ii) 140,744 shares of common stock underlying stock option awards granted under the HealthSpring, Inc. Amended and Restated 2006 Equity Incentive Plan which was approved by HealthSpring, Inc.'s shareholders before Cigna's acquisition of HealthSpring, Inc. in January 2012; and
(iii) 897,338 shares of common stock underlying stock option awards and 1,013,890 restricted stock units granted under the Express Scripts Holding Company 2016 Long-Term Incentive Plan, 8,758 deferred shares granted under the Express Scripts, Inc. Executive Deferred Compensation Plan of 2005, 2,877,922 shares of common stock underlying stock option awards and 63,904 restricted stock units granted under the Express Scripts, Inc. 2011 Long-Term Incentive Plan, 2,249,731 shares of common stock underlying stock option awards and 26,238 restricted stock units granted under the Medco Health Solutions, Inc. 2002 Stock Incentive Plan, and 119,948 shares of common stock underlying stock option awards granted under the Accredo Health, Incorporated 2002 Long-Term Incentive Plan, which were all approved by the applicable company's shareholders before Cigna's acquisition of Express Scripts in December 2018.

(2) The weighted-average exercise price is based only on outstanding stock options. The outstanding stock options assumed due to Cigna's acquisition of HealthSpring, Inc. have a weighted-average exercise price of $22.45. The outstanding stock options assumed due to Cigna's acquisition of Express Scripts, in aggregate, have a weighted-average exercise price of $135.57. Excluding the assumed options from these acquisitions results in a weighted-average exercise price of $117.64.

(3) Includes 239,222 shares of common stock available as of the close of business December 31, 2018 for future issuance under the Cigna Corporation Director Equity Plan, 25,838,360 shares of common stock available as of the close of business on December 31, 2018 for future issuance under the Cigna Long-Term Incentive Plan, which includes 13,120,666 shares of common stock available assumed from the Express Scripts, Inc. 2016 Long-Term Incentive Plan, and 2,814,184 shares of common stock available as of the close of business December 31, 2018 for future issuance under the Express Scripts, Inc. Executive Deferred Compensation Plan of 2005. Because no further grants may be made under the HealthSpring, Inc. Amended and Restated 2006 Equity Incentive Plan, the Express Scripts, Inc. 2016 Long-Term Incentive Plan, the Express Scripts, Inc. 2011 Long-Term Incentive Plan, the Medco Health Solutions, Inc. 2002 Stock Incentive Plan, and the Accredo Health, Incorporated 2002 Long-Term Incentive Plan, shares available for issuance under these plans are not included.

The information under the captions "Ownership of Cigna Common Stock – Stock Held by Directors, Nominees and Executive Officers" and "Ownership of Cigna Common Stock – Stock Held by Certain Beneficial Owners" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

ITEM 13. Certain Relationships and Related Transactions, and Director Independence

The information under the captions "Corporate Governance Matters – Director Independence" and " – Certain Transactions" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

ITEM 14. Principal Accountant Fees and Services

The information under the captions "Audit Matters – Policy for the Pre-Approval of Audit and Non-Audit Services" and " – Fees to Independent Registered Public Accounting Firm" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

PART IV

ITEM 15. Exhibits and Financial Statement Schedules

(a) (1) The following Financial Statements appear on pages 65 through 129:

Report of Independent Registered Public Accounting Firm.

Consolidated Statements of Income for the years ended December 31, 2018, 2017 and 2016.

Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017 and 2016.

Consolidated Balance Sheets as of December 31, 2018 and 2017.

Consolidated Statements of Changes in Total Equity for the years ended December 31, 2018, 2017 and 2016.

Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017 and 2016.

Notes to the Consolidated Financial Statements.

(2) The financial statement schedules are listed in the Index to Financial Statement Schedules on page FS-1.

(b) The exhibits listed in the accompanying "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K.

Index to Exhibits

Number	Description	Method of Filing
2.1(a)	Agreement and Plan of Merger, dated as of March 8, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Express Scripts Holding Company, Cigna Holding Company (formerly Cigna Corporation), Halfmoon I, Inc., and Halfmoon II, Inc.	Filed by Cigna Holding Company ("CHC") as Exhibit 2.1 to the Current Report on Form 8-K on March 13, 2018 and incorporated herein by reference.
2.1(b)	Amendment No. 1, dated as of June 27, 2018, to the Agreement and Plan of Merger, dated as of March 8, 2018, by and among Cigna Corporation, Express Scripts Holding Company, Cigna Holding Company, Halfmoon I, Inc. and Halfmoon II, Inc.	Filed by CHC as Exhibit 2.1 to the Current Report on Form 8-K on July 2, 2018 and incorporated herein by reference.
3.1	Amended and Restated Certificate of Incorporation of the registrant as last amended December 20, 2018	Filed by the registrant as Exhibit 3.1 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
3.2	Amended and Restated By-Laws of the registrant as last amended December 20, 2018	Filed by the registrant as Exhibit 3.2 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.1(a)	Indenture, dated as of September 17, 2018, between Cigna Corporation (formerly Halfmoon Parent, Inc.) and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on September 21, 2018 and incorporated herein by reference.
4.1(b)	Supplemental Indenture, dated as of September 17, 2018, between Cigna Corporation (formerly Halfmoon Parent, Inc.) and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.2 to the Current Report on Form 8-K on September 21, 2018 and incorporated herein by reference.
4.1(c)	Second Supplemental Indenture dated as of December 20, 2018, by and among Express Scripts Holding Company, Cigna Holding Company and U.S. Bank National Association, as Trustee	Filed by the registrant as Exhibit 4.7 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.2	Registration Rights Agreement, dated as of September 17, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.) and Morgan Stanley & Co. LLC, Merrill Lynch, Pierce, Fenner & Smith Incorporated, J.P. Morgan Securities LLC and Wells Fargo Securities, LLC, as representatives of the Initial Purchasers named in Schedule I to the Purchase Agreement	Filed by CHC as Exhibit 4.3 to the Current Report on Form 8-K on September 21, 2018 and incorporated herein by reference.
4.3(a)	Senior Indenture dated August 16, 2006 between Cigna Holding Company (formerly Cigna Corporation) and U.S. Bank National Association	Filed by CHC as Exhibit 4.1(a) to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
4.3(b)	Supplemental Indenture No. 1 dated November 10, 2006 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1(b) to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
4.3(c)	Supplemental Indenture No. 2 dated March 15, 2007 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1(c) to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2011 and incorporated herein by reference.
4.3(d)	Supplemental Indenture No. 3 dated March 7, 2008 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on March 10, 2008 and incorporated herein by reference.
4.3(e)	Supplemental Indenture No. 5 dated May 17, 2010 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 99.2 to the Current Report on Form 8-K on May 28, 2010 and incorporated herein by reference.
4.3(f)	Supplemental Indenture No. 6 dated December 8, 2010 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 99.2 to the Current Report on Form 8-K on December 9, 2010 and incorporated herein by reference.
4.3(g)	Supplemental Indenture No. 7 dated March 7, 2011 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 99.2 to the Current Report on Form 8-K on March 8, 2011 and incorporated herein by reference.
4.3(h)	Supplemental Indenture No. 8 dated November 10, 2011 between Cigna Holding Company and U.S. Bank National Associated	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on November 14, 2011 and incorporated herein by reference.
4.3(i)	Supplemental Indenture No. 9 dated as of March 20, 2015, between Cigna Holding Company and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on March 26, 2015 and incorporated herein by reference.
4.3(j)	Supplemental Indenture No. 10 dated as of September 14, 2017 between Cigna Holding Company and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K filed September 14, 2017 and incorporated herein by reference.
4.3(k)	Supplemental Indenture No. 11 dated as of December 20, 2018, by and among Cigna Corporation, Cigna Holding Company and U.S. Bank National Association, as trustee	Filed by the registrant as Exhibit 4.1 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.4(a)	Indenture dated January 1, 1994 between Cigna Holding Company (formerly Cigna Corporation) and Marine Midland Bank	Filed by CHC as Exhibit 4.2 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
4.4(b)	Supplemental Indenture No. 1 dated as of December 20, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Cigna Holding Company and HSBC Bank USA, National Association (as successor to Marine Midland Bank, N.A.), as Trustee	Filed by the registrant as Exhibit 4.2 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.5(a)	Indenture dated June 30, 1988 between Cigna Holding Company (formerly Cigna Corporation) and Bankers Trust Company	Filed by CHC as Exhibit 4.3 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
4.5(b)	Supplemental Indenture No. 1 dated as of December 20, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Cigna Holding Company and Deutsche Bank Trust Company Americas, a New York banking corporation (as successor to Bankers Trust Company), as Trustee	Filed by the registrant as Exhibit 4.3 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.6(a)	Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company (formerly Aristotle Holding, Inc.), the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by Express Scripts, Inc. ("ESI") as Exhibit 4.1 to the Current Report on Form 8-K filed November 25, 2011 and incorporated herein by reference.

Number	Description	Method of Filing
4.6(b)	Third Supplemental Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESI as Exhibit 4.4 to the Current Report on Form 8-K on November 25, 2011 and incorporated herein by reference.
4.6(c)	Fourth Supplemental Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESI as Exhibit 4.5 to the Current Report on Form 8-K on November 25, 2011 and incorporated herein by reference.
4.6(d)	Seventh Supplemental Indenture, dated as of February 9, 2012, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee, related to Express Scripts Holding Company's 3.900% senior notes due 2022	Filed by ESI as Exhibit 4.3 to the Current Report on Form 8-K filed February 10, 2012 and incorporated herein by reference.
4.6(e)	Eighth Supplemental Indenture, dated as of April 2, 2012, among Express Scripts, Inc., Express Scripts Holding Company, Medco Health Solutions, Inc., the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by Express Scripts Holding Company ("ESRX") as Exhibit 4.1 to the Current Report on Form 8-K on April 6, 2012 and incorporated herein by reference.
4.6(f)	Eleventh Supplemental Indenture, dated as of June 5, 2014, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on June 5, 2014 and incorporated herein by reference.
4.6(g)	Twelfth Supplemental Indenture, dated as of June 5, 2014, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on June 5, 2014 and incorporated herein by reference.
4.6(h)	Thirteenth Supplemental Indenture, dated as of June 5, 2014, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on June 5, 2014 and incorporated herein by reference.
4.6(i)	Sixteenth Supplemental Indenture, dated as of February 25, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on February 25, 2016 and incorporated herein by reference.
4.6(j)	Seventeenth Supplemental Indenture, dated as of February 25, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on February 25, 2016 and incorporated herein by reference.
4.6(k)	Eighteenth Supplemental Indenture, dated as of July 5, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on July 5, 2016 and incorporated herein by reference.
4.6(l)	Nineteenth Supplemental Indenture, dated as of July 5, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on July 5, 2016 and incorporated herein by reference.
4.6(m)	Twentieth Supplemental Indenture, dated as of July 5, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on July 5, 2016 and incorporated herein by reference.
4.6(n)	Twenty-Second Supplemental Indenture, dated as of November 30, 2017, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on November 30, 2017 and incorporated herein by reference.
4.6(o)	Twenty-Third Supplemental Indenture, dated as of November 30, 2017, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee and Calculation Agent	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on November 30, 2017 and incorporated herein by reference.
4.6(p)	Twenty-Fourth Supplemental Indenture, dated as of November 30, 2017, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on November 30, 2017 and incorporated herein by reference.
4.6(q)	Twenty-Fifth Supplemental Indenture dated as of December 20, 2018, by and among Cigna Corporation, Express Scripts Holding Company and Wells Fargo Bank, National Association, as Trustee	Filed by the registrant as Exhibit 4.4 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.7(a)	Indenture, dated as of June 9, 2009, among Express Scripts, Inc., the Subsidiary Guarantors party thereto and Union Bank, N.A., as Trustee	Filed by ESI as Exhibit 4.1 to the Current Report on Form 8-K on June 10, 2009 and incorporated herein by reference.
4.7(b)	Third Supplemental Indenture, dated as of June 9, 2009, among Express Scripts, Inc., the Subsidiary Guarantors party thereto and Union Bank, N.A., as Trustee	Filed by ESI as Exhibit 4.4 to the Current Report on Form 8-K on June 10, 2009 and incorporated herein by reference.
4.7(c)	Seventh Supplemental Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Union Bank, N.A., as Trustee	Filed by ESI as Exhibit 4.6 to the Current Report on Form 8-K on November 25, 2011 and incorporated herein by reference.
4.7(d)	Eighth Supplemental Indenture, dated as of April 2, 2012, among Express Scripts, Inc., Express Scripts Holding Company, Medco Health Solutions, Inc., the other subsidiaries of Express Scripts Holding Company party thereto and Union Bank, N.A., as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on April 6, 2012 and incorporated herein by reference.

Number	Description	Method of Filing
4.7(e)	Ninth Supplemental Indenture dated as of December 20, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Express Scripts, Inc. and MUFG Union Bank, N.A. (as successor to Union Bank, N.A.), as Trustee	Filed by the registrant as Exhibit 4.5 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.8(a)	Indenture, dated as of March 18, 2008, between Medco Health Solutions, Inc. and U.S. Bank Trust National Association, as Trustee	Filed by Medco Health Solutions, Inc. ("Medco") as Exhibit 4.1 to the Current Report on Form 8-K on March 18, 2008 and incorporated herein by reference.
4.8(b)	Form of Medco Solutions, Inc. 4.125% Notes due 2020	Filed by Medco as Exhibit 4.2 to the Current Report on Form 8-K on September 10, 2010 and incorporated herein by reference.
4.8(c)	First Supplemental Indenture, dated as of April 2, 2012, among Medco Health Solutions, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and U.S. Bank Trust National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on April 6, 2012 and incorporated herein by reference.
4.8(d)	Second Supplemental Indenture dated as of December 20, 2018, by and among Cigna Corporation, Medco Health Solutions, Inc. and U.S. Bank Trust National Association, as Trustee	Filed by the registrant as Exhibit 4.6 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
Exhibits 10.1 through 10.40 are identified as compensatory plans, management contracts or arrangements pursuant to Item 15 of Form 10-K.		
10.1(a)	Cigna Long-Term Incentive Plan as amended and restated effective as of April 26, 2017 (the "Cigna LTIP")	Filed by the registrant as Exhibit 10.1 to the Current Report on Form 8-K on May 1, 2017 and incorporated herein by reference.
10.1(b)	Amendment No. 1, effective January 25, 2018, to the Cigna LTIP	Filed by CHC as Exhibit 10.3 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2018 and incorporated herein by reference.
10.1(c)	Form of Cigna LTIP: Strategic Performance Share Grant Agreement	Filed by CHC as Exhibit 10.4 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.1(d)	Form of Cigna LTIP: Nonqualified Stock Option Grant Agreement	Filed by CHC as Exhibit 10.5 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.1(e)	Form of Cigna LTIP: Restricted Stock Grant Agreement	Filed by CHC as Exhibit 10.6 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.1(f)	Form of Cigna LTIP: Restricted Stock Unit Grant Agreement	Filed by CHC as Exhibit 10.7 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.2(a)	HealthSpring, Inc. Amended and Restated 2006 Equity Incentive Plan (the "HealthSpring Equity Incentive Plan")	Filed by the registrant as Exhibit 4.4 to the Registration Statement on Form S-8 (No. 333-228930) filed December 20, 2018 and incorporated herein by reference.
10.2(b)	HealthSpring Equity Incentive Plan: Form of Restricted Share Award	Filed by CHC as Exhibit 10.4 to the Quarterly Report on Form 10-Q for the period ended March 31, 2013 and incorporated herein by reference.
10.2(c)	HealthSpring Equity Incentive Plan: Form of Non-Qualified Stock Option Agreement	Filed by CHC as Exhibit 10.5 to the Quarterly Report on Form 10-Q for the period ended March 31, 2013 and incorporated herein by reference.
10.3	Cigna Corporation Stock Plan, as amended through July 2000	Filed by CHC as Exhibit 10.7 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.4	Cigna Stock Unit Plan, as amended and restated effective February 22, 2017	Filed by CHC as Exhibit 10.5 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2017 and incorporated herein by reference.
10.5(a)	Express Scripts Holding Company 2016 Long-Term Incentive Plan (the "ESRX LTIP")	Filed by ESRX as Appendix A to ESRX's Definitive Proxy Statement on Schedule 14A for its 2016 Annual Meeting of Stockholders, filed March 21, 2016 and incorporated herein by reference.
10.5(b)	Form of Stock Option Grant Notice for Non-Employee Directors used with respect to grants of stock options by Express Scripts Holding Company to non-employee directors under the ESRX LTIP	Filed by ESRX as Exhibit 10.4 to the Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.5(c)	Form of Restricted Stock Unit Grant Notice used with respect to grants of restricted stock units by Express Scripts Holding Company under the ESRX LTIP	Filed by ESRX as Exhibit 10.5 to the Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.5(d)	Form of Stock Option Grant Notice used with respect to grants of stock options by Express Scripts Holding Company under the ESRX LTIP	Filed by ESRX as Exhibit 10.7 to Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.6(a)	Express Scripts, Inc. 2011 Long-Term Incentive Plan (as amended and restated effective April 2, 2012) (the "ESI LTIP")	Filed by the registrant as Exhibit 4.10 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.6(b)	Form of Stock Option Grant Notice for Non-Employee Directors used with respect to grants of stock options by Express Scripts Holding Company under the ESI LTIP	Filed by ESRX as Exhibit 10.6 to Quarterly Report on Form 10-Q for the quarter ended June 30, 2012 and incorporated herein by reference.
10.6(c)	Form of Stock Option Grant Notice used with respect to certain grants of stock options by Express Scripts Holding Company prior to 2013 under the ESI LTIP	Filed by ESRX as Exhibit 10.14 to the Current Report on Form 8-K on April 2, 2012 and incorporated herein by reference.
10.6(d)	Form of Restricted Stock Unit Grant Notice used with respect to grants of restricted stock units by Express Scripts Holding Company under the ESI LTIP	Filed by ESRX as Exhibit 10.2 to the Quarterly Report on Form 10-Q for the quarter ended March 31, 2013 and incorporated herein by reference.
10.6(e)	Form of Stock Option Grant Notice used with respect to grants of stock options by Express Scripts Holding Company under the ESI LTIP	Filed by ESRX as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarter ended March 31, 2013 and incorporated herein by reference.
10.7(a)	Medco Health Solutions, Inc. 2002 Stock Incentive Plan (as amended and restated effective April 2, 2012).	Filed by the registrant as Exhibit 4.11 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.7(b)	Form of terms and conditions for director stock option and restricted stock unit awards	Filed by Medco as Exhibit 10.2 to the Current Report on Form 8-K on February 8, 2005 and incorporated herein by reference.

Number	Description	Method of Filing
10.8	Accredo Health, Incorporated 2002 Long-Term Incentive Plan	Filed by the registrant as Exhibit 4.12 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.9	Deferred Compensation Plan for Directors of Cigna Corporation, as amended and restated January 1, 1997	Filed by CHC as Exhibit 10.1 the Annual Report on Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.10	Cigna Deferred Compensation Plan, as amended and restated October 24, 2001	Filed by CHC as Exhibit 10.14 to the Annual Report on Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.11	Cigna Deferred Compensation Plan of 2005 effective as of January 1, 2005	Filed by the registrant as Exhibit 4.6 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.12	Express Scripts, Inc. Amended and Restated Executive Deferred Compensation Plan (effective December 31, 2004 and grandfathered for the purposes of Section 409A of the Code)	Filed by ESI as Exhibit No. 10.1 to the Current Report on Form 8-K on May 25, 2007 and incorporated herein by reference.
10.13	Express Scripts, Inc. Executive Deferred Compensation Plan of 2005 (as amended and restated effective December 20, 2018)	Filed by the registrant as Exhibit 4.13 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.14(a)	Cigna Supplemental Pension Plan as amended and restated effective August 1, 1998	Filed by CHC as Exhibit 10.15(a) to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.14(b)	Amendment No. 1 to the Cigna Supplemental Pension Plan, amended and restated effective as of September 1, 1999	Filed by CHC as Exhibit 10.15(b) to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.14(c)	Amendment No. 2 dated December 6, 2000 to the Cigna Supplemental Pension	Filed by CHC as Exhibit 10.16(c) to the Annual Report on Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.15(a)	Cigna Supplemental Pension Plan of 2005 effective as of January 1, 2005	Filed by CHC as Exhibit 10.15 to the Annual Report on Form 10-K for the year ended December 31, 2007 and incorporated herein by reference.
10.15(b)	Amendment No. 1 to the Cigna Supplemental Pension Plan of 2005	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2009 and incorporated herein by reference.
10.16	Cigna Supplemental 401(k) Plan effective January 1, 2010	Filed by the registrant as Exhibit 4.7 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.17	Cigna Corporation Non-Employee Director Compensation Program amended and restated effective February 26, 2014	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2014 and incorporated herein by reference.
10.18	Cigna Corporation Non-Employee Director Compensation Program, amended and restated effective January 1, 2019	Filed herewith.
10.19	Cigna Corporation Director Equity Plan	Filed by the registrant as Exhibit 4.5 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.20	Cigna Restricted Share Equivalent Plan for Non-Employee Directors as amended and restated effective January 1, 2008	Filed by CHC as Exhibit 10.4 to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
10.21	Deferred Compensation Plan of 2005 for Directors of Cigna Corporation, Amended and Restated effective April 28, 2010	Filed by the registrant as Exhibit 4.8 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.22	Form of Indemnification Agreement with Express Scripts Holding Company's executive officers and former members of the Express Scripts Holding Company's board of directors	Filed by ESRX as Exhibit 10.1 to the Current Report on Form 8-K on March 5, 2014 and incorporated herein by reference.
10.23	Cigna Executive Severance Benefits Plan as amended and restated effective October 23, 2018	Filed herewith.
10.24	Description of Severance Benefits for Executives in Non-Change of Control Circumstances	Filed by CHC as Exhibit 10.10 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.25	Cigna Executive Incentive Plan amended and restated as of January 1, 2012	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2012 and incorporated herein by reference.
10.26	Description of Cigna Corporation Financial Services Program	Filed by CHC as Exhibit 10.18 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.27	Offer Letter for Eric P. Palmer dated June 16, 2017	Filed by CHC as Exhibit 10.1 to the Current Report on Form 8-K on June 19, 2017 and incorporated herein by reference.
10.28	Nicole Jones' Offer of Employment dated April 27, 2011	Filed by CHC as Exhibit 10.2 to the Quarterly Report on Form 10-Q for the period ended March 31, 2012 and incorporated herein by reference.
10.29	Employment Agreement for Jason D. Sadler dated May 7, 2010	Filed by CHC as Exhibit 10.1(a) to the Quarterly Report on Form 10-Q for the period ended March 31, 2015 and incorporated herein by reference.
10.30	Promotion letter for Jason Sadler dated June 2, 2014	Filed by CHC as Exhibit 10.1(b) to the Quarterly Report on Form 10-Q for the period ended March 31, 2015 and incorporated herein by reference.

Number	Description	Method of Filing
10.31	Retention Agreement by and between Cigna Corporation and Mr. Timothy Wentworth, dated as of May 12, 2018.	Filed by the registrant as Exhibit 10.1 to Amendment No. 1 to the Registration Statement on Form S-4 (No. 333-224960) on June 20, 2018 and incorporated herein by reference.
10.32	Express Scripts Holding Company Executive Employment Agreement with Timothy Wentworth dated May 4, 2016	Filed by ESRX as Exhibit 10.1 to the Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.33	Schedule regarding Amended Deferred Stock Unit Agreements effective December 31, 2008 with John M. Murabito and Form of Amended Deferred Stock Unit Agreement	Filed by CHC as Exhibit 10.20 to the Annual Report on Form 10-K for the year ended December 31, 2008 and incorporated herein by reference.
10.34	Retention Agreement between the Cigna Corporation and Steven B. Miller dated October 9, 2018	Filed herewith.
10.35	Agreement and Release between the Company and Matthew G. Manders dated October 16, 2017	Filed by CHC as Exhibit 10.1 to the Current Report on Form 8-K on October 18, 2017 and incorporated herein by reference.
10.36	Agreement and Release between the Company and Thomas A. McCarthy dated June 16, 2017	Filed by CHC as Exhibit 10.2 to the Current Report on Form 8-K on June 19, 2017 and incorporated herein by reference.
10.37	Advisory Services Agreement between the Company and Thomas A. McCarthy dated June 16, 2017	Filed by CHC as Exhibit 10.3 to the Current Report on Form 8-K on June 19, 2017 and incorporated herein by reference.
10.38	Promotion letter for Christopher Hocevar dated January 30, 2017	Filed by CHC as Exhibit 10.8 to the Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.39	Agreement and Release between the Company and Christopher J. Hocevar dated September 26, 2018	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the period ended September 30, 2018 and incorporated herein by reference.
10.40	Agreement and Release between the Company and Alan Muney, M.D. effective December 21, 2018	Filed herewith.
10.41(a)	Revolving Credit and Letter of Credit Agreement, dated as of April 6, 2018	Filed by CHC as Exhibit 10.1 to Current Report on Form 8-K on April 12, 2018 and incorporated herein by reference.
10.41(b)	Additional Guarantor Supplement dated as of December 20, 2018, by Express Scripts Holding Company and Cigna Holding Company to that certain Revolving Credit and Letter of Credit Agreement dated as of April 6, 2018, by and among Cigna Holding Company, Cigna Corporation, JPMorgan Chase Bank, N.A., as administrative agent, and the other parties thereto.	Filed by the registrant as Exhibit 4.8 to the Current Report on Form 8-K filed December 20, 2018 and incorporated herein by reference.
10.42(a)	Term Loan Credit Agreement, dated as of April 6, 2018	Filed by CHC as Exhibit 10.2 to Current Report on Form 8-K on April 12, 2018 and incorporated herein by reference.
10.42(b)	Additional Guarantor Supplement dated as of December 20, 2018, by Express Scripts Holding Company and Cigna Holding Company to that certain Term Loan Credit Agreement dated as of April 6, 2018, by and among Cigna Holding Company, Cigna Corporation, Morgan Stanley Senior Funding, Inc., as administrative agent, and the other parties thereto.	Filed by the registrant as Exhibit 4.9 to the Current Report on Form 8-K filed December 20, 2018 and incorporated herein by reference.
10.43	Master Transaction Agreement, dated February 4, 2013 among Connecticut General Life Insurance Company, Berkshire Hathaway Life Insurance Company of Nebraska and, solely for purposes of Sections 3.10, 6.1, 6.3, 6.4, 6.6, 6.9 and Articles II, V, VII, and VIII, thereof, National Indemnity Company (including the Forms of Retrocession Agreement, the Collateral Trust Agreement, the Security and Control Agreement, the Surety Policy and the ALC Model Purchase Option Agreement as exhibits)	Filed by CHC as Exhibit 10.29 to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
21	Subsidiaries of the Registrant	Filed herewith.
23	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Certification of Chief Executive Officer of Cigna Corporation pursuant to Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934	Filed herewith.
31.2	Certification of Chief Financial Officer of Cigna Corporation pursuant to Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934	Filed herewith.
32.1	Certification of Chief Executive Officer of Cigna Corporation pursuant to Rule 13a-14(b) or Rule 15d-14(b) and 18 U.S.C. Section 1350	Furnished herewith.
32.2	Certification of Chief Financial Officer of Cigna Corporation pursuant to Rule 13a-14(b) or Rule 15d-14(b) and 18 U.S.C. Section 1350	Furnished herewith.
101	The following materials from Cigna Corporation's Annual Report on Form 10-K for the year ended December 31, 2018, formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Changes in Total Equity; (vi) the Notes to Consolidated Financial Statements; and (vii) Financial Statement Schedules I, II, III, IV and V.	Filed herewith.

Item 16. 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

CIGNA CORPORATION

Date:	February 28, 2019
By:	/s/ Eric P. Palmer
	Eric P. Palmer
	Executive Vice President and Chief Financial Officer (Principal Financial Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated as of February 28, 2019.

Signature	Title
/s/ David M. Cordani	Chief Executive Officer and Director (Principal Executive Officer)
David M. Cordani	
/s/ Eric P. Palmer	Executive Vice President and Chief Financial Officer (Principal Financial Officer)
Eric P. Palmer	
/s/ Mary T. Agoglia Hoeltzel	Senior Vice President, Tax and Chief Accounting Officer (Principal Accounting Officer)
Mary T. Agoglia Hoeltzel	
/s/ William J. DeLaney	Director
William J. DeLaney	
/s/ Eric J. Foss	Director
Eric J. Foss	
/s/ Elder Granger, M.D.	Director
Elder Granger, M.D.	
/s/ Isaiah Harris, Jr.	Chairman of the Board
Isaiah Harris, Jr.	
/s/ Mark McClellan, M.D.	Director
Mark McClellan, M.D.	
/s/ Roman Martinez IV	Director
Roman Martinez IV	
/s/ Kathleen M. Mazzarella	Director
Kathleen M. Mazzarella	
/s/ John M. Partridge	Director
John M. Partridge	
/s/ William L. Roper, M.D.	Director
William L. Roper, M.D.	
/s/ Eric C. Wiseman	Director
Eric C. Wiseman	
/s/ Donna F. Zarcone	Director
Donna F. Zarcone	
/s/ William D. Zollars	Director
William D. Zollars	

Cigna Corporation and Subsidiaries

INDEX TO FINANCIAL STATEMENT SCHEDULES

Schedules other than those listed above are omitted because they are not required or are not applicable, or the required information is shown in the financial statements or notes thereto.

Report of Independent Registered Public Accounting Firm on Financial Statement Schedules

To the Board of Directors and Shareholders of Cigna Corporation

Our audits of the consolidated financial statements referred to in our report dated February 28, 2019 (which report and consolidated financial statements are included under Item 8 in this Annual Report on Form 10-K) also included an audit of the financial statement schedules listed in Item 15(a)(2) of this Form 10-K. In our opinion, these financial statement schedules present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements.

/s/ PricewaterhouseCoopers LLP
Hartford, Connecticut
February 28, 2019

Cigna Corporation and Subsidiaries
Schedule I – Condensed Financial Information of Cigna Corporation (Registrant)

Statements of Income

	For the years ended December 31,		
	Cigna*	Old Cigna*	Old Cigna*
(in millions)	2018	2017	2016
Revenues			
Net investment income	**$ 123**	$ —	$ —
Total revenues	**123**	—	—
Operating expenses			
Selling, general and administrative expenses	**200**	195	281
Total operating expenses	**200**	195	281
Income (loss) from operations	**(77)**	(195)	(281)
Interest and other (expense)	**(244)**	(246)	(244)
Intercompany interest (expense)	**(5)**	(18)	(3)
Debt extinguishment costs	**—**	(321)	—
Realized investment (loss)	**(1)**	—	—
Loss before taxes	**(327)**	(780)	(528)
Income tax (benefit)	**(74)**	(194)	(146)
Loss of Parent Company	**(253)**	(586)	(382)
Equity in income of subsidiaries	**2,890**	2,823	2,249
Shareholders' net income	**2,637**	2,237	1,867
Shareholders' other comprehensive income (loss)			
Net unrealized (depreciation) on securities and derivatives	**(365)**	(37)	(60)
Net translation gains (losses) of foreign currencies	**(152)**	304	(95)
Postretirement benefits liability adjustment	**127**	33	23
Shareholders' other comprehensive income (loss):	**(390)**	300	(132)
Shareholders' comprehensive income	**$ 2,247**	$ 2,537	$ 1,735

* As described in Note 3, on December 20, 2018, through the "Merger," Old Cigna merged into a wholly-owned subsidiary of Cigna, and Cigna became the Registrant. Refer to Note 20 for Condensed Consolidated Financial Statements of Cigna and Old Cigna.

Cigna Corporation and Subsidiaries
Schedule I – Condensed Financial Information of Cigna Corporation (Registrant)

Balance Sheets

	As of December 31,	
	Cigna*	Old Cigna*
(in millions)	2018	2017
Assets		
Cash and cash equivalents	$ 243	$ 9
Short-term investments	—	63
Other current assets	14	31
Total current assets	257	103
Intercompany receivable	—	200
Investments in subsidiaries	68,969	22,631
Other noncurrent assets	48	221
TOTAL ASSETS	$ 69,274	$ 23,155
Liabilities		
Short-term debt	$ —	$ 231
Other current liabilities	418	270
Total current liabilities	418	501
Intercompany payable	4,965	2,980
Long-term debt	22,863	5,112
Other noncurrent liabilities	—	851
TOTAL LIABILITIES	28,246	9,444
Shareholders' Equity		
Common stock (shares issued, 381 and 296; authorized, 600)	4	74
Additional paid-in capital	27,751	2,940
Accumulated other comprehensive loss	(1,711)	(1,082)
Retained earnings	15,088	15,800
Less treasury stock, at cost	(104)	(4,021)
TOTAL SHAREHOLDERS' EQUITY	41,028	13,711
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	$ 69,274	$ 23,155

* As described in Note 3, on December 20, 2018, through the "Merger," Old Cigna merged into a wholly-owned subsidiary of Cigna, and Cigna became the Registrant. Refer to Note 20 for Condensed Consolidated Financial Statements of Cigna and Old Cigna.

Cigna Corporation and Subsidiaries
Schedule I – Condensed Financial Information of Cigna Corporation (Registrant)

Statements of Cash Flows

	For the years ended December 31,		
	Cigna*	Old Cigna*	Old Cigna*
(in millions)	**2018**	**2017**	**2016**
Cash Flows from Operating Activities			
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867
Adjustments to reconcile shareholders' net income to net cash provided by operating activities			
Equity in income of subsidiaries	**(2,890)**	(2,823)	(2,249)
Dividends received from subsidiaries	**—**	758	580
Other liabilities	**412**	(224)	(9)
Debt extinguishment costs	**—**	321	—
Other, net	**(14)**	333	187
NET CASH PROVIDED BY OPERATING ACTIVITIES	**145**	602	376
Cash Flows from Investing Activities			
Short-term investment purchased, net	**—**	(6)	(3)
Other, net	**(27,115)**	(11)	(8)
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	**(27,115)**	(17)	(11)
Cash Flows from Financing Activities			
Net change in amounts due to (from) affiliates	**4,437**	1,955	(78)
Net change in short-term debt	**—**	100	(100)
Payments for debt extinguishment	**—**	(313)	—
Repayment of long-term debt	**—**	(1,250)	—
Net proceeds on issuance of long-term debt	**22,856**	1,581	—
Issuance of common stock	**1**	131	36
Common dividends paid	**—**	(10)	(10)
Repurchase of common stock	**(32)**	(2,725)	(139)
Tax withholding on stock compensation and other	**(49)**	(63)	(72)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	**27,213**	(594)	(363)
Net increase (decrease) in cash and cash equivalents	**243**	(9)	2
Cash and cash equivalents, beginning of year	**—**	18	16
Cash and cash equivalents, end of year	**$ 243**	$ 9	$ 18

* *As described in Note 3, on December 20, 2018, through the "Merger," Old Cigna merged into a wholly-owned subsidiary of Cigna, and Cigna became the Registrant. Refer to Note 20 for Condensed Consolidated Financial Statements of Cigna and Old Cigna.*

Cigna Corporation and Subsidiaries
Schedule I – Condensed Financial Information of Cigna Corporation (Registrant)

Notes to Condensed Financial Statements

The accompanying condensed financial statements should be read in conjunction with the Consolidated Financial Statements and the accompanying notes thereto contained in this Annual Report on Form 10-K ("Form 10-K").

Note 1 – For purposes of these condensed financial statements, Cigna Corporation's (the "Company") wholly-owned and majority-owned subsidiaries are recorded using the equity basis of accounting.

Note 2 – See Note 5 – Debt included in Part II, Item 8 of this Form 10-K for a description of the short-term and long-term debt obligations of Cigna Corporation and its subsidiaries. Maturity of the Company's long-term debt is as follows:

(In millions)		
2019	$	—
2020	$	2,750
2021	$	5,250
2022	$	—
2023	$	3,800
Maturities after 2023	$	11,200

Note 3 – Intercompany liabilities of the Company consist primarily of payables to Old Cigna of $4.3 billion as of December 31, 2018. Intercompany liabilities of Old Cigna consisted primarily of payables to Cigna Holdings, Inc. of $2.8 billion as of December 31, 2017. Interest was accrued at an average monthly rate of 2.33% for 2018 and 1.47% for 2017.

Note 4 – The Company had guarantees of approximately $19.6 billion as of December 31, 2018. These guarantees are related to outstanding debt of certain wholly-owned subsidiaries as described in Note 5 and Note 20. In 2018, no payments have been made on these guarantees.

Cigna Corporation and Subsidiaries
Schedule II – Valuation and Qualifying Accounts and Reserves

(in millions) **Description**	**Balance at beginning of year**	**Charged (Credited) to costs and expenses**	**Charged (Credited) to other accounts**	**Other deductions**	**Balance at end of year**
2018					
Allowance for doubtful accounts					
Premiums, accounts and notes receivable	**$ 207**	**$ 18**	**$ (3)**	**$ (5)**	**$ 217**
Deferred tax asset valuation allowance	**$ 72**	**$ (5)**	**$ 132**	**$ –**	**$ 199**
Reinsurance recoverables	**$ 3**	**$ (1)**	**$ –**	**$ –**	**$ 2**
2017					
Investment asset valuation reserves					
Commercial mortgage loans	$ 5	$ 1	$ –	$ (6)	$ –
Allowance for doubtful accounts					
Premiums, accounts and notes receivable	$ 200	$ 19	$ (11)	$ (1)	$ 207
Deferred tax asset valuation allowance [(1)]	$ 87	$ 11	$ (26)	$ –	$ 72
Reinsurance recoverables	$ 3	$ –	$ –	$ –	$ 3
2016					
Investment asset valuation reserves					
Commercial mortgage loans	$ 15	$ –	$ –	$ (10)	$ 5
Allowance for doubtful accounts					
Premiums, accounts and notes receivable	$ 75	$ 134	$ (8)	$ (1)	$ 200
Deferred tax asset valuation allowance	$ 71	$ 21	$ (5)	$ –	$ 87
Reinsurance recoverables	$ 3	$ –	$ –	$ –	$ 3

(1) Deferred tax valuation allowance amount includes amount assumed from Express Scripts in 2018.

Exhibit 21 Subsidiaries of the Registrant

Listed below are subsidiaries of Cigna Corporation as of December 31, 2018 with their jurisdictions of organization. Those subsidiaries not listed would not, in the aggregate, constitute a "significant subsidiary" of Cigna Corporation, as that term is defined in Rule 1-02(w) of Regulation S-X.

Entity Name	Jurisdiction
Accredo Health Group, Inc.	Delaware
Allegiance Life & Health Insurance Company, Inc.	Montana
Allegiance Re, Inc.	Montana
American Retirement Life Insurance Company	Ohio
Benefits Management Corp.	Montana
Bravo Health Mid-Atlantic, Inc.	Maryland
Bravo Health Pennsylvania, Inc.	Pennsylvania
CareAllies, Inc.	Delaware
Central Reserve Life Insurance Company	Ohio
Ceres Sales of Ohio, LLC	Ohio
Cigna & CMB Life Insurance Company Limited	China
Cigna Apac Holdings Limited	Bermuda
Cigna Arbor Life Insurance Company	Connecticut
Cigna Beechwood Holdings, SdC/MTS	Belgium
Cigna Behavioral Health of California, Inc.	California
Cigna Behavioral Health of Texas, Inc.	Texas
Cigna Behavioral Health, Inc.	Minnesota
Cigna Bellevue Alpha, LLC	Delaware
Cigna Benefits Financing, Inc.	Delaware
Cigna Brokerage & Marketing (Thailand) Limited	Thailand
Cigna Cedar Holdings, Ltd.	Malta
Cigna Chestnut Holdings, Ltd.	United Kingdom
Cigna Corporate Services, LLC	Delaware
Cigna Data Services (Shanghai) Company Limited	China
Cigna Dental Health of California, Inc.	California
Cigna Dental Health of Colorado, Inc.	Colorado
Cigna Dental Health of Delaware, Inc.	Delaware
Cigna Dental Health of Florida, Inc.	Florida
Cigna Dental Health of Illinois, Inc.	Illinois
Cigna Dental Health of Kansas, Inc.	Kansas
Cigna Dental Health of Kentucky, Inc.	Kentucky
Cigna Dental Health of Maryland, Inc.	Maryland
Cigna Dental Health of Missouri, Inc.	Missouri
Cigna Dental Health of New Jersey, Inc.	New Jersey
Cigna Dental Health of North Carolina, Inc.	North Carolina
Cigna Dental Health of Ohio, Inc.	Ohio
Cigna Dental Health of Pennsylvania, Inc.	Pennsylvania
Cigna Dental Health of Texas, Inc.	Texas
Cigna Dental Health of Virginia, Inc.	Virginia
Cigna Dental Health Plan of Arizona, Inc.	Arizona
Cigna Dental Health, Inc.	Florida
Cigna Elmwood Holdings, SPRL	Belgium
Cigna Europe Insurance Company S.A.-N.V.	Belgium
Cigna European Services (UK) Limited	United Kingdom
Cigna Finans Emeklilik ve Hayat A.S.	Turkey
Cigna Global Holdings, Inc.	Delaware
Cigna Global Insurance Company Limited	Guernsey, C.I
Cigna Global Reinsurance Company, Ltd.	Bermuda
Cigna Global Wellbeing Holdings Limited	United Kingdom
Cigna Global Wellbeing Solutions Limited	United Kingdom
Cigna Health and Life Insurance Company	Connecticut
Cigna Health Corporation	Delaware
Cigna Health Management, Inc.	Delaware
Cigna Health Solutions India Pvt. Ltd.	India
Cigna Healthcare Holdings, Inc.	Colorado
Cigna Healthcare Mid-Atlantic, Inc.	Maryland
Cigna Healthcare of Arizona, Inc.	Arizona
Cigna Healthcare of California, Inc.	California
Cigna Healthcare of Colorado, Inc.	Colorado
Cigna Healthcare of Connecticut, Inc.	Connecticut
Cigna Healthcare of Florida, Inc.	Florida
Cigna Healthcare of Georgia, Inc.	Georgia
Cigna Healthcare of Illinois, Inc.	Illinois
Cigna Healthcare of Indiana, Inc.	Indiana
Cigna Healthcare of Maine, Inc.	Maine
Cigna Healthcare of Massachusetts, Inc.	Massachusetts
Cigna Healthcare of New Hampshire, Inc.	New Hampshire
Cigna Healthcare of New Jersey, Inc.	New Jersey
Cigna Healthcare of North Carolina, Inc.	North Carolina

Entity Name	Jurisdiction
Cigna Healthcare of Pennsylvania, Inc.	Pennsylvania
Cigna Healthcare of South Carolina, Inc.	South Carolina
Cigna Healthcare of St. Louis, Inc.	Missouri
Cigna Healthcare of Tennessee, Inc.	Tennessee
Cigna Healthcare of Texas, Inc.	Texas
Cigna Healthcare of Utah, Inc.	Utah
Cigna HLA Technology Services Company Limited	Hong Kong
Cigna Holdings Overseas, Inc.	Delaware
Cigna Holdings, Inc.	Delaware
Cigna Hong Kong Holdings Company Limited	Hong Kong
Cigna Insurance Public Company Limited	Thailand
Cigna Insurance Middle East S.A.	Lebanon
Cigna Insurance Services (Europe) Limited	United Kingdom
Cigna Intellectual Property, Inc.	Delaware
Cigna International Corporation	Delaware
Cigna International Health Services Kenya Limited	Kenya
Cigna International Health Services SDN BHD	Malaysia
Cigna International Health Services BVBA	Belgium
Cigna International Health Services, LLC	Florida
Cigna International Services, Inc.	Delaware
Cigna International Services Australia Pty. Ltd.	Australia
Cigna Investment Group, Inc.	Delaware
Cigna Investments, Inc.	Delaware
Cigna Korean Chusik Hoesa	South Korea
Cigna Laurel Holdings, Ltd.	Bermuda
Cigna Legal Protection UK Ltd.	United Kingdom
Cigna Life Insurance Company of Canada	Canada
Cigna Life Insurance Company of Europe S.A.- N.V.	Belgium
Cigna Life Insurance Company of New York	New York
Cigna Life Insurance New Zealand Limited	New Zealand
Cigna Linden Holdings, Inc.	Delaware
Cigna Magnolia Holdings, Ltd.	Bermuda
Cigna Myrtle Holdings, Ltd.	Malta
Cigna Nederland Alpha Cooperatief U.A.	Netherlands
Cigna Nederland Beta B.V.	Netherlands
Cigna Nederland Gamma B.V.	Netherlands
Cigna Oak Holdings, Ltd.	United Kingdom
Cigna Palmetto Holdings, Ltd.	Bermuda
Cigna Poplar Holdings, Inc.	Delaware
Cigna Sequoia Holdings, SPRL	Belgium
Cigna Taiwan Life Assurance Company Limited	Taiwan
CignaTTK Health Insurance Company Limited	India
Cigna Walnut Holdings, Ltd.	United Kingdom
Cigna Willow Holdings, Ltd.	United Kingdom
Cigna Worldwide General Insurance Company Limited	Hong Kong
Cigna Worldwide Insurance Company	Delaware
Cigna Worldwide Life Insurance Company Limited	Hong Kong
Connecticut General Corporation	Connecticut
Connecticut General Life Insurance Company	Connecticut
Express Scripts, Inc.	Delaware
Express Scripts Holding Company	Delaware
FirstAssist Administration Limited	United Kingdom
Great-West Healthcare of Illinois, Inc.	Illinois
Grown Ups New Zealand Limited	New Zealand
Health-Lynx LLC	New Jersey
Healthsource, Inc.	New Hampshire
HealthSpring, Inc.	Delaware
HealthSpring of Alabama, Inc.	Alabama
HealthSpring of Florida, Inc.	Florida
HealthSpring Life & Health Insurance Company, Inc.	Texas
HealthSpring of Tennessee, Inc.	Tennessee
KDM Thailand Limited	Thailand
Life Insurance Company of North America	Pennsylvania
LINA Financial Services	South Korea
LINA Life Insurance Company of Korea	South Korea
Loyal American Life Insurance Company	Ohio
MCC Independent Practice Association of New York, Inc.	New York
Medco Health Solutions, Inc.	Delaware
NewQuest, LLC	Texas
NewQuest Management Northeast, LLC	Delaware
Olympic Health Management Services, Inc.	Washington
Oz Parent, Inc.	Delaware
Provident American Life and Health Insurance Company	Ohio
PT Asuransi Cigna	Indonesia
Qualcare Alliance Networks, Inc.	New Jersey
Qualcare Captive Insurance Company Inc. PCC	New Jersey

Entity Name	Jurisdiction
Qualcare Management Resources Limited Liability Company	New Jersey
Qualcare, Inc.	New Jersey
RHP (Thailand) Limited	Thailand
Scibal Associates, Inc.	New Jersey
Sterling Life Insurance Company	Illinois
Tel-Drug, Inc.	South Dakota
Tel-Drug of Pennsylvania, LLC	Pennsylvania
Temple Insurance Company Limited	Bermuda
United Benefit Life Insurance Company	Ohio

EXHIBIT 23 Consent of Independent Registered Public Accounting Firm

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (Nos. 333-228930 and 333-228931) of Cigna Corporation of our reports dated February 28, 2019 relating to the financial statements and financial statement schedules and the effectiveness of internal control over financial reporting, which appear in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Hartford, Connecticut
February 28, 2019

EXHIBIT 31.1 Certification

I, DAVID M. CORDANI, certify that:

1. I have reviewed this Annual Report on Form 10-K of Cigna Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ DAVID M. CORDANI

Chief Executive Officer

Date: February 28, 2019

EXHIBIT 31.2 Certification

I, ERIC P. PALMER, certify that:

1. I have reviewed this Annual Report on Form 10-K of Cigna Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ ERIC P. PALMER

Chief Financial Officer

Date: February 28, 2019

EXHIBIT 32.1 Certification of Chief Executive Officer of Cigna Corporation pursuant to 18 U.S.C. Section 1350

I certify that, to the best of my knowledge and belief, the Annual Report on Form 10-K of Cigna Corporation for the fiscal period ending December 31, 2018 (the "Report"):

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

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Cigna Corporation.

/s/ David M. Cordani

David M. Cordani
Chief Executive Officer
February 28, 2019

EXHIBIT 32.2 Certification of Chief Financial Officer of Cigna Corporation pursuant to 18 U.S.C. Section 1350

I certify that, to the best of my knowledge and belief, the Annual Report on Form 10-K of Cigna Corporation for the fiscal period ending December 31, 2018 (the "Report"):

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

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Cigna Corporation.

/s/ ERIC P. PALMER

Eric P. Palmer
Chief Financial Officer
February 28, 2019

Firstsource Financials

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Firstsource Transaction Services LLC

Financial Statements

for the financial year ended March 31, 2016

SHELESH SINGHVI & Co.
Chartered Accountants

E-702,Dheeraj Jamuna
Co operative housing Society,
Chincholi Bunder road,
Malad (West), Mumbai.
Tel: 9314667335, 9773756991
Email- sheleshsinghvi@yahoo.co.in

Independent Auditors' Report

To the Members of Firstsource Solutions Limited

Report on the standalone financial statements

We have audited the accompanying standalone financial statements of Firstsource Transaction Services LLC ("the Company"), which comprise the balance sheet as at 31 March 2016, the statement of profit and loss, the cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory information (hereinafter referred to as "the standalone financial statements").

Management's responsibility for the standalone financial statements

These financial statements are prepared to comply with the requirements of Sec 136 of the Companies Act, 2013 and are the responsibility of the management. This responsibility also includes maintenance of adequate accounting records in accordance with the provisions of the Act for safeguarding of the assets of the Company and for preventing and detecting frauds and other irregularities; selection and application of appropriate accounting policies; making judgments and estimates that are reasonable and prudent; and design, implementation and maintenance of adequate internal financial controls, that were operating effectively for ensuring the accuracy and completeness of the accounting records, relevant to the preparation and presentation of the financial statements that give a true and fair view and are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these standalone financial statements based on our audit. We have taken into account the provisions of the Act, the accounting and auditing standards and matters which are required to be included in the audit report under the provisions of the Act and the Rules made there under. We conducted our audit in accordance with the Standards to comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of the accounting estimates made by the Company's Directors, as well as evaluating the overall presentation of the financial statements.

SHELESH SINGHVI & Co.
Chartered Accountants

E-702,Dheeraj Jamuna
Co operative housing Society,
Chincholi Bunder road,
Malad (West), Mumbai.
Tel: 9314667335, 9773756991
Email- sheleshsinghvi@yahoo.co.in

Independent Auditors' Report *(Continued)*

Auditor's Responsibility (Continued)

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the standalone financial statements.

Opinion

In our opinion and to the best of our information and according to the explanations given to us, the aforesaid standalone financial statements give the information required by the Act in the manner so required and give a true and fair view in conformity with the accounting principles generally accepted in India, of the state of affairs of the Company as at 31 March 2016 and its profit and its cash flows for the year ended on that date.

For **Shelesh Singhvi & Co.**
Chartered Accountants
Firm's Registration No: 014792C

Shelesh Singhvi
Partner
M. No: 079817

Mumbai
12th May 2016

Firstsource Transaction Services, LLC
Balance Sheet
as at 31 March 2016

	Note	Amount In Rupees		Amount In USD	
		31 March 2016	31 March 2015	31 March 2016	31 March 2015
EQUITY AND LIABILITIES					
Shareholders' Funds					
Share Capital	3	-	-	-	-
Reserves and Surplus	4	1,388,247,532	1,033,155,029	20,953,101	15,593,617
		1,388,247,532	1,033,155,029	20,953,101	15,593,617
Non-current liabilities					
Long-term borrowings	5	113,826	326,878	1,718	4,934
Long-term provision	6	49,021,366	52,100,134	739,887	786,356
		49,135,192	52,427,012	741,605	791,290
Current liabilities					
Trade payables	7	43,571,806	48,835,622	657,638	737,085
Other current liabilities	8	179,080,706	123,054,894	2,702,901	1,857,293
		222,652,512	171,890,516	3,360,539	2,594,378
		1,660,035,236	1,257,472,557	25,055,245	18,979,285
ASSETS					
Non current assets					
Fixed assets	9				
Tangible assets		99,549,191	90,534,164	1,502,516	1,366,450
Intangible assets		60,491,729	8,481,837	913,014	128,018
		160,040,920	99,016,001	2,415,530	1,494,468
Capital work in progress		4,798,121	-	72,419	-
		164,839,041	99,016,001	2,487,949	1,494,468
Long-term Loans and Advances	10	18,327,259	19,864,062	276,617	299,812
		18,327,259	19,864,062	276,617	299,812
Current assets					
Trade receivables	11	804,229,559	817,912,720	12,138,398	12,344,921
Cash and bank balances	12	7,358,744	4,521,294	111,087	68,241
Short term loans and advances	13	660,474,562	312,117,307	9,968,675	4,710,849
Other current assets	14	4,806,071	4,041,173	72,539	60,994
		1,476,868,936	1,138,592,494	22,290,679	17,185,005
		1,660,035,236	1,257,472,557	25,055,245	18,979,285

Significant accounting policies 2
The accompanying notes from 1 to 28 form an integral part of the financial statement.

As per our report of even date attached.

For SHELESH SINGHVI & CO.
Chartered Accountants
Firm's Registration No: 014792C

Shelesh Singhvi
Partner
M. No: 079817
Mumbai
Date: 12/5/16

For and on behalf of the Board of Directors

Venkat Raman
Director

Arjun Mitra
Director

Firstsource Transaction Services, LLC
Statement of profit and loss
as at 31 March 2016

	Note	Amount In Rupees		Amount In USD	
		31 March 2016	For the year ended 31 March 2015	For the year ended 31 March 2016	For the year ended 31 March 2015
Income					
Revenue from Operations	15	6,153,739,819	4,703,726,077	92,679,629	70,994,281
Other Income		59,298	-	895	-
		6,153,799,117	4,703,726,077	92,680,524	70,994,281
Expenses					
Cost of Sales		931,570,278	891,675,717	14,060,377	13,458,240
Employee benefits expense	16	4,022,735,003	2,958,999,998	60,715,946	44,660,780
Finance Cost	17	1,870,180	63,741	28,227	962
Depreciation and amortization	9	52,266,083	29,515,201	788,891	445,479
Other expenses	18	790,263,070	553,685,432	11,927,599	8,356,885
		5,798,706,614	4,433,940,089	87,521,040	66,922,346
Profit Before Taxation		355,092,503	269,785,988	5,359,484	4,071,935
Provision for Tax		-			
-Current tax		-	-	-	-
-Deferred tax		-	-	-	-
Profit After Taxation		355,092,503	269,785,988	5,359,484	4,071,935

Significant accounting policies 2
The accompanying notes from 1 to 28 form an integral part of the financial statement.

As per our report of even date attached.

For SHELESH SINGHVI & CO.
Chartered Accountants
Firm's Registration No: 014792C

Shelesh Singhvi
Partner
M. No: 079817

Mumbai
Date : 12/5/16

For and on behalf of the Board of Directors

Venkat Raman
Director

Arjun Mitra
Director

Firstsource Transaction Services, LLC
Cash flow statement
for the year ended 31 March 2016

	Amount in Rupees		Amount in USD	
	2016	2015	2016	2015
Cash flow from operating activities				
Net profit before tax	355,092,503	269,785,088	5,359,484	4,071,035
Adjustments for				
Depreciation and amortization	52,268,083	29,515,201	788,891	445,479
Foreign exchange (gain)/loss net	50,884	-	768	-
Interest costs	1,870,180	-	28,227	-
Operating cash flow before changes in working capital	409,281,650	299,301,189	6,177,370	4,517,414
Changes in working capital				
(Increase)/Decrease in Trade receivables	13,683,160	(213,890,080)	206,523	(3,228,266)
(Increase)/Decrease in other current assets	(347,585,389)	(132,876,109)	(5,246,176)	(2,005,526)
Increase/(Decrease) in liabilities and provisions	47,683,182	37,506,115	719,692	566,087
Net changes in working capital	(286,219,047)	(309,260,074)	(4,319,961)	(4,667,725)
Net cash used in operating activities (A)	123,062,603	(9,958,885)	1,857,409	(150,311)
Cash flow from investing activities				
Capital expenditure	(118,141,921)	(59,125,115)	(1,783,140)	(892,387)
Net cash generated from investing activities (B)	(118,141,921)	(59,125,115)	(1,783,140)	(892,387)
Cash flow from financing activities				
Payment of secured loan	(213,052)	(469,864)	(3,216)	(7,089)
Interest paid	(1,870,180)	-	(28,227)	-
Net cash used in financing activities (C)	(2,083,232)	(469,864)	(31,443)	(7,089)
Net increase in cash and cash equivalents (A+B+C)	2,837,450	(69,553,863)	42,826	(1,049,787)
Cash and cash equivalents at the beginning of the year*	4,521,294	74,074,957	68,241	1,118,028
Cash and cash equivalents at the end of the year*	7,358,744	4,521,294	111,067	68,241

* Refer schedule 12 for components of cash and cash equivalents.

As per our report of even date attached.

For SHELESH SINGHVI & CO.
Chartered Accountants
Firm's Registration No: 014702C

Shelesh Singhvi
Partner
M. No: 079817

Mumbai
Date: 12/5/16

For and on behalf of the Board of Directors

Venkat Raman
Director

Arjun Mitra
Director

Firstsource Transaction Services LLC

Notes to the accounts
for the year ended at 31 March 2016

1 Background

Firstsource Transaction Services LLC ('the Company') was incorporated under the laws of the State of Delaware on 26 May 2011. The Company provides contact centre and transaction processing services for customers in the financial services, telecommunications and healthcare industry. The Company is a wholly owned subsidiary of MedAssist Holding, Inc. who holds the voting rights in the Company.

2 Significant accounting policies

2.1 Basis of preparation

The financial statements of the Company have been prepared under the historical cost convention, on accrual basis of accounting principles generally accepted in India. The Balance Sheet and Statement of Profit and Loss of the Company has been drawn up in the country of its incorporation (United States of America) in the terms of United State Dollars ('USD'). However, for the purpose of compliance with the requirements of Section 129 (3) of the Companies Act 2013,amounts in these financial statements have been translated into Indian rupees at the closing rate on 31 March 2016 which is 1 USD = Rs 66.255 (31st Mar 2015 which was 1 USD = Rs. 62.5). No representation is made that USD amounts have been, could have been or could be converted into Indian rupees at such a rate.

2.2 Use of estimates

The preparation of financial statements in conformity with generally accepted accounting principles ('GAAP') in India requires management to make estimates and assumptions that affect the reported amount of assets and liabilities and disclosures of contingent liabilities on the date of the financial statements. Management believes that the estimates made in the preparation of financial statements are prudent and reasonable. Actual results could differ from those estimates. Any revision to accounting estimates is recognized prospectively in current and future periods.

2.3 Revenue recognition

Revenue from contact centre and transaction processing services comprises from both time/unit price and fixed fee based service contracts. Revenue from time/ unit price based contracts is recognized on completion of the related services and is billed in accordance with the contractual terms specified in the respective customer contracts. Revenue from fixed fee based service contracts is recognized on achievement of performance milestones specified in the customer contracts.

Unbilled receivables represent costs incurred and revenues recognized on contracts to be billed in subsequent periods as per the terms of the contract.

Interest income is recognized using the time proportion method, based on the underlying interest rates.

2 Significant accounting policies *(Continued)*

2.4 Fixed assets and depreciation

Fixed assets are stated at cost less accumulated depreciation. Cost includes freight, duties, taxes and incidental expenses related to acquisition and installation of the fixed assets. Depreciation on fixed assets is provided, using the straight line basis, pro rata to the period of use based on management's best estimate of useful lives of the assets (which are shorter than those prescribed under the Companies Act, 1956) as summarized below:

Asset	Useful life (in years)
Intangible	
Software*	2 - 4
Tangible	
Leasehold improvements*	5 or Lease term which ever is shorter
Computers*	2 - 4
Furniture & Fixtures*	2 - 5
Networks/Service Equipments*	2 - 5
Vehicles*	2 - 5
Office Equipments*	2 - 5

*For these class of assets, based on internal assessment and independent technical evaluation carried out by external values, the management believes that the useful lives as given above best represent the period over which management expects to use these assets. Hence the useful lives for these assets is different from the useful lives as prescribed under Part C of Schedule II to the Companies Act, 2013

Software purchased together with the related hardware is capitalized and depreciated at the rates applicable to related assets.

2.5 Impairment of assets

a) Financial assets

The Group assesses at each balance sheet date whether there is any objective evidence that a financial asset or group of financial assets is impaired. If any such indication exists, the Group estimates the amount of impairment loss. The amount of loss for short-term receivables is measured as the difference between the assets carrying amount and undiscounted amount of future cash flows. Reduction, if any, is recognized in the statement of profit and loss account. If at the balance sheet date there is any indication that a previously assessed impairment loss no longer exists, the recognized impairment loss is reversed, subject to maximum of initial carrying amount of the short-term receivable.

b) Non-financial assets

The Group assesses at each balance sheet date whether there is any indication that a non financial asset including goodwill may be impaired. If any such indication exists, the Group estimates the recoverable amount of the asset. If such recoverable amount of the asset or the recoverable amount of the cash generating unit to which the asset belongs is less than its carrying amount, the carrying amount is reduced to its recoverable amount. The reduction is treated as an impairment loss and is recognised in the statement of profit and loss account. If at the balance sheet date there is an indication that a previously assessed impairment loss no longer exists, the recoverable amount is reassessed and the asset is reflected at the recoverable amount subject to a maximum of depreciated historical cost.

2 Significant accounting policies *(Continued)*

2.6 Foreign currency transactions

Transactions in foreign currency are recorded at the exchange rate prevailing on the date of the transaction. Net exchange gain or loss resulting in respect of foreign exchange transactions settled during the period is, recognized in the statement of profit and loss. Foreign currency denominated assets and liabilities other than fixed assets at year end are translated at the year end exchange rates and the resulting net gain or loss is recognized in the statement of profit and loss. Non Monetary assets are carried at historical cost.

2.7 Taxation

Income-tax expense comprises current tax (i.e. amount of tax for the period determined in accordance with the income-tax law) and deferred tax charge or credit (reflecting the tax effects of timing differences between accounting income and taxable income for the year). The deferred tax charge or credit and the corresponding deferred tax liabilities or assets are recognized using the tax rates that have been enacted or substantively enacted by the balance sheet date. Deferred tax assets are recognized only to the extent there is reasonable certainty that the assets can be realized in future. The tax liability is computed on a consolidated basis and hence the tax liabilities for the company have been included in the financial statements of the parent company i.e. Firstsource Group USA, Inc.

2.8 Provisions and Contingencies

The Company creates a provision when there is present obligation as a result of a past event that probably requires an outflow of resources and a reliable estimate can be made of the amount of the obligation. A disclosure for a contingent liability is made when there is a possible obligation or a present obligation that may, but probably will not, require an outflow of resources. When there is a possible obligation or a present obligation in respect of which the likelihood of outflow of resources is remote, no provision or disclosure is made.

Provisions are reviewed at each Balance Sheet date and adjusted to reflect the current best estimate. If it is no longer probable that the outflow of resources would be required to settle the obligation, the provision is reversed.

Contingent assets are not recognised in the financial statements. However, contingent assets are assessed continually and if it is virtually certain that an economic benefit will arise, the asset and related income are recognised in the period in which the change occurs.

2.9 Leases

Operating lease

Lease rentals in respect of assets acquired under operating lease are charged off to the statement of profit and loss account as incurred.

2.10 Investments

Investments are classified into non-current investments and current investments. Investments which are intended to be held for one year or more are classified as non-current investments and investments which are intended to be held for less than one year are classified as current investments.

2. Significant accounting policies (Continued)

2.10 Investments (Continued)

Non-current investments are carried at cost less other than any temporary diminution in value, determined separately for each investment.

Current investments are carried at lower of cost and fair value. The comparison of cost and fair value is done separately in respect of each category of investment. In case of investments in mutual funds, the net asset value of units declared by the mutual funds is considered as the fair value

2.11 Employee benefits

Defined Contribution Plans

The Companies having a savings and investment plan under section 401 (K) of the internal revenue code of the United States of America. This is a Defined Contribution plan. Contribution made under the plan are charged to the statement of Profit and loss in the period in which that accure. Other retirement benefits are accrued based on the amounts payable as per local regulations.

Contributions payable to the social security, medicare and other employee related contributions as required under the State of New york are charged to the statement of profit and loss.

Other long term employee benefits

Compensated absences

Provision for compensated absences cost has been made based on eligible vacation balances at balance sheet date.

Where employees of the Company are entitled to compensated absences, the employees can carry-forward a portion of the unutilized accrued compensated absence and utilise it in future periods or receive cash compensation at termination of employment for the unutilised accrued compensated absence. The Company records an obligation for compensated absences in the period in which the employee renders the services that increase this entitlement.

The Company measures the expected cost of compensated absences as the additional amount that the Company expects to pay as a result of the unused entitlement that has accumulated as at the balance sheet date.

2.11 *Earnings per share*

The basic earnings per equity share are computed by dividing the net profit or loss for the period attributable to the equity shareholders for the period by the weighted average number of equity shares outstanding during the period. The number of shares used in computing diluted earnings per share comprises the weighted average number of shares considered for deriving basic earnings per share, and also the weighted average number of equity shares which may be issued on the conversion of all dilutive potential shares, unless the results would be anti-dilutive.

Firstsource Transaction Services, LLC

Notes to the accounts
as at 31 March 2016

	Amount in Rupees		Amount in USD	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
3 Share Capital				
Issued, Subscribed and paid up :	-	-	-	-

A. **Details of voting rights holding more than 5% in the Company**	31 March 2016	31 March 2015
	% of Holding	% of Holding
Medassist Holding Inc	100	100

	Amount in Rupees		Amount in USD	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
4 Reserves and Surplus				
Balance at the beginning of the year	**1,033,155,029**	763,369,041	**15,593,617**	11,521,682
Add : Profit for the year	**355,092,503**	269,785,988	**5,359,484**	4,071,935
	1,388,247,532	1,033,155,029	**20,953,101**	15,593,617
5 Long term borrowings				
(Secured)				
Loan from Non banking financials instiution (This loan carries interest at the rate of 6.90% upto July 2017, repayable in monthly installments from the date of its origination. This is secured by way of hypothecation of underlying fixed assets taken)	**113,826**	**326,878**	**1,718**	4,934
	113,826	326,878	**1,718**	4,934
6 Long Term Provisions				
Compensated Absenses	**49,021,366**	52,100,134	**739,887**	786,356
	49,021,366	52,100,134	**739,887**	786,356
7 Trade payables				
Trade payables for Expenses & Services	**43,571,806**	48,835,622	**657,638**	737,085
	43,571,806	48,835,622	**657,638**	737,085
8 Other current liabilities				
Current maturities of long term borrowings				
Loan from Non banking financials instiution	**370,034**	439,707	**5,585**	6,637
Others				
Employee Related Dues	**162,282,347**	112,646,078	**2,449,360**	1,700,190
Advance from Customers	**-**	1,007,142	**-**	15,201
Statutory dues	**16,428,325**	8,961,967	**247,956**	135,265
	179,080,706	123,054,894	**2,702,901**	1,857,293

Firstsource Transaction Services, LLC

Notes to the accounts
as at 31 March 2016

9. Fixed Assets

(Currency: Indian rupees)

	Tangible Assets							Intangible assets		Grand Total
	Computers	Network	Vehicles	Office furniture and Fixture	Office equipment	Leasehold improvements	Total Tangible assets	Software	Total Intangible assets	
Gross Block										
As on 1st April 2015 (INR)	233,207,363	38,691,525	5,670,342	163,768,366	23,607,636	82,035,970	**546,981,202**	198,144,265	**198,144,265**	**745,125,467**
Additions during the year	12,184,122	9,377,318	-	9,374,098	11,218,026	5,384,279	**47,537,843**	65,755,180	**65,755,180**	**113,293,023**
Deletions during the year	11,375,379	4,315,276	-	2,497,454	150,272	-	**18,338,381**	47,557	**47,557**	**18,385,938**
As at 31 March 2016 (INR)	**234,016,106**	**43,753,567**	**5,670,342**	**170,645,010**	**34,675,390**	**87,420,249**	**576,180,664**	**263,851,888**	**263,851,888**	**840,032,552**
Accumulated depreciation / amortization										
As on 1st April 2015 (INR)	212,160,509	16,625,945	3,665,605	143,855,532	9,548,557	70,590,890	**456,447,038**	189,662,428	**189,662,428**	**646,109,466**
Charge for the year	10,827,541	11,609,088	781,305	6,097,196	5,909,690	3,297,976	**38,522,796**	13,745,287	**13,745,287**	**52,268,083**
On deletions during the year	11,375,379	4,315,256	-	2,497,454	150,272	-	**18,338,361**	47,557	**47,557**	**18,385,918**
As at 31 March 2016 (INR)	**211,612,671**	**23,919,777**	**4,446,910**	**147,455,274**	**15,307,975**	**73,888,866**	**476,631,473**	**203,360,158**	**203,360,158**	**679,991,631**
Net Block										
As at 31 March 2016	**22,403,435**	**19,833,790**	**1,223,432**	**23,189,736**	**19,367,415**	**13,531,383**	**99,549,191**	60,491,729	**60,491,729**	**160,040,920**
As at 31 March 2015	21,046,854	22,065,580	2,004,737	19,912,834	14,059,079	11,445,080	90,534,164	8,481,837	8,481,837	99,016,001
Net Block (USD)										
As at 31 March 2016	**338,140**	**299,355**	**18,466**	**350,007**	**292,316**	**204,232**	**1,502,516**	**913,014**	**913,014**	**2,415,530**
As at 31 March 2015	317,664	333,040	30,258	300,548	212,197	172,743	1,366,450	128,018	128,018	1,494,468

Firstsource Transaction Services, LLC

Notes to the accounts
as at 31 March 2016

	Amount in Rupees		Amount in USD	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
10 Long term Loans and Advances				
(Unsecured, considered good)				
Deposits	**15,390,241**	15,522,306	**232,288**	234,281
Prepaid expenses	**2,937,018**	4,341,756	**44,329**	65,531
	18,327,259	19,864,062	**276,617**	299,812
11 Trade receivables				
(Unsecured & Considered Good)				
Debts outstanding for a period exceeding six months				
- considered doubtful	**10,766,438**	1,304,601	**162,500**	19,691
Less: Provision for doubtful debts	**(10,766,438)**	(1,304,601)	**(162,500)**	(19,691)
	-	-	-	-
Others debts				
- considered good	**804,229,559**	817,912,720	**12,138,398**	12,344,921
	804,229,559	817,912,720	**12,138,398**	12,344,921
	804,229,559	817,912,720	**12,138,398**	12,344,921
12 Cash and bank balances				
Cash in hand	-	-	-	-
Balances with banks				
- in current accounts	**7,358,744**	4,521,294	**111,067**	68,241
	7,358,744	4,521,294	**111,067**	68,241
13 Short Term Loans and Advances				
(Unsecured, Considered good)				
Related party				
Receivable from group companies, net	**625,065,041**	287,468,881	**9,434,232**	4,338,825
Others				
Prepaid expenses	**35,409,521**	24,648,426	**534,443**	372,024
	660,474,562	312,117,307	**9,968,675**	4,710,849
14 Other current assets				
(Unsecured, Considered good, unless otherwise stated)				
Unbilled Revenue	**4,806,071**	4,041,173	**72,539**	60,994
	4,806,071	4,041,173	**72,539**	60,994

Firstsource Transaction Services, LLC
Notes to the accounts
as at 31 March 2016

	Amount in Rupees		Amount in USD	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
15 Revenue from Operations				
Sale of services	6,153,739,819	4,703,726,077	92,879,629	70,994,281
	6,153,739,819	4,703,726,077	92,879,629	70,994,281
16 Employee benefits expense				
Salaries and wages	3,674,846,959	2,633,889,756	55,465,202	39,753,826
Contribution to statutory funds	17,857,578	12,042,137	269,528	181,754
Staff welfare expenses	330,030,466	313,068,105	4,981,216	4,725,200
	4,022,735,003	2,958,999,998	60,715,946	44,660,780
17 Finance charges				
Interest on loan	1,870,180	63,741	28,227	962
	1,870,180	63,741	28,227	962
18 Other expenses				
Rent	125,694,944	96,556,561	1,897,139	1,457,348
Rates and taxes	638,963	562,870	9,644	8,496
Bank administration charges	1,045,106	956,631	15,774	14,439
Insurance	36,574,549	27,937,831	552,027	421,671
Travelling and conveyance	41,403,081	52,020,533	624,905	785,156
Electricity, water and power consumption	27,550,154	16,991,254	415,820	256,452
Legal and professional fees	63,043,355	31,921,679	951,526	481,800
Outsource Cost	31,301,446	10,803,586	472,439	163,061
Marketing and support services	8,935,083	8,246,072	134,859	124,460
Communication expenses	80,984,215	48,203,184	1,222,311	727,540
Books & Periodicals, Membership fees	998,529	120,518	15,071	1,819
Computer expenses	57,183,829	59,511,050	863,087	898,212
Recruitment expenses/training expenses	18,463,281	16,634,006	278,670	251,060
Printing and stationery	41,178,145	60,322,813	621,510	910,464
Registration fees	44,722	-	675	-
Miscellaneous expenses	4,572	5,750	69	87
Charitable contribution	-	1,391,355	-	21,000
Exchange (Gain) / Loss	49,161	24,425	742	369
Car hire and other hire charges	132,445,136	53,990,679	1,999,021	814,892
Repairs and maintenance - others	68,810,522	26,249,863	1,038,571	396,194
(Gain)/Loss on sale of Fixed assets	50,884	-	768	-
Common corporate costs	44,401,583	39,930,171	670,162	602,674
Provision For Doubtful	9,461,810	1,304,601	142,809	19,691
	790,263,070	553,685,432	11,927,599	8,356,885

18. Leases

Operating Lease

The Company has taken office facilities under non-cancelable operating leases. The Company intends to renew such leases in the normal course of its business. Rental expenses under non-cancelable operating leases aggregating to Rs.64,697,700 equivalent to USD 976,495 (31 March 2015: Rs.89,761,015 equivalent to USD 1,354,781) have been debited to the profit and loss account.

The future minimum lease payments in respect of non-cancelable operating leases are as follows:

	Amount in Rupees		Amount in USD	
	2016	2015	**2016**	2015
Amount due within one year from the balance sheet date	**36,867,043**	95,137,277	**556,442**	1,435,926
Amount due in the period between one year and five years	**10,726,649**	117,781,116	**161,899**	1,777,694
	47,593,692	212,918,393	**718,341**	3,213,620

Rental expenses under cancelable operating leases aggregating to Rs.155,036,076 equivalent to USD 2,33,9991 (31 March 2015: Rs. 6,795,480 equivalent to USD 102,566) have been debited to the profit and loss account.

19. Transfer pricing

The Company's management is of the opinion that its international transactions with related parties are at arms length and that the Company is in compliance with the transfer pricing legislation. Accordingly, the company's management believes that the transfer pricing legislation will not have any impact on the financial statements for the year ended 31 March 2016, particularly on the amount of tax expense and that of the provision for taxation.

20. Capital commitments

The Company has capital commitments of Rs.90,369,368 in USD 1,363,963 (31 March 2015: Rs. 3,636,935 in USD 54,893) as at the balance sheet date.

Notes to the accounts
as at 31 March 2016

23. EPS

As the company is incorporated under the laws of the State of Delaware, USA . As per Country's laws, company is having voting control & there is no share capital. Earning per share is not calculated in the absence of share capital.

24. Contingent liabilities

The Company has no contingent liabilities as at the balance sheet date Nil (31 March 2015: Nil).

25. Related Party Transactions

Details of related parties including summary of transactions entered into during the year ended 31 March 2016 are summarized below:

Ultimate Holding Company	• Firstsource Solutions Ltd
Holding Company	• MedAssist Holding, LLC
Parties with substantial interests	
	• Firstsource Group USA Inc.
	• Firstsource Advantage LLC
	• Firstsource Solution UK Limited
	• Firstsource Process Management Services Limited (earlier known as Anunta Tech Infrastructure Services Limited)
	• Firstsource BPO Ireland Limited
	• Firstsource Dialog Solutions (Private) Limited
	• Firstsource Business Process Services LLC
	• Firstsource Solutions S.A.
	• Firstsource Solutions USA LLC
	• One Advantage LLC
Directors	• Venkat Raman
	• Arjun Mitra

Firstsource Transaction Services LLC

Notes to the accounts
as at 31 March 2016

26. Segmental Reporting

The company has no separate identifiable segment and in accordance with paragraph 4 of Accounting Standard 17 "Segment Reporting" prescribed in the companies (Accounting Standards) Rules, 2006, issued by the central government, the Company has presented segmental information in the consolidated financial statements (refer note no.30 of the consolidated financial statements).

27. The Company is a foreign company and is not governed by the provisions of Micro, Small and Medium Scale Development Act, 2006 Hence disclosure under the act are not applicable.

28. Previous year's figures have been appropriately regrouped/ reclassified to conform to current year's presentation.

As per our report of even date attached

For SHELESH SINGHVI & CO.
Chartered Accountants
Firm's registration no: 014792C

Shelesh Singhvi
Partner
M. No. 079817
Mumbai
Date: 12/5/16

For and on behalf of the Board of Directors

Venkat Raman
Director

Arjun Mitra
Director

SHELESH SINGHVI & Co.
Chartered Accountants

D-803,Dheeraj Jamuna CHS
Chincholi Bunder road,
Malad (West), Mumbai.
Tel: 9314667335, 9773756991
Email- sheleshsinghvi@yahoo.co.in

Independent Auditor's Report

To the Members of Firstsource Solutions Ltd.

Report on the standalone financial statements

We have audited the accompanying standalone financial statements of Firstsource Transactions Services LLC ("the Company"), which comprise the balance sheet as at 31 March 2017, the statement of profit and loss (including other comprehensive income), the statement of cash flows and the statement of changes in equity for the year then ended and a summary of significant accounting policies and other explanatory information (hereinafter referred to as "the standalone financial statements").

Management's responsibility for the standalone financial statements

The Company's Board of Directors is responsible for the matters stated in Section 134(5) of the Companies Act, 2013 ("the Act") with respect to preparation of these standalone financial statements that give a true and fair view of the financial position, financial performance including other comprehensive income, cash flows and changes in equity of the Company in accordance with accounting principles generally accepted in India, including the Indian Accounting Standards (Ind AS) prescribed under Section 133 of the Act, read with relevant rules issued there under. This responsibility also includes maintenance of adequate accounting records in accordance with the provisions of the Act for safeguarding of the assets of the Company and for preventing and detecting frauds and other irregularities; selection and application of appropriate accounting policies; making judgments and estimates that are reasonable and prudent; and the design, implementation and maintenance of adequate internal financial controls, that were operating effectively for ensuring the accuracy and completeness of the accounting records, relevant to the preparation and presentation of the standalone financial statements that give a true and fair view and are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these standalone financial statements based on our audit.

We have taken into account the provisions of the Act, the accounting and auditing standards and matters which are required to be included in the audit report under the provisions of the Act and the Rules made thereunder.

We conducted our audit in accordance with the Standards on Auditing specified under Section 143(10) of the Act. Those Standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the standalone financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the standalone financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the standalone financial statements, whether due to fraud or error. In making those risk assessments,

Shelesh Singhvi & Co. Chartered Accountants Mumbai

Independent Auditors' Report *(Continued)*

Auditor's responsibility *(Continued)*

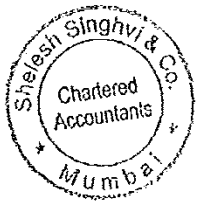
the auditor considers internal financial control relevant to the Company's preparation of the standalone financial statements that give a true and fair view in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of the accounting estimates made by the Company's Board of Directors, as well as evaluating the overall presentation of the standalone financial statements.

We believe that the audit evidence obtained by us is sufficient and appropriate to provide a basis for our audit opinion on the standalone financial statements.

Opinion

In our opinion and to the best of our information and according to the explanations given to us, the aforesaid standalone financial statements give the information required by the Act in the manner so required and give a true and fair view in conformity with the accounting principles generally accepted in India including the Ind AS, of the financial position of the Company as at 31 March 2017 and its financial performance including other comprehensive income, its cash flows and the changes in equity for the year then ended.

For **Shelesh Singhvi & Co.**
Chartered Accountants
Firm's Registration No: 014792C



Shelesh Singhvi
Partner
Membership No: 079817

Mumbai
5 May 2017

Firstsource Transaction Services LLC

Balance sheet

as at 31 March 2017

	Note	Amount in USD 31 March 2017	Amount in USD 31 March 2016	Amount in USD 1 April 2015
ASSETS				
Non-current assets				
Property, plant and equipment	4	1,578,867	1,502,516	1,366,450
Capital work-in-progress		69,549	72,419	-
Other intangible assets	4	481,105	913,014	128,018
Financial assets				
Other financial assets	5(i)	215,896	232,288	234,281
Other assets	6(i)	124,973	44,329	65,531
Total non-current assets		2,470,390	2,764,566	1,794,280
Current assets				
Financial assets				
Trade receivables	7	10,339,400	12,138,398	12,344,921
Cash and cash equivalents	8	-	111,067	68,241
Other financial assets	5(ii)	483,685	72,539	60,994
Other assets	6(ii)	14,292,389	9,968,675	4,710,849
Total current assets		25,115,474	22,290,679	17,185,005
Total assets		27,585,864	25,055,245	18,979,285
EQUITY AND LIABILITIES				
Equity				
Equity share capital	9	-	-	-
Other equity		23,718,734	20,964,989	15,605,505
Total equity		23,718,734	20,964,989	15,605,505
LIABILITIES				
Non-current liabilities				
Financial liabilities				
Long-term borrowings	13(i)	-	1,718	4,934
Total non-current liabilities		-	1,718	4,934
Current liabilities				
Financial liabilities				
Short-term borrowings	13(ii)	2,215	5,585	6,637
Trade and other payables	10	690,101	645,750	725,197
Other financial liabilities	11	261,655	-	-
Provisions for employee benefits	12	498,629	739,887	786,356
Other liabilities	13(iii)	2,414,530	2,697,316	1,850,657
Total current liabilities		3,867,130	4,088,538	3,368,847
Total equity and liabilities		27,585,864	25,055,245	18,979,285
Significant accounting policies	2			

The accompanying notes from 1 to 25 are an integral part of these financial statements.

As per our report of even date attached.

For SHELESH SINGHVI & CO.
Chartered Accountants
Firm's Registration No: 014792C

Shelesh Singhvi
Partner
Membership No: 079817
May 5, 2017
Mumbai

Shelesh Singhvi & Co. Chartered Accountants Mumbai

For and on behalf of the Board of Directors

Venkat Raman
Director

Arjun Mitra
Director

Firstsource Transaction Services LLC

Statement of profit and loss

for the year ended 31 March 2017

	Note	Amount in USD Year ended 31 March 2017	31 March 2016
INCOME			
Revenue from operations	*13*	90,709,697	92,879,629
Other income	*14*	(1,662)	153
Cost Of Sales		15,950,169	14,060,377
Employee benefits expense	*15*	57,809,063	60,715,946
Finance costs	*16*	44,587	28,227
Depreciation and amortization	*4(i),(ii)*	780,654	788,891
Other expenses	*17*	13,369,817	11,926,857
Total expenses		87,954,290	87,520,298
Profit before taxation		2,753,745	5,359,484
Tax expense			
Current tax		-	-
Deferred tax		-	-
Profit for the year		2,753,745	5,359,484
Other comprehensive income		-	-
Total other comprehensive income for the year		2,753,745	5,359,484
Significant accounting policies	*2*		

The accompanying notes from 1 to 25 are an integral part of these financial statements.
As per our report of even date attached.

For SHELESH SINGHVI & CO.
Chartered Accountants

Firm's Registration No: 014792C

Shelesh Singhvi
Partner
Membership No: 079817
May 5, 2017
Mumbai

Shelesh Singhvi & Co. Chartered Accountants Mumbai

For and on behalf of the Board of Directors

Venkat Raman
Director

Arjun Mitra
Director

Firstsource Transaction Services LLC

Statement of cash flows

for the year ended 31 March 2017

	Amount in USD	
	31 March 2017	31 March 2016
Cash flow from operating activities		
Profit before tax	2,753,745	5,359,484
Adjustments for		
Depreciation and amortisation	780,654	788,891
(Gain) / loss on sale of fixed assets, net	-	768
Finance costs	44,587	28,227
Operating cash flow before changes in working capital	3,578,986	6,177,370
Changes in working capital		
Decrease / (increase) in trade receivables	1,798,998	206,523
Decrease / (increase) in loans and advances and other assets	(4,799,112)	(5,246,175)
(Decrease) / Increase in liabilities and provisions	(206,150)	708,855
Net changes in working capital	(3,206,264)	(4,330,797)
Income taxes paid	-	-
Net cash generated from operating activities (A)	372,722	1,846,573
Cash flow from investing activities		
Purchase of property plant and equipment and capital advances given	(422,226)	(1,783,140)
Net cash used in investing activities (B)	(422,226)	(1,783,140)
Cash flow from financing activities		
Proceeds from secured loan	(5,088)	(4,268)
Interest paid	(44,587)	(28,227)
Net cash used in financing activities (C)	(49,675)	(32,495)
Net decrease in cash and cash equivalents at the end of the year (A+B+C)	(99,179)	30,938
Cash and cash equivalents at the beginning of the year	99,179	68,241
Cash and cash equivalents at the end of the year	(0)	99,179

Notes to the cash flow statement

Cash and cash equivalents consist of cash on hand and balances with bank. Cash and cash equivalents included in the cash flow statement comprise the following balance sheet amounts:

	Amount in USD	
	31 March 2017	31 March 2016
Cash on hand	-	-
Balances with banks	-	111,067
Cash and cash equivalents	-	111,067

As per our report of even date attached.

For SHELESH SINGHVI & CO.
Chartered Accountants
Firm's Registration No: 014792C

Shelesh Singhvi
Partner
Membership No: 079817
May 5, 2017
Mumbai

Shelesh Singhvi & Co. Chartered Accountants Mumbai

For and on behalf of the Board of Directors

Venkat Raman
Director

Arjun Mitra
Director

Firstsource Transaction Services LLC

Statement of changes in equity

for the year ended 31 March 2017

B. Equity share capital and other equity (continued)

	Equity share capital	Attributable to Reserve and Retained earnings	Total
Balance as at 1 April 2016	-	20,964,989	20,964,989
Other comprehensive income for the period		-	-
Profit for the year		2,753,745	2,753,745
Balance at the end of the 31 March 2017	-	23,718,734	23,718,734

	Equity share capital	Attributable to owners of the Company Reserve and surplus Retained earnings	Total
Balance as at 1 April 2015	-	15,605,505	15,605,505
Profit for the year	-	5,359,484	5,359,484
Balance at the end of the 31 March 2016	-	20,964,989	20,964,989

As per our report of even date attached.

For SHELESH SINGHVI & CO.
Chartered Accountants
Firm's Registration No: 014792C

Shelesh Singhvi
Partner
Membership No: 079817
May 5, 2017
Mumbai

Shelesh Singhvi & Co. Chartered Accountants Mumbai

For and on behalf of the Board of Directors of

Venkat Raman
Director

Arjun Mitra
Director

1 Company overview

Firstsource Transaction Services LLC ('the Company') was incorporated under the laws of the State of Delaware on 26 May 2011. The Company provides contact centre and transaction processing services for customers in the financial services, telecommunications and healthcare industry. The Company is a wholly owned subsidiary of MedAssist Holding, Inc. who holds the voting rights in the Company.

2 Significant accounting policies

2.1 *Basis of Preparation and Statement of compliance with IND AS*

The Company has adopted all the Ind AS standards and the adoption was carried out in accordance with Ind AS 101 - First time adoption of Indian Accounting Standards. The transition was carried out from Indian Accounting Principles generally accepted in India as prescribed under Section 133 of the Act, read with Rule 7 of the Companies (Accounts) Rules, 2014 (IGAAP), which was the previous GAAP. Reconciliations and description of the effects of the transition have been summarized in Note 3.

In accordance with the notification dated February 16, 2015, issued by the Ministry of Corporate Affairs, the Ultimate Holding Company has adopted Indian Accounting Standards(IND AS) notified under Sec 133 read with Rule 4A of the Company (Indian Accounting Standards) Rules, 2015 and the relevant provisions of the Companies Act, 2013 (Collectively, IND AS), with effect from April 1, 2016 and is required to prepare its financial statements in accordance with Ind AS for the year ended March 31, 2017. Accordingly as per the requirements of Section 129(3) of the Act, these financial statements of the Company has been prepared in the same form and manner as that of its Ultimate Holding Company.

The financial statements the Company have been prepared under the historical cost convention, on accrual basis of accounting principles generally accepted in India. The Balance Sheet and Statement of profit and loss of the Company has been drawn up in the country of its incorporation (United States of America) in the terms of United States Dollar ('USD').

2.2 *Use of estimates*

The preparation of the financial statements in conformity with Ind AS requires management to make estimates and assumptions that affect the reported amount of assets and liabilities and disclosure of contingent liabilities on the date of the financial statements and the reported amount of income and expenses for the period. Management believes that the estimates made in the preparation of financial statements are prudent and reasonable. Actual results could differ from those estimates. Any revisions to accounting estimates are recognised prospectively in current and future periods. Application of accounting policies that require critical accounting estimates involving complex and subjective judgments and the use of assumptions in these financial statements have been disclosed.

2.3.1 *Critical accounting estimates*

Property, plant and equipment

The charge in respect of periodic depreciation is derived after determining an estimate of an asset's expected useful life and the expected residual value at the end of its life. The useful lives and residual values of the Company's assets are determined by management at the time the asset is acquired and reviewed periodically, including at each financial year end. The lives are based on historical experience with similar assets as well as anticipation of future events, which may impact their life, such as changes in technology.

2.4 *Revenue recognition*

Revenue from contact centre and transaction processing services comprises from both time/unit price and fixed fee based service contracts. Revenue from time/unit price based contracts is recognised on completion of the related service and is billed in accordance with contractual terms specified in the respective customer contracts.
Customer contracts. Revenue from fixed fee based service contracts is recognized on achievement of performance milestones specified in the customer contracts.

Unbilled receivables represent costs incurred and revenues recognized on contracts to be billed in subsequent periods as per the terms of the contract.

Dividend income is recognized when the right to receive dividend is established.

Interest income is recognized using the time proportion method, based on the underlying interest rates.

2 Significant accounting policies *(continued)*

2.5 Property, plant and equipment

Asset category	Useful life (in years)
Tangible assets	
Leasehold improvements	Lease term or 5 years, whichever is shorter
Computers*	2 – 4
Service equipment*	2 – 5
Furniture and fixtures*	2 – 5
Office equipment*	2 – 5
Vehicles	2 – 5
Intangible assets	
Software*	2 – 4

* For these class of assets, based on internal assessment and independent technical evaluation carried out by external valuers, the management believes that the useful lives as given above best represent the period over which management expects to use these assets. Hence the useful lives for these assets is different from the useful lives as prescribed under Part C of Schedule II to the Companies Act, 2013.

Depreciation methods, useful lives and residual values are reviewed periodically at the end of each financial year.
The Company has elected to apply fair value method on transition for Leasehold improvements as permitted under Ind AS 16 - Property, plant and equipments.

2.6 Impairment

a. Financial assets

The Company recognizes loss allowances using the expected credit loss (ECL) model for the financial assets which are not fair valued through profit and loss. Loss allowance for trade receivables with no significant financing component is measured at an amount equal to lifetime ECL. For all other financial assets, expected credit losses are measured at an amount equal to the 12 month expected credit losses or at an amount equal to the life time expected credit losses if the credit risk on the financial asset has increased significantly since initial recognition.

b. Non-financial assets

i Intangible assets and property, plant and equipment

Intangible assets and property, plant and equipment are evaluated for recoverability whenever events or changes in circumstances indicate that their carrying amounts may not be recoverable. For the purpose of impairment testing, the recoverable amount (i.e. the higher of the fair value less cost to sell and the value-in-use) is determined on an individual asset basis unless the asset does not generate cash flows that are largely independent of those from other assets. In such cases, the recoverable amount is determined for the CGU to which the asset belongs.

If such assets are considered to be impaired, the impairment to be recognized in the statement of profit and loss is measured by the amount by which the carrying value of the assets exceeds the estimated recoverable amount of the asset. An impairment loss is reversed in the statement of profit and loss if there has been a change in the estimates used to determine the recoverable amount. The carrying amount of the asset is increased to its revised recoverable amount, provided that this amount does not exceed the carrying amount that would have been determined (net of any accumulated amortization or depreciation) had no impairment loss been recognized for the asset in prior years.

2.7 Foreign Currency transactions

Transactions in foreign currency are recorded at the exchange rate prevailing on the date of the transaction. Net exchange gain or loss resulting in respect of foreign exchange transactions settled during the period is, recognized in the statement of profit and loss. Foreign currency denominated assets and liabilities other than fixed assets at year end are translated at the year end exchange rates and the resulting net gain or loss is recognized in the statement of profit and loss. Non Monetary assets are carried at historical cost.

2 Significant accounting policies *(continued)*

2.8 Taxation

Income-tax expense comprises current tax (i.e. amount of tax for the period determined in accordance with the income-tax law) and deferred tax charge or credit (reflecting the tax effects of timing differences between accounting income and taxable income for the year). The deferred tax charge or credit and the corresponding deferred tax liabilities or assets are recognized using the tax rates that have been enacted or substantively enacted by the balance sheet date. Deferred tax assets are recognized only to the extent there is reasonable certainty that the assets can be realized in future. The tax liability (Income tax and deferred tax) is computed on a consolidated basis and hence the tax liabilities for the company have been included in the financial statements of the parent company fe Firstsource Group USA, Inc.

2.9 Employee benefits

Defined contribution plans

The Companies having a savings and investment plan under section 401 (K) of the internal revenue code of the United States of America. This is a Defined Contribution plan. Contribution made under the plan are charged to the statement of Profit and loss in the period in which that accure. Other retirement benefits are accrued based on the amounts payable as per local regulations.

Contributions payable to the social security, medicare and other employee related contributions as required under the State of New york are charged to the statement of profit and loss.

Other long-term employee benefits

Compensated absences

Provision for compensated absences cost has been made based on eligible vacation balances at balance sheet date.

Where employees of the Company are entitled to compensated absences, the employees can carry-forward a portion of the unutilized accrued compensated absence and utilise it in future periods or receive cash compensation at termination of employment for the unutilised accrued compensated absence. The Company records an obligation for compensated absences in the period in which the employee renders the services that increase this entitlement.

2.10 Leases

Finance leave

Assets acquired on finance leases, including assets acquired under sale and lease back transactions, have been recognised as an asset and a liability at the inception of the lease and have been recorded at an amount equal to the lower of the fair value of the leased asset or the present value of the future minimum lease payments. Such leased assets are depreciated over the lease term or its estimated useful life, whichever is shorter. Further, the instalments of minimum lease payments have been apportioned between finance charge / expense and principal repayment. Assets given on finance lease are shown as amounts recoverable from the lessee. The rentals received on such leases are apportioned between the finance income and principal amount using the implicit rate of return.

The finance charge / (income) is recognised as income, and principal received is reduced from the amount receivable. All initial direct costs incurred are included in the cost of the asset.

Operating lease

Lease arrangements where the risks and rewards incidental to ownership of an asset substantially vest with the lessor, are recognised as operating lease. Operating lease payments are recognised on a straight line basis over the lease term, unless the increase is on account of inflation, in the statement of profit and loss.

2 Significant accounting policies *(continued)*

2.11 Earnings per equity share

The basic earnings per equity share is computed by dividing the net profit or loss for the period attributable to the equity shareholders by the weighted average number of equity shares outstanding during the reporting period. The number of shares used in computing diluted earnings per share comprises the weighted average number of shares considered for deriving basic earnings per share, and also the weighted average number of equity shares which may be issued on the conversion of all dilutive potential shares, unless the results would be anti-dilutive.

2.12 Provisions and contingencies

The Company creates a provision when there is present obligation as a result of a past event that probably requires an outflow of resources and a reliable estimate can be made of the amount of the obligation. A disclosure for a contingent liability is made when there is a possible obligation or a present obligation that may, but probably will not, require an outflow of resources. When there is a possible obligation or a present obligation in respect of which the likelihood of outflow of resources is remote, no provision or disclosure is made. Provisions are reviewed at each balance sheet date and adjusted to reflect the current best estimate. If it is no longer probable that an outflow of resources would be required to settle the obligation, the provision is reversed.

Contingent assets are not recognised in the financial statements. However, contingent assets are assessed continually and if it is virtually certain that an economic benefit will arise, the asset and related income are recognised in the period in which the change occurs.

2.13 Financial instruments

2.13.1 Initial recognition

Financial assets and liabilities are recognised when the Company becomes a party to the contractual provisions of the instrument. Financial assets and liabilities are initially measured at fair value. Transaction costs that are directly attributable to the acquisition or issue of financial assets and financial liabilities (other than financial assets and financial liabilities at fair value through profit or loss) are added to or deducted from the fair value measured on initial recognition of financial asset or financial liability.

a) Non-derivative financial instruments

i) Cash and cash equivalents

The Company considers all highly liquid financial instruments, which are readily convertible into known amounts of cash that are subject to an insignificant risk of change in value and having original maturities of three months or less from the date of purchase, to be cash equivalents. Cash and cash equivalents consist of balances with banks which are unrestricted for withdrawal and usage.

2.13.2 Classification and subsequent measurement

i) Financial assets at amortised cost

Financial assets are subsequently measured at amortised cost if these financial assets are held within a business whose objective is to hold these assets in order to collect contractual cash flows and the contractual terms of the financial asset give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding.

ii) Financial assets at fair value through other comprehensive income ('FVOCI')

Financial assets are measured at fair value through other comprehensive income if these financial assets are held within a business whose objective is achieved by both collecting contractual cash flows and selling financial assets and the contractual terms of the financial asset give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding.The Company has made an irrevocable election to present in other comprehensive income subsequent changes in the fair value of equity investments not held for trading.

iii) Financial assets at fair value through profit and loss ('FVTPL')

Financial assets are measured at fair value through profit and loss unless it is measured at amortised cost or at fair value through other comprehensive income on initial recognition. The transaction costs directly attributable to the acquisition of financial assets and liabilities at fair value through profit and loss are immediately recognised in statement of profit and loss.

2 **Significant accounting policies** *(continued)*

2.13 Financial instruments (continued)

2.13.2 Classification and subsequent measurement (continued)

iv) Financial liabilities

Financial liabilities are measured at amortised cost using the effective interest method. For trade and other payables maturing within one year from the balance sheet date, the carrying amount approximate fair value to short-term maturity of these instruments

v) Equity instruments

An equity instrument is a contract that evidences residual interest in the assets of the company after deducting all of its liabilities. Equity instruments are recognised by the Company at the proceeds received net of direct issue cost.

b) Share capital

Ordinary shares

Ordinary shares are classified as equity. Incremental costs directly attributable to the issuance of new ordinary shares and share options are recognized as a deduction from equity, net of any tax effects.

De-recognition of financial instruments

The Company de-recognises a financial asset when the contractual rights to the cash flows from the financial assets expire or it transfers the financial assets and such transfer qualifies for de-recognition under Ind AS 109. A financial liability (or a part of financial liability) is de-recognised from the Company's balance sheet when obligation specified in the contract is discharged or cancelled or expired.

Fair value of financial instrument

In determining the fair value of its financial instrument, the Company uses the methods and assumptions based on market conditions and risk existing at each reporting date. Methods of assessing fair value result in general approximation of value, and such value may never actually be realized. For all other financial instruments, the carrying amounts approximate the fair value due to short maturity of those instruments.

2.14 Cash flow statement

Cash flows are reported using the indirect method, whereby profit for the period is adjusted for the effects of transactions of a non-cash nature, any deferrals or accruals of past or future operating cash receipts or payments and item of income or expenses associated with investing or financing cash flows. The cash flows from operating, investing and financing activities of the Company are segregated.

2.15 Onerous contracts

Provisions for onerous contracts are recognised when the expected benefits to be derived by the Company from a contract are lower than the unavoidable costs of meeting the future obligations under the contract. The provision is measured at lower of the expected cost of terminating the contract and the expected net cost of fulfilling the contract.

3) First-time adoption of Ind AS

These financial statements of Firstsource Transaction Services LLC for the year ended 31 March 2017 have been prepared in accordance with Ind AS. For the purposes of transition to Ind AS, the Company has followed the guidance prescribed in Ind AS 101 - First Time adoption of Indian Accounting Standard, with 1 April 2015 as the transition date and IGAAP as the previous GAAP.

The transition to Ind AS has resulted in changes in the presentation of the financial statements, disclosures in the notes thereto and accounting policies and principles. The accounting policies set out in note 2 have been applied in preparing the financial statements for the year ended 31 March 2017 and the comparative information. An explanation of how the transition from IGAAP to Ind AS has affected the Company's balance sheet and statement of profit and loss is set out in Notes 3.1 and 3.2.

3.1) Reconciliation of equity as previously reported under IGAAP to Ind AS

	Note	Opening balance sheet as at 1 April 2015			Balance sheet as at 31 March 2016		
		IGAAP	Effect of transition to Ind AS	IND AS	IGAAP	Effect of transition to Ind AS	IND AS
ASSETS							
Non-current assets							
Property, plant and equipment		1,366,450		1,366,450	1,502,516		1,502,516
Capital work-in-progress		-		-	72,419		72,419
Other intangible assets		128,018		128,018	913,014		913,014
Financial assets							
Other financial assets		234,281		234,281	232,288		232,288
Others non-current assets		65,531		65,531	44,329		44,329
Total non-current assets		1,794,280	-	1,794,280	2,764,566	-	2,764,566
Current assets							
Financial assets							
Trade receivables		12,344,921		12,344,921	12,138,398		12,138,398
Cash and cash equivalents		68,241		68,241	111,067		111,067
Other financial assets		60,994		60,994	72,539		72,539
Other current assets		4,710,849	-	4,710,849	9,968,675	-	9,968,675
Total current assets		17,185,005	-	17,185,005	22,290,679	-	22,290,679
Total assets		18,979,285	-	18,979,285	25,055,245	-	25,055,245
EQUITY AND LIABILITIES							
Equity							
Equity share capital		-		-	-		-
Other equity		15,593,617	(11,888)	15,605,505	20,953,101	(11,888)	20,964,989
Total equity attributable to equity share holders of the company		15,593,617	(11,888)	15,605,505	20,953,101	(11,888)	20,964,989
LIABILITIES							
Non-current liabilities							
Financial liabilities							
Long-term borrowings		4,934		4,934	1,718		1,718
Total non-current liabilities		4,934		4,934	1,718		1,718
Current liabilities							
Financial liabilities							
Short-term borrowings		6,637		6,637	5,585		5,585
Trade and other payables		737,085	11,888	725,197	657,638	11,888	645,750
Provision for employee Benefits		786,356		786,356	739,887		739,887
Other liabilities		1,850,657		1,850,657	2,697,316		2,697,316
Total current liabilities		3,380,735	11,888	3,368,847	4,100,426	11,888	4,088,538
Total equity and liabilities		18,979,285	-	18,979,285	25,055,245	-	25,055,245

3.2) Reconciliation of statement of profit and loss as previously reported under IGAAP to Ind AS

	Note	Year ended 31 March 2016		
		IGAAP	Effect of transition to Ind AS	Ind AS
Revenue from operations		92,879,629	-	92,879,629
Total income		92,879,782	-	92,879,782
Expenses				
Cost Of Sales		14,060,377		14,060,377
Employee benefits expense		60,715,946		60,715,946
Finance costs		28,227		28,227
Depreciation and amortisation		788,891		788,891
Other expenses		11,926,857		11,926,857
Total expenses		87,520,298	-	87,520,298
Profit before taxation		5,359,484	-	5,359,484
Tax expenses				
- Current tax			-	-
- Deferred tax			-	-
Profit for the period		5,359,484	-	5,359,484
Other comprehensive income				
Total comprehensive income for the period		5,359,484	-	5,359,484

4) **Property, plant and equipment (continued)**

Amount in USD

Particulars	Computers	Network	Vehicles	Office Equipment	Furniture & Fixture	Leasehold Improvements	Total	Software	Grand Total
Gross block (at deemed cost)									
As at 1 April 2016	3,532,052	660,381	85,584	523,362	2,575,579	1,319,449	8,696,407	3,982,370	12,678,777
Additions / adjustments during the year	136,597	394,267	-	72,656	5,974	13,214	622,708	195,323	818,031
Deletions during the year							-	(532,368)	(532,368)
As at 31 March 2017	3,668,649	1,054,648	85,584	596,018	2,581,553	1,332,663	9,319,115	3,645,325	12,964,440
Accumulated depreciation / amortization									
As at 1 April 2016	3,193,912	361,026	67,118	231,045	2,225,572	1,115,217	7,193,891	3,069,356	10,263,247
Charge for the year	163,731	130,281	9,213	99,912	104,311	38,909	546,357	234,297	780,654
On deletions / adjustments during the year								(139,433)	(139,433)
As at 31 March 2017	3,357,643	491,307	76,331	330,957	2,329,883	1,154,126	7,740,248	3,164,220	10,904,468
Net block									
As at 31 March 2017	311,006	563,341	9,253	265,061	251,670	178,537	1,578,867	481,105	2,059,972
As at 31 March 2016	338,140	299,355	18,466	292,316	350,007	204,232	1,502,516	913,014	2,415,530

4) **Property, plant and equipment (continued)**

Particulars	Tangible Asset							Intangible Asset	Grand Total
	Computers	Network	Vehicles	Office Equipment	Furniture & Fixture	Leasehold Improvements	Total	Software	
Gross block (at deemed cost)									
As at 1 April 2015	3,519,845	583,979	85,584	356,315	2,471,788	1,238,185	8,255,696	2,990,631	11,246,327
Additions / adjustments during the year	183,898	141,533	-	169,316	141,486	81,264	717,497	992,457	1,709,954
Transfer	-	-	-		-	-	-	-	-
Deletions during the year	171,691	65,131	-	2,269	37,695	-	276,786	718	277,504
As at 31 March 2016	3,532,052	660,381	85,584	523,362	2,575,579	1,319,449	8,696,407	3,982,370	12,678,777
Accumulated depreciation / amortization									
As at 1 April 2015	3,202,181	250,939	55,326	144,118	2,171,240	1,065,442	6,889,247	2,862,613	9,751,862
Charge for the year	163,422	175,218	11,792	89,196	92,026	49,775	581,430	207,460	788,891
Transfer to OAL							-		-
On deletions / adjustments during the year	171,691	65,131	-	2,269	37,695	-	276,785	718	277,503
							-		
As at 31 March 2016	3,193,912	361,026	67,118	231,045	2,225,572	1,115,217	7,193,891	3,069,356	10,263,247
Net block									
As at 31 March 2016	338,140	299,355	18,466	292,316	350,007	204,232	1,502,516	913,014	2,415,530
As at 31 March 2015	317,664	333,040	30,258	212,197	300,548	172,743	1,366,450	128,018	1,494,468

	Amount in USD 31 March 2017	31 March 2016	Amount in USD 1 April 2015
5) Other financial assets			
(i) Other non-current financial assets			
Deposits	215,896	232,288	234,281
	215,896	232,288	234,281
(ii) Other current financial assets			
Unbilled receivables	483,685	72,539	60,994
	483,685	72,539	60,994
Financial assets carried at amortised cost	699,581	304,827	295,275
6) Other assets			
(i) Other non-current assets			
(Unsecured, considered good)			
Prepaid expenses	124,973	44,329	65,531
	124,973	44,329	65,531
(ii) Other current assets			
Advances to subsidiaries	13,566,987	9,434,232	4,338,825
Prepaid expenses	725,364	532,493	372,024
Other advances	38	1,950	-
	14,292,389	9,968,675	4,710,849
7) Trade receivables			
(Unsecured)			
Considered doubtful	-	162,500	19,691
	-	162,500	19,691
Less: Impairment allowance	-	162,500	19,691
	-	-	-
Considered good	10,339,400	12,138,398	12,344,921
	10,339,400	12,138,398	12,344,921
8) Cash and cash equivalents			
Balances with banks			
in current accounts	-	111,067	68,241
	-	111,067	68,241

	Amount in USD 31 March 2017	31 March 2016	Amount in USD 1 April 2015
9) Share capital			
Authorised			
Issued, subscribed and paid-up	-	-	-
	-	-	-
10) Trade Payables			
Trade Payables	690,101	645,750	725,197
	690,101	645,750	725,197
11) Other financial liabilities			
Other current financial liabilities			
Book credit in bank account	261,655	-	-
	261,655	-	-
12) Provision for employee benefits			
Current			
Compensated absences	498,629	739,887	786,356
	498,629	739,887	786,356
13) Financial Liabilities			
(i) Long term Borrowings			
loan from Non Banking Financial Institutions	-	1,718	4,934
	-	1,718	4,933.64
Short term Borrowings			
loan from Non Banking Financial Institutions	2,215	5,585	6,637
	2,215	5,585	6,637
(iii) Other current liabilities			
Statutory Dues	116,393	247,956	135,265
Employee benefits payable	2,298,135	2,449,360	1,700,190
Payable to Client	-	-	15,201
	2,414,528	2,697,316	1,850,657

		Amount in USD Year ended 31 March 2017	31 March 2016
14)	**Revenue from operations**	90,709,697	92,879,629
		90,709,697	92,879,629
15)	**Other income**		
	Foreign exchange gain, net	(2,321)	(742)
	Miscellaneous income	659	895
		(1,662)	153
16)	**Employee benefits expense**		
	Salaries and wages	52,626,767	55,465,202
	Contribution to provident and other funds	259,453	269,528
	Staff welfare expenses	4,922,843	4,981,216
		57,809,063	60,715,946
17)	**Finance cost**		
	Interest expense	44,587	28,227
		44,587	28,227
18)	**Other expenses**		
	Rent	2,606,761	1,897,139
	Repairs, maintenance and upkeep	1,029,120	1,038,571
	Insurance	592,024	552,027
	Rates and taxes	137,172	9,644
	Legal and professional fees	1,226,778	951,526
	Car and other hire charges	2,527,177	1,999,021
	Information and communication expenses	1,684,763	1,222,311
	Recruitment and training expenses	457,011	278,670
	Marketing and Supporting Sevices	230,153	134,859
	Outsource Cost	320,628	472,439
	Electricity, water and power consumption	394,484	415,820
	Registration fees	9,848	675
	Travel and conveyance	568,093	624,905
	Computer expenses	581,235	863,087
	Printing and stationery	472,090	621,510
	Provision for doubtful debts/ written off/ (written back), net	(162,500)	142,809
	Common corporate cost	652,829	670,162
	Charitable Contribution	500	-
	(Gain)/Loss on sale of Fixed assets	-	768
	Bank administration charges	19,139	15,774
	Miscellaneous expenses	22,512	15,140
		13,369,817	11,926,857

19) Financial instruments

I. Financial instruments by category:

	Amortized cost	FVTPL	FVOCI	Total carrying amount	Total fair value
Financial assets					
Trade receivables	10,339,400	-	-	10,339,400	10,339,400
Other financial assets	699,581	-	-	699,581	699,581
Total	11,038,981	-	-	11,038,981	11,038,981
Financial liabilities					
Other financial liability	261,655		-	261,655	261,655
Trade and other payables	690,101	-	-	690,101	690,101
Total	951,756	-	-	951,756	951,756

The carrying value and fair value of financial instruments by categories as of 31 March 2016 were as follows:

	Amortized cost	FVTPL	FVOCI	Total carrying amount	Total fair value
Financial assets					
Investments			-	-	-
Trade receivables	12,138,398		-	12,138,398	
Cash and cash equivalents	111,067		-	111,067	
Other financial assets	72,539		-	72,539	
Total	12,322,004	-	-	12,322,004	-
Financial liabilities					
Trade and other payables	645,750		-	645,750	
Total	645,750	-	-	645,750	-

The carrying value and fair value of financial instruments by categories as of 1 April 2015 were as follows:

	Amortized cost	FVTPL	FVOCI	Total carrying amount	Total fair value
Financial assets					
Trade receivables	12,344,921		-	12,344,921	12,344,921
Cash and cash equivalents	68,241		-	68,241	68,241
Other financial assets	60,994		-	60,994	60,994
Total	12,474,156	-	-	12,474,156	12,474,156
Financial liabilities					
Borrowings	4,934		-	4,934	4,934
Trade and other payables	725,197		-	725,197	725,197
Total	730,131	-	-	730,131	730,131

19) **Financial instruments** *(continued)*

II. Financial risk management:

The Company operates in the US and there is no major transactions outside the US, so there is no major market risk for the Company.

b) **Credit Risk**

Credit risk refers to the risk of default on its obligation by the counterparty resulting in a financial loss. The maximum exposure to the credit risk at the reporting date is primarily from trade receivables amounting to USD 10,339,400, USD 12,138,398 and USD 12,344,920 as of 31 March 2017, 31 March 2016 and 1 April 2015 respectively and unbilled revenue amounting to USD 483,685, USD 72,539 and USD 60,994 as of 31 March 2017, 31 March 2016 and 1 April 2015, respectively. Trade receivables and unbilled revenue are typically unsecured and are derived from revenue earned from customers primarily located in the United States. Credit risk has always been managed by the Company by continuously monitoring the credit worthiness of customers to which the Company grants credit terms in the normal course of business.

c) **Liquidity Risk**

Liquidity risk is the risk that the company will encounter difficulty in meeting the obligations associated with its financial liabilities that are settled by delivering cash or another financial asset. The Company's approach to manage liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risk to the Company's reputation.

The table below provides details regarding the contractual maturities of significant financial liabilities as of 31 March 2017, 31 March 2016 and 1 April 2015:

	31 March 2017		31 March 2016		01 April 2015	
	Less than 1 Year	More than 1 year	Less than 1 Year	More than 1 year	Less than 1 Year	More than 1 year
Trade payables	690,101	-	645,750	-	725,197	-
Other borrowings	2,215	-	5,585	1,718	6,637	4,934
Book credit in bank account	261,655	-	-	-		-

20) **Leases**

Operating lease

The Company is obligated under Cancellable operating leases for office space and office equipment which are renewable on a periodic basis at the option of both the lessor and lessee. Expenses under cancellable operating leases for the year ended 31 March 2017 aggregated to USD 2,606,761 (31 March 2016: USD 1,897,139).Expenses under non-cancellable operating leases for the year ended 31 March 2017 is Nil.

21) Related party transactions

Details of related parties including summary of transactions entered into during the year ended 31 March 2017 are summarized below:

Ultimate Holding Company	Firstsource Solutions Ltd
Fellow Subsidiary Companies	MedAssist Holding, Inc.,
	Firstsource Solutions USA LLC (earlier known as MedAssist LLC)
	Firstsource Solution UK Limited
	Firstsource Process Management Services Limited (earlier known as Anunta Tech Infrastructure Services Limited)
	Firstsource BPO Ireland Limited
	Firstsource Dialog Solutions (Private) Ltd.
	Firstsource Business Process Services LLC
	Firstsource Solutions USA LLC
	ISGN Fulfillment Services, Inc
	ISGN Solutions, Inc.
	One Advantage LLC
Directors	Venkat Raman
	Arjun Mitra

Particulars of related party transactions:

Name of the related party	Description	Transaction value during year ended		Receivable / (Payable) at	
		31 March 2017	31 March 2016	31 March 2017	31 March 2016
Firstsource Solutions Limited	Cost of Sales	15,950,169	14,060,377	-	-
	Recovery of expenses	51,447	18,222	-	-
	Reimbursement of expenses	1,002,851	951,973	-	-
	Receiveable / (Payable)	-	-	(14,502,873)	(5,426,289)
Firstsource Group USA Inc	Reimbursement of expenses	3,684,853	2,415,699	-	-
	Recovery of expense	1,063,674	404,624	-	-
	Receiveable / (Payable)	-	-	42,911,631	19,208,599
Mediassit Holdings LLC	Reimbursement of expenses	7,239,443	7,205,227	-	-
	Recovery of expense	431,898	346,448	-	-
	Receiveable / (Payable)	-	-	(14,633,201)	(7,514,155)
Firstsource Advantage LLC	Reimbursement of expenses	64,658	99,082	-	-
	Recovery of expense	2,549	5,393	-	-
	Receiveable / (Payable)	-	-	(23,947)	4,881,092
ISGN Solutions, Inc.	Recovery of expense	6,422	-	-	-
	Receiveable / (Payable)	-	-	6,422	
ISGN Fulfillment Services, Inc	Reimbursement of expenses	219,891	-	-	-
	Recovery of expense	24,306	-	-	-
	Receiveable / (Payable)	-	-	(195,075)	-
One Advantage LLC	Reimbursement of expenses	3,226	17,468	-	-
	Recovery of expense	7,702	2,453	-	-
	Receiveable / (Payable)	-	-	4,030	(1,715,015)

22) Segment reporting

As per Ind AS 108 - Operating Segment, if a financial report contains both consolidated financial statements of a parent that is within the scope of this Ind AS as well as the parent's separate financial statements, segment information is required only in the consolidated financial statements. Accordingly, information required to be presented under Ind AS 108 - Operating Segment has been given in the consolidated financial statements of the Ultimate Holding Company.

23) Capital and other commitments and contingent liabilities

The Company has capital commitments of USD 49,425 (31 March 2016: USD 1,363,963) as at the balance sheet date. Their are no contingent liabilities as at the balance sheet date.

24) Long-term contracts

The Company has a process whereby periodically all long-term contracts (including derivative contracts) are assessed for material foreseeable losses. At the period end, the Company has reviewed and ensured that adequate provision as required under any law / Accounting Standards for material foreseeable losses on such long term contracts (including derivative contracts) has been made in the books of account.

25) Subsequent events

The Board of directors at its meeting held on 5 May 2017 approved the financial statements of the company for the year ended 31 March 2017. The company evaluated subsequent events from the balance sheet date through 5 May 2017 and determined there are no material items to report.

As per our report of even date attached.

For SHELESH SINGHVI & CO.
Chartered Accountants
Firm's Registration No: 014792C

Shelesh Singhvi
Partner
Membership No: 079817

May 5, 2017

Mumbai

Shelesh Singhvi & Co. Chartered Accountants Mumbai

For and on behalf of the Board of Directors

Venkat Raman
Director

Arjun Mitra
Director

Firstsource Transaction Services LLC

Special Purpose Financial statements
together with the Independent Auditors' Report
for the year ended 31 March 2018

Firstsource Transaction Services LLC

Special Purpose Financial statements together with the Independent Auditors' Report

for the year ended 31 March 2018

Contents

Firstsource Transaction Services LLC

Balance sheet

as at 31 March 2018

(Currency: In US Dollar)

	Note	**31 March 2018**	31 March 2017
ASSETS			
Non-current assets			
Property, plant and equipment	*3*	**1,461,958**	1,578,867
Capital work-in-progress		**27,255**	69,549
Other intangible assets	*3*	**363,545**	481,105
Financial assets			
Other financial assets	*4(i)*	**183,818**	215,896
Other non-current assets	*6(i)*	**116,108**	124,973
Total non-current assets		**2,152,684**	2,470,390
Current assets			
Financial assets			
Trade receivables	*5*	**13,492,980**	10,339,400
Cash and cash equivalents		**-**	-
Other financial assets	*4(ii)*	**14,055,578**	14,050,672
Other current assets	*6(ii)*	**904,320**	725,402
Total current assets		**28,452,878**	25,115,474
Total assets		**30,605,562**	27,585,864
EQUITY AND LIABILITIES			
Equity			
Equity share capital	*7*	**-**	-
Other equity		**25,882,276**	23,718,734
Total equity		**25,882,276**	23,718,734
LIABILITIES			
Current liabilities			
Financial liabilities			
Short-term borrowings	*8*	**-**	2,215
Trade payables		**3,421,391**	2,965,084
Other financial liabilities	*9*	**359,724**	284,809
Provisions for employee benefits	*10*	**686,240**	498,629
Other current liabilities	*11*	**255,931**	116,393
Total current liabilities		**4,723,286**	3,867,130
Total equity and liabilities		**30,605,562**	27,585,864
Significant accounting policies	*2*		

The accompanying notes from 1 to 23 are an integral part of these financial statements.

As per our report of even date attached.

For DELOITTE HASKINS & SELLS LLP
Chartered Accountants
Firm's Registration No: 117366W/W-100018

G.K. Subramaniam
Partner
Membership No: 109839
13 July 2018
Mumbai

For and on behalf of the Board of Directors

Arjun Mitra
Director

Venkat Raman
Director

Firstsource Transaction Services LLC

Statement of profit and loss

for the year ended 31 March 2018
(Currency: In US Dollar)

	Note	Year ended 31 March 2018	31 March 2017
INCOME			
Revenue from operations	*12*	**90,830,835**	90,709,697
Other income,net	*13*	**(15,860)**	(1,662)
Total income		**90,814,975**	90,708,035
EXPENSES			
Services rendered by business associates and others		**17,313,337**	16,232,900
Employee benefits expenses	*14*	**56,664,664**	57,898,542
Finance costs	*15*	**42,246**	44,587
Depreciation and amortisation expense	*3*	**1,093,356**	780,654
Other expenses	*16*	**13,537,830**	12,997,607
Total expenses		**88,651,433**	87,954,290
Profit before tax		**2,163,542**	2,753,745
Tax expense			
Current tax		**-**	-
Deferred tax		**-**	-
Profit for the year		**2,163,542**	2,753,745
Other comprehensive income			
Total other comprehensive income, net of taxes		**-**	-
Total comprehensive income for the year		**2,163,542**	2,753,745

Significant accounting policies *2*

The accompanying notes from 1 to 23 are an integral part of these financial statements.
As per our report of even date attached.

For DELOITTE HASKINS & SELLS LLP
Chartered Accountants
Firm's Registration No: 117366W/W-100018

G.K. Subramaniam
Partner
Membership No: 109839

13 July 2018
Mumbai

For and on behalf of the Board of Directors

Arjun Mitra
Director

Venkat Raman
Director

Firstsource Transaction Services LLC

Statement of changes in equity

for the year ended 31 March 2018

(Currency: In US Dollar)

Statement of changes in Equity

	Equity share capital	Attributable to owners of the Company Reserve and Retained earnings	Total
Balance as at 1 April 2017	-	23,718,734	23,718,734
Profit for the year	-	2,163,542	2,163,542
Balance as at 31 March 2018	**-**	**25,882,276**	**25,882,276**

Statement of changes in Equity

	Equity share capital	Attributable to owners of the Company Reserve and Retained earnings	Total
Balance as at 1 April 2016	-	20,964,989	20,964,989
Profit for the year	-	2,753,745	2,753,745
Balance as at 31 March 2017	**-**	**23,718,734**	**23,718,734**

As per our report of even date attached.

For DELOITTE HASKINS & SELLS LLP
Chartered Accountants
Firm's Registration No: 117366W/W-100018

For and on behalf of the Board of Directors

G.K. Subramaniam
Partner
Membership No: 109839

Arjun Mitra
Director

Venkat Raman
Director

13 July 2018
Mumbai

Firstsource Transaction Services LLC

Statement of cash flows

for the year ended 31 March 2018

(Currency: In US Dollar)

	31 March 2018	31 March 2017
Cash flow from operating activities		
Profit before tax	**2,163,542**	2,753,745
Adjustments for		
Depreciation and amortisation	**1,093,356**	780,654
Provision for doubtful debts	**140,000**	-
Finance costs	**42,246**	44,587
Loss on sale of Fixed Assets, net	**15,038**	
Operating cash flow before changes in working capital	**3,454,182**	3,578,986
Changes in working capital		
(Increase) / Decrease in trade receivables	**(3,293,580)**	1,798,998
(Increase) / Decrease in loans and advances and other assets	**(142,881)**	(4,799,112)
Increase / (Decrease) in liabilities and provisions	**858,371**	(206,150)
Net changes in working capital	**(2,578,090)**	(3,206,264)
Income taxes paid		
Net cash generated from / (used in) operating activities (A)	**876,092**	372,722
Cash flow from investing activities		
Purchase of property plant and equipment and intangible assets	**(849,267)**	(422,226)
Proceeds from Sale of fixed assets	**17,636**	-
Net cash generated from / (used in) investing activities (B)	**(831,631)**	**(422,226)**
Cash flow from financing activities		
(Repayment) / Proceeds from short term borrowings*	**(2,215)**	(5,088)
Interest paid	**(42,246)**	(44,587)
Net cash generated from / (used in) financing activities (C)	**(44,461)**	(49,675)
Net Increase / (decrease) in cash and cash equivalents at the end of the year (A+B+C)	-	(99,179)
Cash and cash equivalents at the beginning of the year	-	99,179
Cash and cash equivalents at the end of the year	-	-

Notes to the cash flow statement

Cash and cash equivalents consist of cash on hand and balances with bank. Cash and cash equivalents included in the cash flow statement comprise the following balance sheet amounts:

	31 March 2018	31 March 2017
Cash on hand	-	-
Balances with banks	-	-
- in current accounts	-	-
Cash and cash equivalents	-	-

As per our report of even date attached.

For DELOITTE HASKINS & SELLS LLP
Chartered Accountants
Firm's Registration No: 117366W/W-100018

For and on behalf of the Board of Directors

G.K. Subramaniam
Partner
Membership No: 109839

Arjun Mitra
Director

Venkat Raman
Director

Mumbai
13 July 2018

Firstsource Transaction Services LLC

Notes to the financial statements
for the year ended 31 March 2018
(Currency: In US Dollar)

1 Company overview

Firstsource Transaction Services LLC ('the Company') was incorporated under the laws of the State of Delaware on 26 May 2011. The Company provides contact centre and transaction processing services for customers in the financial services, telecommunications and healthcare industry. The Company is a wholly owned subsidiary of MedAssist Holding, Inc. who holds the voting rights in the Company.

Basis of Preparation and Statement of Compliance

The special purpose financial statements are prepared in accordance with Indian Accounting Standards (Ind AS), under the historical cost convention on the accrual basis except for certain financial instruments which are measured at fair values and the provisions of the Companies Act, 2013 (the 'Act') (to the extend notified). The Ind AS are prescribed under Section 133 of the Act read with Rule 3 of the Companies (Indian Accounting Standards) Rules, 2015 and Companies (Indian Accounting Standards) Amendment Rules, 2016 (the 'Rules').

These special purpose financial statements have been prepared for the limited purpose of facilitating the preparation of the consolidated financial statements of Firstsource Solutions Limited, the Holding Company, as at and for the year ended March 31, 2018 in accordance with Generally Accepted Accounting Principles in India ('Indian GAAP') and to assist the Holding Company Firstsource Solutions Limited to comply with the requirements of section 129(3) of the Act.

These special purpose financial statements were approved by the Board of Directors of Firstsource Solutions Limited the Holding Company, and authorised for issue on 7 May 2018.

2 Significant accounting policies

2.1 Use of estimates

The preparation of the financial statements in conformity with Ind AS requires management to make estimates and assumptions that affect the reported amount of assets and liabilities and disclosure of contingent liabilities on the date of the financial statements and the reported amount of income and expenses for the period. Management believes that the estimates made in the preparation of financial statements are prudent and reasonable. Actual results could differ from those estimates. Any revisions to accounting estimates are recognised prospectively in current and future periods. Application of accounting policies that require critical accounting estimates involving complex and subjective judgments and the use of assumptions in these financial statements have been disclosed in Note 2.1.1.

2.1.1 Critical accounting estimates

Income taxes

The Company's major tax jurisdiction is United States of America. Significant judgments are involved in determining the provision for income taxes, including amount expected to be paid / recovered for uncertain tax positions. Also refer to Note 2.5.

Property, plant and equipment and Intangible assets

The charge in respect of periodic depreciation/amortisation is derived after determining an estimate of an asset's expected useful life and the expected residual value at the end of its life. The useful lives and residual values of the Company's assets are determined by management at the time the asset is acquired and reviewed periodically, including at each financial year end. The lives are based on historical experience with similar assets as well as anticipation of future events, which may impact their life, such as changes in technology.

2 Significant accounting policies *(continued)*

2.2 Revenue recognition

Revenue from contact centre and transaction processing services comprises from both time / unit price and fixed fee based service contracts. Revenue from time / unit price based contracts is recognised as services are rendered and is billed in accordance with the contractual terms specified in the customer contracts. Revenue from fixed fee based service contracts is recognised on achievement of performance milestones specified in the customer contracts. Unbilled receivables represent costs incurred and revenues recognised on contracts to be billed in subsequent periods as per the terms of the contract.

Dividend income is recognised when the right to receive dividend is established.

For all instruments measured either at amortised cost or at fair value through other comprehensive income, interest income is recorded using the effective interest rate (EIR). EIR is the rate that exactly discounts the estimated future cash payments or receipts over the expected life of the financial instrument or a shorter period, where appropriate, to the gross carrying amount of the financial asset or to the amortised cost of a financial liability. When calculating the effective interest rate, the Company estimates the expected cash flows by considering all the contractual terms of the financial instrument but does not consider the expected credit losses.

2.3 Property, plant and equipment and Intangible assets

Property, plant and equipment and Intangible are stated at cost less accumulated depreciation / amortisation and impairment, if any. Cost includes freight, duties, taxes and incidental expenses related to acquisition and installation of the property, plant and equipment. Depreciation on Property, plant and equipment and intangible assets is provided pro-rata to the period of use based on management's best estimate of useful lives of the assets as summarized below:

Asset category	**Useful life (in years)**
Tangible assets	
Leasehold improvements	Lease term or 5 years, whichever is shorter
Service equipment*	2 – 5
Computers*	2 – 4
Vehicles	2 – 5
Office equipment*	2 – 5
Furniture and fixtures*	2 – 5
Intangible assets	
Software*	2 – 4

* For these class of assets, based on internal assessment and independent technical evaluation carried out by external valuers, the management believes that the useful lives as given above best represent the period over which management expects to use these assets. Hence the useful lives for these assets is different from the useful lives as prescribed under Part C of Schedule II to the Companies Act, 2013.

Depreciation and amortisation methods, useful lives and residual values are reviewed periodically at the end of each financial year.

Borrowing costs are interest and other costs (including exchange differences arising from foreign currency borrowings to the extent that they are regarded as an adjustment to interest costs) incurred by the Company in connection with the borrowing of funds. Borrowing costs directly attributable to acquisition or construction of those property, plant and equipment which necessarily take a substantial period of time to get ready for their intended use are capitalised. Other borrowing costs are recognised as an expense in the period in which they are incurred.

2.4 Impairment

a. Financial assets

The Company recognises loss allowances using the expected credit loss ('ECL') model for the financial assets which are not fair valued through profit and loss. Loss allowance for trade receivables with no significant financing component is measured at an amount equal to lifetime ECL.For all other financial assets, expected credit losses are measured at an amount equal to the 12 month expected credit losses or at an amount equal to the life time expected credit losses if the credit risk on the financial asset has increased significantly since initial recognition.

2 Significant accounting policies *(continued)*

b. Non-financial assets

i Property, plant and equipment and Intangible assets

Property, plant and equipment and Intangible assets are evaluated for recoverability whenever events or changes in circumstances indicate that their carrying amounts may not be recoverable. For the purpose of impairment testing, the recoverable amount (i.e. the higher of the fair value less cost to sell and the value-in-use) is determined on an individual asset basis unless the asset does not generate cash flows that are largely independent of those from other assets. In such cases, the recoverable amount is determined for the cash generating unit to which the asset belongs.

If such assets are considered to be impaired, the impairment to be recognised in the statement of profit and loss is measured by the amount by which the carrying value of the assets exceeds the estimated recoverable amount of the asset. An impairment loss is reversed in the statement of profit and loss if there has been a change in the estimates used to determine the recoverable amount. The carrying amount of the asset is increased to its revised recoverable amount, provided that this amount does not exceed the carrying amount that would have been determined (net of any accumulated amortization or depreciation) had no impairment loss been recognised for the asset in prior years.

***2.5* Income taxes**

Current income taxes
Income-tax expense comprises current tax (i.e. amount of tax for the year determined in accordance with the income-tax law) and deferred tax charge or credit (reflecting the tax effects of timing differences between accounting income and taxable income for the year). The deferred tax charge or credit and the corresponding deferred tax liabilities or assets are recongised using the tax rates that have been enacted or substantively enacted by the balance sheet date. Deferred tax assets are recognised to the extent that it is probable that taxable profit will be available aganist which the deductible temporary differences and the carry forward of unused tax credits and unused tax losses can be recongised.

The income tax liability and deferred tax asset and liability is computed on combined basis for all subsidiaries of First Source Solutions Limited operating in the United States of America.

The Income tax liability and Deferred Tax Asset and Liability are computed on a combined basis and a combined tax return is filed for all subsidiaries of Firstsource Solutions Limited operating in the United States of America and the charge, the asset and the liability is accounted on a combined basis by Firstsource Group USA, Inc. (parent company in the United States of America) in its financial statements. Deferred Tax Asset and Liability and Income tax charge accounted in these Special Purpose Financial Statements relate only to the pre-acquisition period and adjustments thereof.

2 Significant accounting policies *(continued)*

2.6 Foreign Currency transactions

Functional currency

The functional currency of the Company is the US Dollar (USD).

Transactions and translations
Foreign currency denominated monetary assets and liabilities are translated into the relevant functional currency at exchange rates in effect at the balance sheet date. The gains or losses resulting from such translations are included in net profit in the statement of profit and loss. Non-monetary assets and non-monetary liabilities denominated in a foreign currency and measured at fair value are translated at the exchange rate prevalent at the date when the fair value was determined. Non-monetary assets and non-monetary liabilities denominated in a foreign currency and measured at historical cost are translated at the exchange rate prevalent at the date of transaction.

Gains or losses realised upon settlement of foreign currency transactions are included in determining net profit for the period in which the transaction is settled. Revenue, expense and cash flow items denominated in foreign currencies are translated into the relevant functional currencies using the exchange rate in effect on the date of the transaction.

2.7 Employee benefits

Defined contribution plans

The Companies having a savings and investment plan under section 401 (k) of the internal revenue code of the United States of America. This is a Defined Contribution plan. Contributions made under the plan are charged to the Statement of profit and loss in the period in which they accrue. The Company has no further obligation to the plan beyond its monthly contributions. Other retirement benefits, including social security and medicare are accrued based on the amounts payable as per local regulations.

Compensated absences

Provision for compensated absences cost has been made based on eligible vacation balances at balance sheet date.

Employees of the Company are entitled to compensated absences, the employees can carry-forward a portion of the unutilised accrued compensated absence and utilise it in future periods or receive cash compensation at termination of employment for the unutilised accrued compensated absence. The Company records an obligation for compensated absences in the period in which the employee renders the services that increase this entitlement.
The Company measures the expected cost of compensated absences as the additional amount that the Company expects to pay as a result of the unused entitlement that has accumulated at the balance sheet date.

2.8 Leases

Finance lease

Assets acquired on finance leases, including assets acquired under sale and lease back transactions, have been recognised as an asset and a liability at the inception of the lease and have been recorded at an amount equal to the lower of the fair value of the leased asset or the present value of the future minimum lease payments. Such leased assets are depreciated over the lease term or its estimated useful life, whichever is shorter. Further, the instalments of minimum lease payments have been apportioned between finance charge / expense and principal repayment. Assets given on finance lease are shown as amounts recoverable from the lessee. The rentals received on such leases are apportioned between the finance income and principal amount using the implicit rate of return.

The finance charge / (income) is recognised as income, and principal received is reduced from the amount receivable. All initial direct costs incurred are included in the cost of the asset.

Operating lease

Lease arrangements where the risks and rewards incidental to ownership of an asset substantially vest with the lessor, are recognised as operating lease. Operating lease payments are recognised on a straight line basis over the lease term, unless the increase is on account of inflation, in the statement of profit and loss.

2 Significant accounting policies *(continued)*

2.9 Provisions and contingencies

The Company creates a provision when there is present obligation as a result of a past event that probably requires an outflow of resources and a reliable estimate can be made of the amount of the obligation. A disclosure for a contingent liability is made when there is a possible obligation or a present obligation that may, but probably will not, require an outflow of resources. When there is a possible obligation or a present obligation in respect of which the likelihood of outflow of resources is remote, no provision or disclosure is made. Provisions are reviewed at each balance sheet date and adjusted to reflect the current best estimate. If it is no longer probable that an outflow of resources would be required to settle the obligation, the provision is reversed.

Contingent assets are not recognised in the financial statements. However, contingent assets are assessed continually and if it is virtually certain that an economic benefit will arise, the asset and related income are recognised in the period in which the change occurs.

2.10 Financial instruments

2.10.1 Initial recognition

Financial assets and liabilities are recognised when the Company becomes a party to the contractual provisions of the instrument. Financial assets and liabilities are initially measured at fair value. Transaction costs that are directly attributable to the acquisition or issue of financial assets and financial liabilities (other than financial assets and financial liabilities at fair value through profit or loss) are added to or deducted from the fair value measured on initial recognition of financial asset or financial liability.

a) Non-derivative financial instruments

i) Cash and cash equivalents

The Company considers all highly liquid financial instruments, which are readily convertible into known amounts of cash that are subject to an insignificant risk of change in value and having original maturities of three months or less from the date of purchase, to be cash equivalents. Cash and cash equivalents consist of balances with banks which are unrestricted for withdrawal and usage.

2.10.2 Classification and subsequent measurement

i) Financial assets at amortised cost

Financial assets are subsequently measured at amortised cost if these financial assets are held within a business whose objective is to hold these assets in order to collect contractual cash flows and the contractual terms of the financial asset give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding.

ii) Financial assets at fair value through other comprehensive income ('FVOCI')

Financial assets are measured at fair value through other comprehensive income if these financial assets are held within a business whose objective is achieved by both collecting contractual cash flows and selling financial assets and the contractual terms of the financial asset give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding.The Company has made an irrevocable election to present in other comprehensive income subsequent changes in the fair value of equity investments not held for trading.

iii) Financial assets at fair value through profit and loss ('FVTPL')

Financial assets are measured at fair value through profit and loss unless it is measured at amortised cost or at fair value through other comprehensive income on initial recognition. The transaction costs directly attributable to the acquisition of financial assets and liabilities at fair value through profit and loss are immediately recognised in the statement of profit and loss.

2 Significant accounting policies *(continued)*

2.10 Financial instruments (continued)

2.10.2 Classification and subsequent measurement (continued)

iv) Financial liabilities

Financial liabilities are measured at amortised cost using the effective interest method. For trade and other payables maturing within one year from the balance sheet date, the carrying amount approximate fair value to short-term maturity of these instruments

v) Equity instruments

An equity instrument is a contract that evidences residual interest in the assets of the company after deducting all of its liabilities.
Equity instruments are recognised by the Company at the proceeds received net of direct issue cost.

b) Share capital

Ordinary shares are classified as equity. Incremental costs directly attributable to the issuance of new ordinary shares and share options are recognized as a deduction from equity, net of any tax effects.

2.10.3 De-recognition of financial instruments

The Company de-recognises a financial asset when the contractual rights to the cash flows from the financial assets expire or it transfers the financial assets and such transfer qualifies for de-recognition under Ind AS 109. A financial liability (or a part of financial liability) is de-recognised from the Company's balance sheet when obligation specified in the contract is discharged or cancelled or expired.

2.10.4 Fair value of financial instrument

In determining the fair value of its financial instrument, the Company uses the methods and assumptions based on market conditions and risk existing at each reporting date. Methods of assessing fair value result in general approximation of value, and such value may never actually be realised. For all other financial instruments, the carrying amounts approximate the fair value due to short maturity of those instruments.

2.11 Cash flow statement

Cash flows are reported using the indirect method, whereby profit for the year is adjusted for the effects of transactions of a non-cash nature, any deferrals or accruals of past or future operating cash receipts or payments and item of income or expenses associated with investing or financing cash flows. The cash flows from operating, investing and financing activities of the Company are segregated.

2.12 Onerous contracts

Provisions for onerous contracts are recognised when the expected benefits to be derived by the Company from a contract are lower than the unavoidable costs of meeting the future obligations under the contract. The provision is measured at lower of the expected cost of terminating the contract and the expected net cost of fulfilling the contract.

2.13 Recent accounting pronouncements

Ind AS 21 Foreign currency transactions and advance consideration:

On 28 March 2018, MCA has notified the Companies (Indian Accounting Standards) Amendment Rules, 2018 containing Appendix B to Ind AS 21, Foreign currency transactions and advance consideration which clarifies the date of the transaction for the purpose of determining the exchange rate to use on initial recognition of the related asset, expense or income, when an entity has received or paid advance consideration in a foreign currency. This amendment will come into force from 1 April 2018. The Company has evaluated the effect of this on the financial statements and the impact is not material.

Ind AS 115 Revenue from Contract with Customers:

On 28 March 2018, Ministry of Corporate Affairs has notified the Ind AS115, Revenue from Contract with Customers. The core principle of the new standard is that an entity should recognise revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. Further the new standard requires enhanced disclosures about the nature, amount, timing and uncertainty of revenue and cash flows arising from the entity's contracts with customers. The effective date for adoption of Ind AS 115 is financial periods beginning on or after 1 April 2018. The effect on adoption of Ind AS 115 on the financial statements is expected to be insignificant.

Firstsource Transaction Services LLC

Notes to the financial statements (Continued)

as at 31 March 2018

(Currency: In US Dollar)

3) Property, plant and equipment and Intangible assets

Particulars	Tangible Asset							Intangible Asset	
	Leasehold improvements	Service Equipment	Computers	Vehicles	Office equipment	Furniture and fixture	Total	Softwares	Grand Total
Gross block (at deemed cost)									
As at 1 April 2017	**1,332,663**	**1,054,648**	**3,668,649**	**85,584**	**596,018**	**2,581,553**	**9,319,115**	**3,645,325**	**12,964,440**
Additions / adjustments during the year	**65,412**	**82,923**	**208,190**	**-**	**185,353**	**24,423**	**566,301**	**325,260**	**891,561**
Deletions during the year	**(25,418)**	**(5,761)**	**(3,824)**	**-**	**(234)**	**(19,781)**	**(55,018)**	**-**	**(55,018)**
As at 31 March 2018	**1,372,657**	**1,131,810**	**3,873,015**	**85,584**	**781,137**	**2,586,195**	**9,830,398**	**3,970,585**	**13,800,983**
Accumulated depreciation / amortization									
As at 1 April 2017	**1,154,126**	**491,307**	**3,357,643**	**76,331**	**330,958**	**2,329,883**	**7,740,248**	**3,164,220**	**10,904,468**
Charge for the year	**50,728**	**170,939**	**204,437**	**4,660**	**121,131**	**98,641**	**650,536**	**442,820**	**1,093,356**
On deletions / adjustments during the year	**(7,613)**	**(3,099)**	**(743)**	**-**	**(839)**	**(10,050)**	**(22,344)**	**-**	**(22,344)**
As at 31 March 2018	**1,197,241**	**659,147**	**3,561,337**	**80,991**	**451,250**	**2,418,474**	**8,368,440**	**3,607,040**	**11,975,480**
Net block									
As at 31 March 2018	**175,416**	**472,663**	**311,678**	**4,593**	**329,887**	**167,721**	**1,461,958**	**363,545**	**1,825,503**
As at 31 March 2017	**178,537**	**563,341**	**311,006**	**9,253**	**265,060**	**251,670**	**1,578,867**	**481,105**	**2,059,972**

Particulars	Tangible Asset							Intangible Asset	
	Leasehold improvements	Service Equipment	Computers	Vehicles	Office equipment	Furniture and fixture	Total	Softwares	Grand Total
Gross block (at deemed cost)									
As at 1 April 2016	1,319,449	660,381	3,532,052	85,584	523,362	2,575,579	8,696,407	3,982,370	12,678,777
Additions / adjustments during the year	13,214	394,267	136,597	-	72,656	5,974	622,708	195,323	818,031
Deletions during the year	-	-	-	-	-	-	-	(532,368)	(532,368)
As at 31 March 2017	1,332,663	1,054,648	3,668,649	85,584	596,018	2,581,553	9,319,115	3,645,325	12,964,440
Accumulated depreciation / amortization									
As at 1 April 2016	1,115,217	361,026	3,193,912	67,118	231,046	2,225,572	7,193,891	3,069,356	10,263,247
Charge for the year	38,909	130,281	163,731	9,213	99,912	104,311	546,357	234,297	780,654
On deletions / adjustments during the year	-	-	-	-	-	-	-	(139,433)	(139,433)
As at 31 March 2017	1,154,126	491,307	3,357,643	76,331	330,958	2,329,883	7,740,248	3,164,220	10,904,468
Net block									
As at 31 March 2017	178,537	563,341	311,006	9,253	265,060	251,670	1,578,867	481,105	2,059,972
As at 31 March 2016	204,232	299,355	338,140	18,466	292,316	350,007	1,502,516	913,014	2,415,530

Firstsource Transaction Services LLC

Notes to the financial statements (Continued)

as at 31 March 2018

(Currency: In US Dollar)

		31 March 2018	31 March 2017
4)	**Other financial assets**		
	(Unsecured, considered good)		
	(i) Other non-current financial assets		
	Deposits	**183,818**	215,896
		183,818	215,896
	(ii) Other current financial assets		
	Unbilled receivables	**1,353,745**	483,685
	Advances to Related parties	**12,701,833**	13,566,987
		14,055,578	14,050,672
5)	**Trade receivables**		
	(Unsecured)		
	Considered doubtful	**140,000**	-
	Less: Impairment allowance	**140,000**	-
		-	-
	Considered good	**13,492,980**	10,339,400
		13,492,980	10,339,400

a) Trade receivables are non-interest bearing.

b) No trade or other receivables are due from directors or other officers of the Company either severally or jointly.

c) For receivables from related party refer note 19

6)	**Other assets**		
	(Unsecured, considered good)		
	(i) Other non-current assets		
	Prepaid expenses	**116,108**	124,973
		116,108	124,973
	(ii) Other current assets		
	Prepaid expenses	**826,215**	725,364
	Other advances	**78,105**	38
		904,320	725,402

Firstsource Transaction Services LLC

Notes to the financial statements (Continued)

as at 31 March 2018

(Currency: In US Dollar)

		31 March 2018	31 March 2017
7)	**Share capital**		
	Issued, subscribed and paid-up	**-**	-
		-	-

Management confirms to a framework of capital through agreement without any contributions thereby providing 100% ownership and voting rights and right to 100% of profits / losses. Hence, the financials do not disclose any Earnings per share value.

8)	**Borrowings**		
	Short-term borrowings		
	Unsecured		
	Loan from non-banking financing companies (refer note 'c')	-	2,215
		-	2,215
9)	**Other financial liabilities**		
	Other current financial liabilities		
	Book credit in bank account	**336,570**	261,655
	Creditors for capital goods	**23,154**	23,154
		359,724	284,809
10)	**Provision for employee benefits**		
	Current		
	Compensated absences	**686,240**	498,629
		686,240	498,629
11)	**Other liabilities**		
	Other current liabilities		
	Statutory Dues	**148,810**	116,393
	Others	**107,121**	-
		255,931	116,393

Firstsource Transaction Services LLC

Notes to the financial statements (Continued)

for the year ended 31 March 2018

(Currency: In US Dollar)

		Year ended	
		31 March 2018	31 March 2017
12)	**Revenue from operations**		
	Sale of services	90,830,835	90,709,697
		90,830,835	90,709,697
13)	**Other income**		
	Net Foreign Exchange loss	**(822)**	(2,321)
	Loss on sale of fixed assets, net	**(15,038)**	-
	Miscellaneous income	-	659
		(15,860)	(1,662)
14)	**Employee benefits expense**		
	Salaries and wages	**51,420,812**	52,626,767
	Contribution to social security and other benefits	**248,256**	259,453
	Staff welfare expenses	**4,995,596**	5,012,322
		56,664,664	57,898,542
15)	**Finance cost**		
	Interest expense		
	- on working capital demand loan and others	**42,246**	44,587
		42,246	44,587

16) Other expenses

	Year ended 31 March 2018	31 March 2017
Rent	**2,486,168**	2,606,761
Car and other hire charges	**2,362,276**	2,466,733
Information and communication expenses	**1,633,597**	1,655,539
Connectivity charges	**380,606**	134,513
Legal and professional fees	**1,409,228**	1,264,675
Repairs, maintenance and upkeep	**1,089,149**	993,934
Computer expenses	**767,743**	511,131
Travel and conveyance	**527,836**	628,537
Recruitment and training expenses	**456,399**	457,011
Insurance	**327,152**	502,544
Printing and stationery	**388,700**	481,556
Electricity, water and power consumption	**285,085**	394,484
Provision for doubtful debts/ written off/ (written back), net	**139,999**	(162,500)
Rates and taxes	**130,400**	137,172
Bank administration charges	**15,167**	19,139
Registration and Membership Fees	**15,141**	9,848
Miscellaneous expenses	**331,157**	243,701
Allocated corporate costs	**792,027**	652,829
	13,537,830	12,997,607

17) Financial instruments

I. Financial instruments by category:

The carrying value and fair value of financial instruments by categories as of 31 March 2018 were as follows:

	Amortized cost	FVTPL	FVOCI	Total carrying amount	Total fair value
Financial assets					
Trade receivables	**13,492,980**	-	-	**13,492,980**	**13,492,980**
Other financial assets	**14,239,396**	-	-	**14,239,396**	**14,239,396**
Total	**27,732,376**	-	-	**27,732,376**	**27,732,376**
Financial liabilities					
Other financial liability	**359,724**	-	-	**359,724**	**359,724**
Trade payables	**3,421,391**	-	-	**3,421,391**	**3,421,391**
Total	**3,781,115**	-	-	**3,781,115**	**3,781,115**

The carrying value and fair value of financial instruments by categories as of 31 March 2017 were as follows:

	Amortized cost	FVTPL	FVOCI	Total carrying amount	Total fair value
Financial assets					
Trade receivables	10,339,400	-	-	10,339,400	10,339,400
Other financial assets	14,266,568	-	-	14,266,568	14,266,568
Total	24,605,968	-	-	24,605,968	24,605,968
Financial liabilities					
Borrowings	2,215	-	-	2,215	2,215
Other financial liability	284,809	-	-	284,809	284,809
Trade payables	2,965,084	-	-	2,965,084	2,965,084
Total	3,252,108	-	-	3,252,108	3,252,108

Fair value hierachy for the above stated financial assets and liabilities is using measurement principles at Level 3 as at 31 March 2018 and 31 March 2017.

II. Financial risk management:

a) Market risk

The Company operates in the US and there are no major transactions outside the US. So there is no market risk for the Company.

b) Credit risk

Credit risk refers to the risk of default on its obligation by the counterparty resulting in a financial loss. The maximum exposure to the credit risk at the reporting date is primarily from trade receivables amounting to USD 13,492,980 as at 31 March 2018 (31 March 2017 : USD 10,339,400) and unbilled revenue amounting to USD 1,353,745 as at 31 March 2018 (31 March 2017 : USD 483,685). Trade receivables and unbilled revenue are typically unsecured and are derived from revenue earned from customers primarily located in the United States, United Kingdom and other locations. Credit risk has always been managed by the Company by continuously monitoring the credit worthiness of customers to which the Company grants credit terms in the normal course of business.

c) Liquidity risk

Liquidity risk is the risk that the Company will encounter difficulty in meeting the obligations associated with its financial liabilities that are settled by delivering cash or another financial asset. The Company's approach to manage liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risk to the Company's reputation.

The table below provides details regarding the contractual maturities of significant financial liabilities as of 31 March 2018 and 31 March 2017:

	31 March 2018		31 March 2017	
	Less than 1 Year	**More than 1 year**	Less than 1 Year	More than 1 year
Trade payables	**3,421,391**	-	2,965,084	-
Other borrowings	-	-	2,215	-
Book credit in bank account	**336,570**	-	261,655	-
Creditors for capital goods	**23,154**	-	23,154	-

18) Leases

Operating lease

The Company is obligated under non-cancellable operating leases for office space and office equipment which are renewable on a periodic basis at the option of both the lessor and lessee. Expenses under non-cancellable operating leases for the year ended 31 March 2018 aggregated to USD 564,511 (31 March 2017: USD 266,305).

The future minimum lease payments in respect of non-cancellable operating leases are as follows:

	As at 31 March 2018	As at 31 March 2017
Amount due within one year from the balance sheet date	**578,622**	564,511
Amount due in the period between one year and five years	**1,509,360**	2,087,982
Amount due in the period beyond five years	**-**	-
	2,087,982	2,652,493

The Company is also obligated under cancellable operating leases for office space and office equipment which are renewable on a periodic basis at the option of both the lessor and lessee. Expenses under cancellable operating leases for the year ended 31 March 2018 aggregated to USD 1,921,657 (31 March 2017: USD 2,606,761).

19) Related party transactions

Details of related parties including summary of transactions entered into during the year ended 31 March 2018 are summarized below:

Ultimate Holding Company	CESC Limited
Holding Company	Firstsource Solutions Limited Firstsource Group USA, Inc
Fellow Subsidiary	Firstsource Solutions USA LLC Firstsource Solutions UK Limited Firstsource Process Management Services Limited Firstsource BPO Ireland Limited Firstsource Dialog Solutions (Private) Ltd. Firstsource Solutions USA LLC ISGN Fulfillment Services, Inc ISGN Solutions, Inc. ISGN Fulfillment Agency LLC One Advantage LLC Firstsource Process Services Limited Firstsource Advantage LLC MedAssist Holding LLC
Directors	Venkat Raman Arjun Mitra

Particulars of related party transactions:

Name of the related party	**Description**	**Transaction value during year ended Amount in USD**	Transaction value during year ended Amount in USD	**Receivable / (Payable) as at in USD**	**Amount**
		31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
Firstsource Solutions Limited	Services Rendered by business associates and others	**17,313,337**	16,232,900	-	-
	Recovery of expenses	**70,373**	51,447	-	-
	Reimbursement of expenses	**1,277,444**	1,002,851	-	-
	Receivable/ (Payable)	**-**	-	**(17,473,379)**	(14,502,873)
Firstsource Group USA Inc	Reimbursement of expenses	**3,049,998**	1,852,180		-
	Recovery of expenses	**377,658**	1,098,436		-
	Receivable/ (Payable)		-	**50,740,878**	42,911,631
Medassist Holdings LLC	Reimbursement of expenses	**7,211,255**	7,239,443		-
	Recovery of expenses	**477,108**	431,898		-
	Receivable/ (Payable)		-	**(21,497,347)**	(14,633,201)
Firstsource Advantage LLC	Reimbursement of expenses	**80,397**	64,658		-
	Recovery of expenses	**3,896**	2,549		-
	Receivable/ (Payable)		-	**(100,448)**	(23,947)
Firstsource Solutions UK Limited	Reimbursement of expenses	**672**			-
	Receivable/ (Payable)			**(672)**	-
ISGN Solutions Inc.	Recovery of expense	**809**	6,422		-
	Receivable/ (Payable)			**607,231**	6,422
ISGN Fulfillment Services Inc.	Reimbursement of expenses	**83,864**	219,891		-
	Recovery of expense	**4,498**	24,306		-
	Receivable/ (Payable)		-	**425,559**	(195,075)
One Advantage LLC	Reimbursement of expenses	**-**	3,226		-
	Recovery of expense	**5,278**	1,922,271		-
	Receivable/ (Payable)		-	**11**	4,030

20) Segment reporting

As per Ind AS 108 - Operating Segment, if a financial report contains both consolidated financial statements of a parent that is within the scope of this Ind AS as well as the parent's separate financial statements, segment information is required only in the consolidated financial statements. Accordingly, information required to be presented under Ind AS 108 - Operating Segment has been given in the consolidated financial statements of the Holding Company.

21) Capital and other commitments and contingent liabilities

The Company has capital commitments of USD 610,227 (31 March 2017: USD 49,425) as at the balance sheet date and there are no contingent liabilities as at the balance sheet date (31 March 2017 Nil).

22) Long-term contracts

The Company has a process whereby periodically all long-term contracts are assessed for material foreseeable losses. At the year end, the Company has reviewed and ensured that adequate provision as required under any law / accounting standards for material foreseeable losses on such long term contracts has been made in the books of account.

23) Subsequent events

The Company evaluated subsequent events from the balance sheet date through 13 July 2018 and determined there are no material items to report.

As per our report of even date attached.

For DELOITTE HASKINS & SELLS LLP
Chartered Accountants
Firm's Registration No: 117366W/W-100018

For and on behalf of the Board of Directors

G.K. Subramaniam
Partner
Membership No: 109839

Arjun Mitra
Director

Venkat Raman
Director

Mumbai
13 July 2018

LogistiCare Financials

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UNITED ST ATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2017

OR

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission file number 001-34221

The Pr ovidence Service Corporation
(Exact name of r egistrant as specified in its charter)

Delawar e	86-0845127
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
700 Canal Str eet, Third Floor , Stamford, CT	06902
(Addr ess of principal executive offices)	(Zip code)

Registrant' s telephone number , including ar ea code: (203) 307-2800

Securities r egister ed pursuant to Section 12(b) of the Act:

Title of each Class	Name of each exchange on which r egister ed
Common Stock, $0.001 par value per shar e	The NASDAQ Global Select Market

Securities r egister ed pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐ Yes ☒ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☒ No

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☐	Accelerated filer	☒
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 7(a)(2)(B) of the Securities Act. ☐

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

The aggregate market value of the voting and non-voting common equity of the registrant held by non-affiliates based on the closing price for such common equity as reported on The NASDAQ Global Select Market on the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2017) was $576.8 million.

As of March 5, 2018, there were outstanding 12,866,551 shares (excluding treasury shares of 4,656,738) of the registrant's Common Stock, $0.001 par value per share.

DOCUMENTS INCORPORA TED BY REFERENCE

All or a portion of Items 10 through 14 in Part III of this Annual Report on Form 10-K are incorporated by reference to our definitive proxy statement on Schedule 14A for our 2018 stockholder meeting; provided that if such proxy statement is not filed on or before April 30, 2018, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

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PART IV

Part I

In this Annual Report on Form 10-K, the words the "Company", the "registrant", "we", "our", "us", "Providence" and similar terms refer to The Providence Service Corporation and, except as otherwise specified herein, to our subsidiaries. When such terms are used in reference to the Company's common stock, $0.001 par value per share (the "Common Stock), and the Series A Convertible Preferred Stock, $0.001 par value per share (the "Preferred Stock"), they refer specifically to The Providence Service Corporation.

DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains certain statements that may be deemed "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), including statements related to the Company's strategies or expectations about revenues, liabilities, results of operations, cash flows, ability to fund operations, profitability, ability to meet financial covenants, contracts or market opportunities. The Company may also make forward-looking statements in other reports filed with the Securities and Exchange Commission (the "SEC"), in materials delivered to stockholders and in press releases. In addition, the Company's representatives may from time to time make oral forward-looking statements. In certain cases, you may identify forward looking-statements by words such as "may", "will", "should", "could", "expect", "plan", "project", "intend", "anticipate", "believe", "seek", "estimate", "predict", "potential", "target", "forecast", "likely", the negative of such terms or comparable terminology. In addition, statements that are not historical statements of fact should also be considered forward-looking statements. These forward-looking statements are based on the Company's current expectations, assumptions, estimates and projections about its business and industry, and involve risks, uncertainties and other factors that may cause actual events to be materially different from those expressed or implied by such forward-looking statements. These risks and uncertainties include, but are not limited to, the risks described under Item 1A in Part I of this Annual Report on Form 10-K.

You are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date the statement was made. The Company is under no obligation to (and expressly disclaims any such obligation to) update any of the information in any forward-looking statement if such forward-looking statement later turns out to be inaccurate, whether as a result of new information, future events or otherwise.

Item 1. Business.

Background

The Providence Service Corporation owns subsidiaries and investments primarily engaged in the provision of healthcare services in the United States and workforce development services internationally. The subsidiaries and other investments in which we hold interests comprise the following segments:

- Non-Emergency Transportation Services ("NET Services") – Nationwide manager of non-emergency medical transportation ("NET") programs for state governments and managed care organizations.
- Workforce Development Services ("WD Services") – Global provider of employment preparation and placement services, legal offender rehabilitation services, youth community service programs and certain health related services to eligible participants of government sponsored programs.
- Matrix Investment – Minority interest in CCHN Group Holdings, Inc. and its subsidiaries ("Matrix"), a nationwide provider of in-home care optimization and management solutions, including comprehensive health assessments ("CHAs"), to members of managed care organizations, accounted for as an equity method investment. On February 16, 2018, Matrix acquired HealthFair, expanding its service offerings to include mobile health assessments, advanced diagnostic testing, and additional care optimization services.

In addition to its segments' operations, the Corporate and Other segment includes the Company's activities at its corporate office that include executive, accounting, finance, internal audit, tax, legal, public reporting, certain strategic and corporate development functions and the results of the Company's captive insurance company. We are actively monitoring these activities as they relate to our capital allocation and acquisition strategy to ensure alignment with Providence's overall strategic objectives and its goal of enhancing shareholder value.

The Company is a Delaware corporation formed in 1996 and headquartered in Stamford, Connecticut.

Business Strategies

Our businesses are operated on a decentralized basis and do not share any integrated functions such as sales, marketing, purchasing, human resources, accounting, finance or legal. They pursue strategies reflective of their respective industries and operating models. Our segments' core competencies include developing and managing large provider networks, tailoring healthcare and workforce development service offerings to the unique needs of diverse communities and populations, and implementing technology-enabled delivery models to achieve superior outcomes in low cost settings. We pursue both organic and inorganic growth through entry into adjacent markets and complementary service lines, particularly with offerings that may leverage the advantages inherent in our large-scale, technology-enabled, networks. In particular, as it relates to inorganic growth, we are actively evaluating the optimal industry sectors, such as the non-emergency medical transportation industry and others in which businesses complementary to our NET Services business operate, around which to focus our merger and acquisition activity. This ongoing evaluation takes into consideration and balances a number of factors, including the strategic goals, competitive landscape, and growth opportunities of our current segments, in an attempt to direct our capital towards those areas of our business most likely to drive long-term value creation and generate the highest levels of return for our shareholders. We also may enter into strategic partnerships or dispose of businesses, as demonstrated by the Matrix Transaction (defined below) and the Human Services Sale (defined below), based on a variety of factors, including availability of alternative opportunities to deploy capital or otherwise maximize shareholder value as well as other strategic considerations. The outcome of our active evaluation of the optimal industry sectors around which to focus our merger and acquisition activity as well as the potential future entry into strategic partnerships or potential disposition of businesses may impact the extent and manner in which we deploy resources across Providence, including strategic and administrative resources between Corporate and Other and our operating segments.

Discontinued Operations

On October 19, 2016, affiliates of Frazier Healthcare Partners purchased a controlling equity interest in Matrix, with Providence retaining a noncontrolling equity interest (the "Matrix Transaction"). Matrix's financial results prior to October 19, 2016 are presented as a discontinued operation. In addition, on November 1, 2015, the Company completed its sale of the Human Services Segment (the "Human Services Sale"), which is accounted for as a discontinued operation for all periods presented.

Description of Our Segments

The Company operates in two principal business segments, NET Services and WD Services. In addition, Providence holds a noncontrolling interest in Matrix, which is a reportable segment for financial reporting purposes (the "Matrix Investment"). Financial information about segments and geographic areas, including revenues, operating income (loss), and long-lived assets of each segment, is included in Note 21, Segments, to our consolidated financial statements and is incorporated herein by reference. See Item 1A, Risk Factors, for a discussion of risks related to our operations and investments.

NET Services

Services offered. NET Services provides non-emergency transportation solutions to clients in 38 states and the District of Columbia. As of December 31, 2017, approximately 23.6 million individuals were eligible to receive our transportation services, and during 2017, NET Services managed 66.8 million trips. For 2017, 2016 and 2015, NET Services accounted for 81.2%, 78.2% and 73.3%, respectively, of Providence's consolidated service revenue, net.

NET Services primarily contracts with state Medicaid programs and managed care organizations ("MCOs" and collectively "NET customers") for the coordination of their members' ("NET end-users") non-emergency transportation needs. NET end-users are typically Medicaid or Medicare eligible members, whose limited mobility or financial resources hinders their ability to access necessary healthcare and social services. We believe our transportation services enable access to care that not only improves the quality of life and health of the populations we serve, but also enables many of the individuals we serve to pursue independent living in their homes rather than in more expensive institutional care settings.

NET Services program delivery is dependent upon a highly-integrated technology platform and business process as well as the management of a multifaceted network of subcontracted transportation providers. Our technology platform is purpose-built for the unique needs of our industry and is highly scalable, capable of supporting substantial growth in our clients' current and future membership base. In addition, our technology platform efficiently provides a broad interconnectivity among NET end-users, NET customers, and our network of transportation providers. We believe this technological capability and our industry experience uniquely position us as a future focal point in the evolving healthcare industry to introduce valuable population insights. In 2016 and 2017, we introduced service offerings and new technological features for NET end-users to improve service levels, lower costs and build the foundation for additional data analytics capabilities.

To fulfill the transportation needs of NET end-users, we apply our proprietary technology platform to an extensive network of approximately 5,100 transportation resources. This includes our in-network roster of fully contracted transportation providers who operate sedans, wheelchair equipped vehicles, multi-passenger vans and ambulances. Our system also utilizes partnerships with on-demand transportation network companies, mass transit entities, mileage reimbursement programs, taxis and county-based emergency medical service providers. To promote safety, quality, and compliance, our in-network transportation providers undergo an in-depth credentialing and education process. Our proprietary technology platform is designed to connect with our external partners' application program interfaces to improve on-time and on-demand performance, provide real time information and analytics (including live vehicle location data), minimize cancellations and better allow for the scale required to provide an effective, nationwide service.

Our transportation management services also include fraud, waste, and abuse and utilization review programs designed to monitor that our transportation services are provided in compliance with Medicaid program rules and remediate issues that are identified. Compliance controls include ongoing monitoring, auditing and remediation efforts, such as validating NET end-user eligibility for the requested date of service and employing a series of gatekeeping questions to check that the treatment type is covered and the appropriate mode of transportation is assigned. We also conduct post-trip confirmations of attendance directly with the healthcare providers for certain repetitive trips and we employ field monitors to inspect transportation provider vehicles and observe some transports in real time. Our claims validation process generally limits payment to trips that are properly documented, have been authorized in advance, and are billed at the pre-trip estimated amount.

In 2016, NET Services launched a strategic initiative to enhance client and member satisfaction and drive greater operational efficiencies. This initiative focuses on developing and deploying new processes and technologies needed to: progress towards an industry-leading call center and reservation scheduling platform; improve member communication, accessibility, and satisfaction; optimize the utilization of our extensive network of transportation providers; and build the foundation for additional analytical capabilities. Implementations under this strategic initiative that were completed in 2017 include new workforce management tools aimed at streamlining our call center operations and decreasing payroll costs, tools and models to better monitor transportation provider performance and capacity availability, and rate setting protocols aimed at lowering transportation costs and improving service quality. The full implementation of the initiative is expected to be substantially completed by the end of 2018.

Revenue and customers. In 2017, contracts with state Medicaid agencies and MCOs represented 55.9% and 44.1%, respectively, of NET Services' revenue. NET Services derived 13.8%, 13.1% and 15.0% of its revenue from a single state Medicaid agency for the years ended December 31, 2017, 2016 and 2015, respectively. The next four largest NET Services customers in the aggregate comprised 22.3%, 22.6% and 24.2% of NET Services' revenue for the years ended December 31, 2017, 2016 and 2015, respectively.

Contracts with state Medicaid agencies are typically for three to five years with multiple renewal options. Contracts with MCOs continue until terminated by either party upon reasonable notice (as determined in accordance with the contract), and allow for regular price adjustments based upon utilization and transportation cost. As of December 31, 2017, 30.8% of NET Services revenue was generated under state Medicaid contracts that are subject to renewal within the next 12 months. In 2017, NET Services renewed contracts representing 29.5% of its revenue in such year, including its contract with the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, to provide non-emergency medical transportation management services to Medicaid-eligible New Jersey residents.

77.9% of NET Services' revenue in 2017 was generated under capitated contracts where we assume the responsibility of meeting the covered healthcare related transportation requirements of a specific population based on per-member per-month fees for the number of members in the customer's program. Revenue is recognized based on the population served during the period. Under certain capitated contracts, partial payment is received as a prepayment during the month service is provided. These partial payments may be due back to the customer, or additional payments may be due to the Company, after each reconciliation period, based on a reconciliation of actual utilization and cost compared to the prepayment made. 22.1% of NET Services' revenue was generated under other types of fee arrangements, including administrative services only, fee for service ("FFS"), cost plus and flat fee contracts, under which fees are generated based upon billing rates for specific services or defined membership populations.

Seasonality. While revenue is generally fixed, primarily as a result of the capitated nature of the majority of our contracts, service expense varies based on the utilization of our services. The quarterly operating income and cash flows of NET Services normally fluctuate as a result of seasonal variations in the business, principally due to lower transportation demand during the winter season and higher demand during the summer season.

Competition. We compete with a variety of national organizations that provide similar healthcare and social services related transportation, such as Medical Transportation Management, Southeastrans, Veyo, and American Medical Response, as

well as local and regional providers. Most local competitors seek to win contracts for specific counties or small geographic territories whereas we and other larger competitors seek to win contracts for an entire state or large regional area. We compete based upon a number of factors, including our nationwide network, technical expertise, experience, service capability, service quality, and price.

Business development. Our sales and marketing strategy relies on a concentrated business development effort, with centralized marketing programs. Due to the critical nature of our services, our customers rely upon our past delivery performance record, network development and management expertise, technical expertise and capability, and specialized knowledge. A significant portion of our revenue is generated from long-term, repeat customers. Our long-term strategy is to improve our position as the preferred provider of transportation, complementary network-based services and data analytics offerings to a broad array of healthcare payers. Key elements of our long-term strategy include continued investment in our technologies, enabling us to both lower costs and improve service delivery. We also consider acquisitions of businesses that serve our market or leverage our nationwide infrastructure.

WD Services

Services offered. WD Services is a global provider of employment preparation and placement services, legal offender rehabilitation services, youth community service programs and certain health related services to eligible participants of government sponsored programs. For 2017, 2016 and 2015, WD Services accounted for 18.8%, 21.8% and 26.7%, respectively, of Providence's consolidated revenue.

WD Services' end user client base ("WD end-users") is broad and includes the disabled, recently and long-term unemployed and individuals seeking new skills, as well as individuals that are coping with medical illnesses, are newly graduated from educational institutions, or are being released from incarceration.

As of December 31, 2017, WD Services operated in 10 countries outside of the U.S. These countries included the United Kingdom ("UK"), France, Saudi Arabia, South Korea, Canada, Germany, Australia, Switzerland and Singapore. WD Services also holds a noncontrolling interest in a joint venture in Spain.

In order to build upon its leadership position in the UK employment services industry, enhance client satisfaction and drive greater operational efficiencies, WD Services implemented the Ingeus Futures program, which was substantially completed in 2017. This program included organizational restructuring, the development and deployment of new processes and technologies, and increased business development resources. Each aspect of the program was aimed at improving operational efficiencies and client services as well as developing the internal capabilities necessary to ensure long-term profitable growth in the employment, training and healthcare industries.

Revenue, customers and clients. The majority of WD Services' revenue is generated through the provision of employability, legal offender rehabilitation and training programs to national government entities seeking to reduce unemployment or recidivism rates. For the years ended December 31, 2017, 2016 and 2015, 61.4%, 68.3% and 75.5%, respectively, of WD Services' revenue was derived from operations in the UK, with 38.6%, 31.7% and 24.5%, respectively, derived from operations outside the UK. Additionally, during the years ended December 31, 2017, 2016 and 2015, respectively, 19.6%, 28.9% and 40.0% of WD Services' revenue was derived from a contract with the UK government's Department of Work and Pensions for employability services and 27.1%, 25.9% and 28.2% of WD Services' revenue was derived from a contract with the UK government's Ministry of Justice (the "MOJ"), for legal offender rehabilitation services. Revenue under the UK employability services contract is decreasing as expected, as referrals ended under this program in March 31, 2017. In late 2017, WD Services was awarded three new employability contracts and one sub-contract under the new Work and Health Programme in the UK, allowing Ingeus to continue to maintain its position as a leader in the UK workforce development market, although overall this program has a smaller scale than the legacy employability services contract. During 2017, there was negligible revenue under the new Work and Health Programme.

The revenue earned by WD Services under its contracts is often derived through a combination of different revenue channels including, but not limited to, fees contingent upon: (1) the volume of WD end-users referred to and/or admitted into a specific program, (2) the achievement of defined outcomes for specific individuals, such as a job placement or continued employment and (3) the achievement of defined outcomes for a population of individuals over a specific time period, such as aggregate employment or recidivism rates. The relative contributions of different revenue channels under a specific contract can fluctuate meaningfully over the life of a contract and thus contribute to significant earnings volatility. Revenue recognition related to our National Citizen Services ("NCS") youth programs can be particularly volatile due to the timing of services provided, which typically occur in the second and third quarters of each year. WD Services also earns revenue under fixed FFS arrangements, based

upon contractual rates established at the outset of the contract or the applicable contract year, although the rate may be prospectively adjusted during the contract year based upon actual volumes. Volume levels are typically not guaranteed under contracts.

The nature of the services offered by WD Services often relies on our ability to improve a certain set of outcomes at a reduced cost versus previously utilized in-sourced delivery models. As a result, as we commence new contracts using transformational delivery models, we are often required to invest significant upfront capital for information technology, human resources, facilities and other onboarding costs, such as consultants and redundancy payments. The level of upfront funding required is dependent upon the size and nature of the contract. Although significant upfront funding may be required, revenues are often payable only as services are delivered and, in some cases, only after incentive measures have been achieved over a multi-year period. As a result of these two factors, there can be significant variability in our earnings from quarter-to-quarter and year-to-year. In addition, under the majority of WD Services' contracts, the Company relies on its customers, which include government agencies, to provide referrals, for which the Company can provide services and earn revenue. The timing and magnitude of referrals can fluctuate significantly, leading to volatility in revenue. The Company also relies on certain customers to periodically provide information regarding the achievement of service delivery targets, which information could result in reductions in future payments if targets are not met. As a result, we often measure a contracts success over the entire term of the contract and believe the financial results of WD Services are best viewed from a multi-year perspective.

The MOJ is currently reviewing its program for outsourcing probationary services, which includes its contracts with our subsidiary Reducing Reoffending Partnership ("RRP"), which is in our WD Services segment. The review includes an investigation regarding sustainability of the economic terms of such contracts, as well as data relating to reoffending statistics and other factors that could impact contractual performance measures. The potential impact of this review on RRP's agreement with the MOJ, including with respect to any potential payments to the MOJ that may be required, cannot be determined at this time because the review is ongoing. See also "Risk Factors—Risks Related to our Business—If we fail to satisfy our contractual obligations, we could be liable for damages and financial penalties, which may place existing pledged performance and payment bonds at risk as well as harm our ability to keep our existing contracts or obtain new contracts and future bonds."

Seasonality. While there has been period-to-period variability in WD Services' earnings due to the factors discussed above and also set forth in Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations – Revenues and Expenses – WD Services", there has not been a material seasonal effect on WD Services' results of operations.

Competition. In the UK, U.S., Saudi Arabia and Singapore the workforce development market is served by large, often multi-national, corporations, along with national and regional for-profit and non-profit entities. In Canada, France, Germany, South Korea, Spain and Switzerland, our competition is primarily companies specific to the geography, nationally or regionally, and both privately owned for-profit and non-profit entities. In the UK, the offender rehabilitation market is served by large corporations, often working with charitable sector providers. In general our larger competitors internationally include Maximus, Interserve, Sodexo, The Reed Group and Working Links.

The market for services to governments is competitive and subject to change and pricing pressure, particularly during the bidding for new contracts and contract renewals. However, due to the critical nature of our offerings and the WD end-users we serve, market entry can be difficult for new entrants or those without prior established track-records. Other barriers to entry include operational service complexity and significant upfront investments. This can include establishment of complex IT systems which often must interface with government systems, significant monitoring and reporting obligations, delivery from sites across wide geographies, and management and development of supply chains.

Business development. Our business development activities are performed both locally and centrally from WD Services' London headquarters. Through local and global networks and relationships, we become aware of new opportunities for which we develop bids through competitive processes. The nature of the competitive processes varies from highly competitive to being one of a few providers, or the sole provider, to bid on a contract. We pursue only those contracts that meet certain investment criteria, including risk-weighted return on capital thresholds, and involve the provision of services where we believe our experience will allow us to deliver differentiated and improved outcomes for our clients.

Matrix Investment

Providence's Matrix Investment is comprised of our interest in Matrix. Since the completion of the Matrix Transaction, the Company has had a noncontrolling equity interest in Matrix. The Company and an affiliate of Frazier Health Partners (the "Frazier Subscriber"), which holds the controlling equity interest in Matrix, are party to the Second Amended and Restated Limited Liability Company Agreement (the "Operating Agreement") of Mercury Parent, LLC, the company through which the parties hold their equity interests in Matrix. The Operating Agreement sets forth certain terms and conditions regarding the ownership by the Company and Frazier Subscriber of interests in Mercury Parent and their indirect ownership of common stock of Matrix, and

provides for, among other things, certain liquidity and governance rights and other obligations and rights, in each case, on the terms and conditions contained therein.

At December 31, 2017, the Company owned a 46.6% noncontrolling interest in Matrix. Prior to the closing of the Matrix Transaction, the financial results of Matrix were included in our Health Assessment Services ("HA Services") segment. The Company's proportionate share of Matrix's net assets and financial results for the period following the closing of the Matrix Transaction are presented under the equity method. The assets, liabilities and financial results of Matrix for the period prior to the closing of the Matrix Transaction are presented within discontinued operations. For additional information regarding the Matrix Transaction, see Note 20, Discontinued Operations, to our consolidated financial statements.

Services offered. Matrix provides in-home care optimization and care management solutions, which include CHAs. As of December 31, 2017, Matrix utilized a national network of over 5,800 clinical providers, including 1,700 nurse practitioners ("NPs"), located across 50 states, to provide its services primarily to members of Medicare Advantage ("MA") health plans.

Matrix recently expanded its provider network and service offerings through a series of acquisitions. In December 2017, Matrix grew its clinical provider network through its acquisition of LP Health Services, a provider of quality and wellness visits on behalf of Medicaid/Duals managed care plans across the U.S., for a purchase price of $3.8 million. LP Health Services' revenue for the year ended December 31, 2017 was approximately $6 million.

In February 2018, Matrix completed its acquisition of HealthFair, a leading operator of mobile clinics which offer preventative health assessment and advanced diagnostic testing services, including laboratory, ultrasound, EKG and mammography testing, for a purchase price of $160 million plus an earnout payment contingent on HealthFair's 2018 performance. With the addition of HealthFair, Matrix's network increased to more than 6,000 community-based providers across all 50 states, including over 1,700 NPs. We believe the combination of the two organizations will provide health plan members with more convenient access to important care management and preventative health services. As a result of the rollover of certain equity interests of HealthFair, Providence's equity ownership in Matrix was 43.6% as of February 16, 2018. HealthFair's revenue for the year ended December 31, 2017 was approximately $45 million.

Matrix primarily generates revenue from CHAs, which obtain a health plan members' information related to health status, social, environmental and medical risks and help the MA plans improve the accuracy of such information. Matrix's services typically commence with a member analysis that utilizes client data, such as medical claims data, to maximize its ability to improve client and member outcomes as a result of the assessment process. Through Matrix's contact centers, which include approximately 160 colleagues, Matrix pursues additional data collection and schedules assessments. Matrix's NPs then conduct a CHA, which is comprised of a physical examination and other diagnostic services, in the member's home. Matrix also operates a care management offering which provides additional data analytics and chronic care management services.

Matrix's services are dependent upon its technology platform which integrates the clinical provider network, operations infrastructure, call centers and clients. Matrix's platform is designed for the unique needs of its industry, is highly scalable and can support substantial growth. We believe Matrix's network and platform positions Matrix as a future focal point in the evolving healthcare industry in the introduction of both additional population insights and care management services. With data provided by its health plan clients, Matrix utilizes analytics to determine which members it can most effectively lower costs and improve outcomes through face-to-face engagements with clinicians. Each program is customized and is served by a comprehensive team of case managers, nurse practitioners, registered nurses, and trained call center colleagues.

Revenue, customers and clients. As of December 31, 2017, Matrix's customers included 48 health plans, including for-profit multi-state health plans and non-profit health plans that operate in only one state or several counties within one state. For the year ended December 31, 2017, Matrix's top five customers accounted for 72.2% of its revenue, as its largest customer accounted for 30.9% of its revenue and its second largest customer account for 26.8% of its revenue. Matrix enters into annual or multi-annual contracts with its customers under which it is paid on a per assessment basis.

Seasonality. The Company attempts to perform CHAs evenly throughout the year to efficiently utilize NP capacity, although the timing of performance is driven by client demand.

Competition. We believe that Matrix and CenseoHealth, which announced in December 2017 a combination with Advance Health, a smaller competitor, are the largest independent providers of CHAs to the health plan market. There are many smaller competitors, such as EMSI Healthcare Services, MedXM, which was acquired by Quest Diagnostics on February 1, 2018, and Inovalon. In addition, some health plans in-source CHA services. Matrix's chronic care management competitors include Landmark Healthcare, PopHealthcare and Optum.

Employees

As of December 31, 2017, there were approximately 7,100 employees across Providence and our subsidiaries. Of such employees, approximately 3,800 work in NET Services and approximately 3,300 work in WD Services. In addition, 30 employees primarily conduct corporate activities.

None of our U.S. employees are members of a union. We have nearly 1,950 and 330 full-time employees in the UK and France, respectively. Certain of our UK employees are members of the NAPO and Unison unions and certain of our employees in France are members of the Confederation Generale du Travail and have collective bargaining rights. In other countries employees may be members of a trade union but these trade unions are not formally recognized by us. Participation in unions is confidential under European employment laws. We believe we have good relationships with our employees, both unionized and non-unionized, in the U.S. and internationally.

Regulatory Environment

NET Services and Matrix Investment

Overview

Our NET Services and Matrix Investment segments (the "U.S. Healthcare Segments") are subject to numerous U.S. federal, state and local laws, regulations and agency guidance (collectively, "Laws"). These Laws significantly affect the way in which these segments operate various aspects of their businesses. Our U.S. Healthcare Segments must also comply with state and local licensing requirements, state and federal requirements for participation in Medicare and Medicaid, requirements for contracting with MA plans, and contractual requirements imposed upon them by the federal, state and local agencies and third-party commercial customers to which they provide services. Failure to follow the rules and requirements of these programs can significantly affect our U.S. Healthcare Segments' ability to be paid for the services they provide and be authorized to provide services on an ongoing basis.

The Medicare and Medicaid programs are governed by significant and complex Laws. Both Medicare and Medicaid are financed, at least in part, with federal funds. Therefore, any direct or indirect recipients of those funds are subject to federal fraud, waste and abuse Laws. In addition, there are federal privacy and security Laws that govern the healthcare industry. State Laws primarily pertain to the licensure of certain categories of healthcare professionals and providers and the state's interest in regulating the quality of healthcare in the state, regardless of the source of payment, but may also include state Laws pertaining to fraud, waste and abuse, privacy and security Laws, and the state's regulation of its Medicaid program. Federal and state regulatory laws that may affect our U.S. Healthcare Segments' businesses, include, but are not limited to the following:

- false and other improper claims or false statements Laws pertaining to reimbursement;
- the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its privacy, security, breach notification and enforcement and code set regulations and guidance, along with evolving state Laws protecting patient privacy and requiring notifications of unauthorized access to, or use of, patient medical information;
- civil monetary penalties Law;
- anti-kickback Laws;
- the Stark Law and other self-referral, financial inducement, fee splitting, and patient brokering Laws;
- CMS regulations pertaining to Medicare as well as CMS releases applicable to the operation of MA plans, such as reimbursement rates, risk adjustment and data collection methodologies, adjustments to quality management measurements and other relevant factors; and
- state licensure laws.

A violation of certain of these Laws could result in civil and criminal damages and penalties, the refund of monies paid by government or private payers, our U.S. Healthcare Segments' exclusion from participation in federal healthcare payer programs, or the loss of our segments' license to conduct business within a particular state's boundaries.

Federal Law

Federal healthcare Laws apply in any case in which our U.S. Healthcare Segments are providing an item or service that is reimbursable or provide information to such segments' customers that results in reimbursement by a federal healthcare payer program to such segments or to them. The principal federal Laws that affect our U.S. Healthcare Segments' businesses include those that prohibit the filing of false or improper claims or other data with federal healthcare payer programs and those that prohibit unlawful inducements for the referral of business reimbursable under federal healthcare payer programs.

False and Other Improper Claims

Under the federal False Claims Act (31 U.S.C. §§ 3729-3733) and similar state Laws, the government may impose civil liability on our U.S. Healthcare Segments if they knowingly submit a false claim to the government or cause another to submit a false claim to the government, or knowingly make a false record or statement intended to get a false claim paid by the government. The False Claims Act defines a claim as a demand for money or property made directly to the government or to a contractor, grantee, or other recipient if the money is to be spent on the government's behalf or if the government will reimburse the contractor or grantee. Liability can be incurred for submitting (or causing another to submit) false claims with actual knowledge or for submitting false claims with reckless disregard or deliberate ignorance. Liability can also be incurred for knowingly making or using a false record or statement to receive payment from the federal government or for knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government. Consequently, a provider need not take an affirmative action to conceal or avoid an obligation to the government, but the mere retention of an overpayment from the government could lead to potential liability under the False Claims Act.

Many states also have similar false claims statutes. In addition, healthcare fraud is a priority of the U.S. Department of Justice, the Department of Health and Human Services ("DHHS"), its program integrity contractors and its Office of Inspector General, the Federal Bureau of Investigation and state Attorneys General. These agencies have devoted a significant amount of resources to investigating healthcare fraud.

If our U.S. Healthcare Segments are ever found to have violated the False Claims Act, they could be required to make significant payments to the government (including damages and penalties in addition to the return of reimbursements previously collected) and could be excluded from participating in federal healthcare programs or providing services to entities which contract with those programs. Although our U.S. Healthcare Segments monitor their billing practices for compliance with applicable laws, such laws are very complex, and they might not be able to detect all errors or interpret such laws in a manner consistent with a court or an agency's interpretation. While the criminal statutes generally are reserved for instances evidencing fraudulent intent, the civil and administrative penalty statutes are being applied by the federal government in an increasingly broad range of circumstances. Examples of the types of activities giving rise to liability for filing false claims include billing for services not rendered, misrepresenting services rendered (i.e., miscoding), applications for duplicate reimbursement and providing false information that results in reimbursement or impacts reimbursement amounts. Additionally, the federal government takes the position that a pattern of claiming reimbursement for unnecessary services violates these statutes if the claimant should have known that the services were unnecessary. The federal government also takes the position that claiming reimbursement for services that are substandard is a violation of these statutes if the claimant should have known that the care was substandard. Criminal penalties also are available even in the case of claims filed with private insurers if the federal government shows that the claims constitute mail fraud or wire fraud or violate any of the federal criminal healthcare fraud statutes.

State Medicaid agencies and state Attorneys General also have authority to seek criminal or civil sanctions for fraud and abuse violations. In addition, private insurers may bring actions under state false claim laws. In certain circumstances, federal and state laws authorize private whistleblowers to bring false claim or "qui tam" suits on behalf of the government against providers and reward the whistleblower with a portion of any final recovery. In addition, the federal government has engaged a number of private audit organizations to assist it in tracking and recovering claims for healthcare services that may have been improperly submitted.

Governmental investigations and whistleblower "qui tam" suits against healthcare companies have increased significantly in recent years, and have resulted in substantial penalties and fines and exclusions of persons and entities from participating in government healthcare programs. For more information on the risks related to a failure to comply with applicable government coding and billing rules, see "Risk Factors—Regulatory Risks—Our segments could be subject to actions for false claims or recoupment of funds pursuant to certain audits if they do not comply with government coding and billing rules, which could have a material adverse impact on our segments' operating results."

Health Information Practices

Under HIPAA, DHHS issued rules to define and implement standards for the electronic transactions and code sets for the submission of transactions such as claims, and privacy and security of individually identifiable health information in whatever manner it is maintained.

The Final Rule on Enforcement of the HIPAA Administrative Simplification provisions, including the transaction standards, the security standards and the privacy rule, published by DHHS addresses, among other issues, DHHS's policies for determining violations and calculating civil monetary penalties, how DHHS will address the statutory limitations on the imposition of civil monetary penalties, and various procedural issues. The rule extends enforcement provisions currently applicable to the

healthcare privacy regulations to other HIPAA standards, including security, transactions and the appropriate use of service code sets.

The Health Information Technology for Economic and Clinical Health Act ("HITECH"), enacted as part of the American Recovery and Reinvestment Act of 2009, extends certain of HIPAA's obligations to parties providing services to healthcare entities covered by HIPAA known as "business associates," imposes new notice of privacy breach reporting obligations, extends enforcement powers to state attorney generals and amends the HIPAA privacy and security laws to strengthen the civil and criminal enforcement of HIPAA. HITECH establishes four categories of violations that reflect increasing levels of culpability, four corresponding tiers of penalty amounts that significantly increase the minimum penalty amount for each violation, and a maximum penalty amount of $1.5 million for all violations of an identical provision. With the additional HIPAA enforcement power under HITECH, the Office of Civil Rights of the Department of Health and Human Services and states are increasing their investigations and enforcement of HIPAA compliance. Our U.S. Healthcare Segments have taken steps to ensure compliance with HIPAA and we are monitoring compliance on an ongoing basis.

Additionally, the HITECH Final Rule imposes various requirements on covered entities and business associates, and expands the definition of "business associates" to cover contractors of business associates. Even when our U.S. Healthcare Segments are not operating as covered entities, they may be deemed to be "business associates" for HIPAA rule purposes of such covered entities. Our U.S. Healthcare Segments monitor their compliance obligations under HIPAA as modified by HITECH, and implement operational and systems changes, associate training and education, conduct risk assessments and allocate resources as needed. Any noncompliance with HIPPA requirements could expose such segments to the criminal and increased civil penalties provided under HITECH and require them to incur significant costs in order to seek to comply with its requirements or to remediate potential issues that may arise.

Federal and State Anti-Kickback Laws

Federal law commonly known as the "Anti-Kickback Statute" prohibits the knowing and willful offer, solicitation, payment or receipt of anything of value (direct or indirect, overt or covert, in cash or in kind) which is intended to induce: the referral of an individual for a service for which payment may be made by Medicare, Medicaid or certain other federal healthcare programs; or the ordering, purchasing, leasing, or arranging for, or recommending the purchase, lease or order of, any service or item for which payment may be made by Medicare, Medicaid or certain other federal healthcare programs.

Interpretations of the Anti-Kickback Statute have been very broad and under current Law, courts and federal regulatory authorities have stated that the Anti-Kickback Statute is violated if even one purpose (as opposed to the sole or primary purpose) of the arrangement is to induce referrals. Even bona fide investment interests in a healthcare provider may be questioned under the Anti-Kickback Statute if the government concludes that the opportunity to invest was offered as an inducement for referrals.

This act is subject to numerous statutory and regulatory "safe harbors." Compliance with the requirements of a safe harbor offers defenses against Anti-Kickback Statute allegations. Failure of an arrangement to satisfy all of the requirements of a particular safe harbor does not mean that the arrangement is unlawful. However, it may mean that such an arrangement will be subject to scrutiny by the regulatory authorities.

Many states, including some where our U.S. Healthcare Segments do business, have adopted anti-kickback laws that are similar to the federal Anti-Kickback Statute. Some of these state laws are very closely patterned on the federal Anti-Kickback Statute; others, however, are broader and reach reimbursement by private payers. If our U.S. Healthcare Segments' activities were deemed to be inconsistent with state anti-kickback or illegal remuneration laws, they could face civil and criminal penalties or be barred from such activities, any of which could harm such segments' businesses.

If our U.S. Healthcare Segments' arrangements are found to violate the Anti-Kickback Statute or applicable state laws, these segments, along with their clients would be subject to civil and criminal penalties, and these segments' arrangements would not be legally enforceable, which could materially and adversely affect their business. For more information on the risks related to failure to comply with applicable anti-bribery and anti-corruption regulations, see "Risk Factors—Regulatory Risks—Our segments' business could be subject to civil penalties and loss of business if we fail to comply with applicable bribery, corruption and other regulations governing business with governments."

Federal and State Self-Referral Prohibitions

Our U.S. Healthcare Segments may be subject to federal and state statutes banning payments for referrals of patients and referrals by physicians to healthcare providers with whom the physicians have a financial relationship. Section 1877 of the Social Security Act, also known as the "Stark Law", prohibits physicians from making a "referral" for "designated health services" for

Medicare (and in many cases Medicaid) patients from entities or facilities in which such physicians directly or indirectly hold a "financial relationship".

A financial relationship can take the form of a direct or indirect ownership, investment or compensation arrangement. A referral includes the request by a physician for, or ordering of, or the certifying or recertifying the need for, any designated health services.

Certain services that our U.S. Healthcare Segments provide may be identified as "designated health services" for purposes of the Stark Law. Such segments cannot provide assurance that future regulatory changes will not result in other services they provide becoming subject to the Stark Law's ownership, investment or compensation prohibitions in the future.

Many states, including some states where our U.S. Healthcare Segments do business, have adopted similar or broader prohibitions against payments that are intended to induce referrals of clients. Moreover, many states where such segments operate have laws similar to the Stark Law prohibiting physician self-referrals. While our U.S. Healthcare Segments believe that they are operating in compliance with the Stark Law, there can be no guarantee that violations will not occur.

Healthcare Reform

On March 23, 2010, the President of the United States signed into law comprehensive health reform through the Patient Protection and Affordable Care Act (Pub. L. 11-148) ("PPACA"). On March 30, 2010, the President signed a reconciliation budget bill that included amendments to the PPACA (Pub. L. 11-152). These laws in combination form the "ACA" referred to herein. The changes to various aspects of the healthcare system in the ACA were far-reaching and included, among many others, substantial adjustments to Medicare reimbursement, establishment of individual mandates for healthcare coverage, extension of coverage to certain populations, expansion of Medicaid, restrictions on physician-owned hospitals, and increased efficiency and oversight provisions.

Some of the provisions of the ACA took effect immediately, while others will take effect later or will be phased in over time, ranging from a few months following approval to ten years. Due to the complexity of the ACA, it is likely that additional legislation will be considered and enacted. The ACA requires the promulgation of regulations that will likely have significant effects on the healthcare industry and third-party payers. Thus, the healthcare industry and our operations may be subjected to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges.

The ACA also implemented significant changes to healthcare fraud and abuse laws that intensify the risks and consequences of enforcement actions. These included expansion of the False Claims Act by: (a) narrowing the public disclosure bar; and (b) explicitly stating that violations of the Anti-Kickback Statute trigger false claims liability. In addition, the ACA lessened the intent requirements under the Anti-Kickback Statute to provide that a person may violate the statute without knowledge or specific intent. The ACA also provided new funding and expanded powers to investigate fraud, including through expansion of the Medicare Recovery Audit Contractor ("RAC") program to Medicare Parts C and D and Medicaid and authorizing the suspension of Medicare and Medicaid payments to a provider of services pending an investigation of a credible allegation of fraud. Finally, the legislation created enhanced penalties for noncompliance, including increased criminal penalties and expansion of administrative penalties under Medicare and Medicaid. Collectively, such changes could have a material adverse impact on our U.S. Healthcare Segments' operations.

On January 20, 2017, the President of the United States issued an executive order that directed federal agencies to take steps to ensure the government's implementation of the ACA minimizes the burden on impacted parties (such as individuals and states). The underlying intent of the executive order was to take the first steps to repeal and replace the ACA. The executive order specifically instructed agencies to "waive, defer, grant exemptions from, or delay implementation of provisions" that place a "fiscal burden on any State" or that impose a "cost, fee, tax, penalty, or regulatory burden" on stakeholders including patients, providers, and insurers. The order stated that any changes should be made only to the extent "permitted by law" and should comply with the law governing administrative rule-making. The executive order did not, however, provide specifics on next steps or provisions that would be reexamined nor was it clear how the executive branch would be reconciled with Republican congressional efforts to repeal and replace the ACA or what portions of the ACA may continue in any replacement legislation. There are multiple pending legislative proposals to amend the ACA which, among other effects, could repeal all or parts of the ACA without replacing its extension of coverage to expansion populations. In addition, there are pending legislative proposals to materially restructure Medicaid and other government health care programs.

In 2017, legislation was proposed in the U.S. Congress, but did not advance out of committee and was not passed, which would reduce or eliminate certain non-emergency medical transportation services provided by NET Services as a required Medicaid

benefit. A similar proposal was made in 2018 by the President of the United States in a federal budget proposal. If additional privatization initiatives are not proposed or enacted, or if previously enacted privatization initiatives are challenged, repealed or invalidated, there could be a material adverse impact on our segments' operating results.

Surveys and Audits

Our U.S. Healthcare Segments' programs are subject to periodic surveys by government authorities or their contractors to ensure compliance with various requirements. Regulators conducting periodic surveys often provide reports containing statements of deficiencies for alleged failures to comply with various regulatory requirements. In most cases, if a deficiency finding is made by a reviewing agency, our segments will work with the reviewing agency to agree upon the steps to be taken to bring our program into compliance with applicable regulatory requirements. In some cases, however, an agency may take a number of adverse actions against a program, including:

- the imposition of fines or penalties or the recoupment of amounts paid;
- temporary suspension of admission of new clients to our program's service;
- in extreme circumstances, exclusion from participation in Medicaid, Medicare or other programs;
- revocation of our license; or
- contract termination.

While our U.S. Healthcare Segments believe that our programs are in compliance with Medicare, Medicaid and other program certification requirements and state licensure requirements, failure to comply with these requirements could have a material adverse impact on such segments' businesses and their ability to enter into contracts with other agencies to provide services.

Billing/claims Reviews and Audits

Agencies and other third-party commercial payers periodically conduct pre-payment or post-payment medical reviews or other audits of our U.S. Healthcare Segments' claims or other audits in conjunction with their obligations to comply with the requirements of Medicare or Medicaid. In order to conduct these reviews, payers request documentation from our U.S. Healthcare Segments and then review that documentation to determine compliance with applicable rules and regulations, including the eligibility of clients to receive benefits, the appropriateness of the care provided to those clients, and the documentation of that care. Any determination that such segments have not complied with applicable rules and regulations could result in adjustment of payments or the incurrence of fines and penalties, or in situations of significant compliance failures review or non-renewal of related contracts.

Corporate Practice of Medicine and Fee Splitting

Some states in which our U.S. Healthcare Segments operate prohibit general business entities, such as these segments, from "practicing medicine," which definition varies from state to state and can include employing physicians, as well as engaging in fee-splitting arrangements with these healthcare providers. Among other things, our U.S. Healthcare Segments currently contract with and employ NPs to perform CHAs. We believe that such segments have structured their operations appropriately; however, they could be alleged or found to be in violation of some or all of these laws. If a state determines that some portion of our U.S. Healthcare Segments' businesses violate these laws, it may seek to have such segments discontinue or restructure those portions of their operations or subject them to increased costs, penalties, fines, certain license requirements or other measures. Any determination that such segments have acted improperly in this regard may result in liability to them. In addition, agreements between the corporation and the professional may be considered void and unenforceable.

Professional Licensure and Other Requirements

Many of our U.S. Healthcare Segments' employees are subject to federal and state laws and regulations governing the ethics and practice of their professions. For example, our mid-level practitioners (e.g., NPs) are subject to state laws requiring physician supervision and state laws governing mid-level scope of practice. As the use of mid-level practitioners by physicians increases, state governing boards are implementing more robust regulations governing mid-levels and their scope of practice under physician supervision. Our U.S. Healthcare Segments' ability to provide mid-level practitioner services may be restricted by the enactment of new state laws governing mid-level scope of practice and by state agency interpretations and enforcement of such existing laws. In addition, services rendered by mid-level practitioners may not be reimbursed by payors at the same rates as payors may reimburse physicians for the same services. Lastly, professionals who are eligible to participate in Medicare and Medicaid as individual providers must not have been excluded from participation in government programs at any time. Our U.S. Healthcare Segments' ability to provide services depends upon the ability of their personnel to meet individual licensure and other requirements and maintain such licensure in good standing.

WD Services

Overview

As a provider of workforce development services in the U.S. and 10 countries outside the U.S., WD Services is subject to numerous national and local laws and regulations. These laws and regulations significantly affect the way in which we operate various aspects of our business. WD Services has implemented compliance policies to help assure our compliance with these laws and regulations as they become effective; however, different interpretations or enforcement of these laws and regulations in the future could subject our practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services or the manner in which we conduct our business.

WD Services' revenue is primarily derived from contracts that are funded by national governments that are seeking to reduce the overall unemployment rate or improve job placement success for targeted cohorts, and to reduce the recidivism rate. Further, the revenue we receive from these contracts is typically tied to milestones that are largely uncontrolled by us. Such milestones include the job placement success of clients, duration and tenure of clients in jobs once they are placed, and various other market and industry factors including the overall unemployment rate. For more information on the risks related to failure to satisfy our contractual obligations, see "Risk Factors—Risks Related to Our Business—If we fail to satisfy our contractual obligations, we could be liable for damages and financial penalties, which may place existing pledged performance and payment bonds at risk as well as harm our ability to keep our existing contracts or obtain new contracts and future bonds."

Data Security and Protection

WD Services is also subject to the European Union's and other countries' data security and protection laws and regulations. These laws and regulations impose broad obligations on the organizations that collect such data, as well as confer broad rights on individuals about whom such data is collected. There are amendments which will come into effect in 2018 with respect to European data privacy legislation which will significantly increase the fines for any breaches. In addition to their power to impose fines, information privacy regulators in Europe have significant powers to require organizations that breach regulations to put in place measures to ensure that such breaches do not occur again, and require businesses to stop processing personal information until the required measures are in place. For more information on the risks related to a failure to comply with privacy and security regulations, see "Risk Factors—Regulatory Risks—Our segments are subject to regulations relating to privacy and security of patient and service user information. Failure to comply with privacy and security regulations could result in a material adverse impact on our segments' operating results."

The data security and protection laws and regulations may also restrict the flow of information, including information about employees or service users, from WD Services to Providence in the U.S. In certain instances, informed consent to the data transfer must be given by the affected employee or service user. Compliance with such laws and regulations is costly and requires our segment management to expend substantial time and resources which could negatively impact our segments' results of operations. Compliance may also make it more difficult for the Company to gather data necessary to ensure the appropriate operation of its internal controls or to detect corruption, resulting in the need for additional controls or increasing the Company's costs to maintain appropriate controls.

Anti-Bribery and Corruption

WD Services' international operations are subject to various U.S. and foreign statutes that prohibit bribery and corruption, including the U.S. Foreign Corrupt Practices Act and the UK's Bribery Act. These statutes generally require organizations to prohibit bribery by or for the organization and demand the implementation of systems to counter bribery, including risk management, training and guidance and the maintenance of adequate record-keeping and internal accounting practices. The statutes also, among other things, prevent the provision of anything of value to government officials for the purposes of influencing official decisions or obtaining or retaining business or otherwise obtaining favorable treatment. In addition, many countries in which we operate have antitrust or competition regulations which, among other things, prohibit collusive tendering or bid-rigging behavior. For more information on the risks related to a failure to comply with applicable anti-bribery and anti-corruption regulations, see "Risk Factors—Regulatory Risks—Our segments' business could be subject to civil penalties and loss of business if we fail to comply with applicable bribery, corruption and other regulations governing business with governments."

Licensing

In many of the locations where WD Services operates, it is required by local laws to obtain and maintain licenses. The applicable state and local licensing requirements govern the services our segments provide, the credentials of staff, record keeping, treatment planning, client monitoring and supervision of staff. The failure to maintain these licenses or the loss of a license could

have a material adverse impact on WD Services businesses and could prevent them from providing services to clients in a given jurisdiction.

Surveys and audits

WD Services' contracts permit clients to review its compliance or performance, as well as its records, at the client's discretion. In most cases, if a deficiency is found by a reviewing agency, WD Services' will work with the reviewing agency to agree upon the steps to be taken to bring our program into compliance with applicable regulatory requirements. In the case of any deficiency, however, a client may take a number of adverse actions against WD Services, including: (i) termination or modification of existing contracts, (ii) prevention of receipt of new contracts or extension of existing contracts or (iii) reduction of fees paid under existing contract.

Billing Requirements

In WD Services, particularly in Europe, our contracts are subject to stringent claims and invoice processing regimes which vary depending on the customer and nature of the payment mechanism. Under European procurement legislation which has been implemented in each EU member state, any conviction for fraud can result in a ban from participating in public procurement tenders for up to five years, or until the organization in question has put in place "self clean" measures to the satisfaction of the procuring authority. For more information on the risks related to a failure to comply with applicable government coding and billing rules, see "Risk Factors—Regulatory Risks—Our segments could be subject to actions for false claims or recoupment of funds pursuant to certain audits if they do not comply with government coding and billing rules, which could have a material adverse impact on our segments' operating results."

Brexit

On June 23, 2016, the UK held a referendum in which eligible persons voted in favor of a proposal that the UK leave the EU, also known as "Brexit". The result of the referendum increased political and economic uncertainty in the UK for the foreseeable future, in particular during any period where the terms of any UK exit from the EU are negotiated. In turn, Brexit could cause disruptions to and create uncertainty surrounding our business, including affecting our relationships with our existing and future payers and employees, which could have an adverse effect on our financial results, operations and prospects, including being adversely affected in ways that cannot be anticipated at present. For more information on the risks related to the UK's exit from the European Union, see "Risk Factors—Regulatory Risks—Our business could be adversely affected by the referendum on the UK's exit from the European Union."

Additional Information

The Company's website at www.prscholdings.com provides access to its periodic reports, certain corporate governance documents, press releases, interim shareholder reports and links to its subsidiaries' websites. The Company makes available to the public on its website its annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act, as soon as reasonably practicable after it electronically files such material with, or furnishes such material to, the SEC. Copies are also available, without charge, upon request to The Providence Service Corporation, 700 Canal Street, Third Floor, Stamford, CT 06902, (203) 307-2800, Attention: Corporate Secretary. The information contained on our website is not part of, and is not incorporated by reference in, this Annual Report on Form 10-K or any other report we file with or furnish to the SEC.

Item 1A. Risk Factors.

You should consider and read carefully all of the risks and uncertainties described below, as well as other information included in this Annual Report on Form 10-K, including our consolidated financial statements and related notes. The risks described below are not the only ones facing us. The occurrence of any of the following risks or additional risks and uncertainties not presently known to us or that we currently believe to be immaterial could materially and adversely affect our business, financial condition and results of operations. This Annual Report on Form 10-K also contains forward-looking statements and estimates that involve risks and uncertainties. Our actual results could differ materially from those anticipated in any forward-looking statements as a result of specific factors, including the risks and uncertainties described below.

Risks Related to Our Business

There can be no assurance that our contracts will survive until the end of their stated terms, or that upon their expiration will be renewed or extended on satisfactory terms, if at all. Disruptions to, the early expiration of or the failure to renew our contracts could have a material adverse impact on our financial condition and results of operations.

Our NET Services contracts, and certain WD Services contracts, are subject to frequent renewal. For example, many of the state Medicaid contracts held by NET Services, which represented 55.9% of NET Services revenue for the year ended December 31, 2017, have terms ranging from three to five years and are typically subject to a competitive bidding process near the end of the term. NET Services also contracts with MCOs, which represented 44.1% of NET Services revenue for the year ended December 31, 2017. MCO contracts typically continue until terminated by either party upon reasonable notice (as determined in accordance with the contract). We cannot anticipate if, when or to what extent we will be successful in renewing our state government contracts or retaining our MCO contracts. During 2017, we experienced a decline in operating income as a percentage of revenue due to the nonrenewal of certain state contracts. In addition, with respect to many of our contracts, the payer may terminate the contract without cause, at will and without penalty to the payer, either immediately or upon the expiration of a short notice period in the event that, among other reasons, government appropriations supporting the programs serviced by the contract are reduced or eliminated or the payer deems our performance under the contract to be unsatisfactory.

We cannot anticipate if, when or to what extent a payer might terminate its contract with us prior to its expiration, or fail to renew or extend a contract with us. If we are unable to retain or renew our contracts, or replace lost contracts, on satisfactory terms our financial conditions and results of operations could be materially adversely affected. While we pursue new contract awards and also undertake efficiency measures, there can be no assurance that such measures will fully offset the impact of contracts that are not renewed or are cancelled on our operating income and results of operations.

We obtain a significant portion of our business through responses to government requests for proposals and we may not be awarded contracts through this process in the future, or contracts we are awarded may not be profitable.

We obtain, and will continue to seek to obtain, a significant portion of our business from national, state, and local government entities. To obtain business from government entities, we are often required to respond to requests for proposals ("RFPs"). To propose effectively, we must accurately estimate our cost structure for servicing a proposed contract, the time required to establish operations and the terms of the proposals submitted by competitors. We must also assemble and submit a large volume of information within rigid and often short timetables. Our ability to respond successfully to RFPs will greatly impact our business. If we misinterpret bid requirements as to performance criteria or do not accurately estimate performance costs in a binding bid for an RFP, we will seek to correct such mistakes in the final contract. However, there can be no assurance that we will be able to modify the proposed contract and we may be required to perform under a contract that is not profitable.

WD Services' ability to win contracts to administer and manage programs traditionally administered by government employees is also dependent on the impact of government unions. Many WD Services government employees belong to labor unions with considerable financial resources and lobbying networks. Union opposition could result in our losing government contracts, being precluded from providing services under government contracts, or maintaining or renewing existing contracts. If we could not renew certain contracts or obtain new contracts due to opposition political actions, it could have a material adverse impact on our operating results.

If we fail to satisfy our contractual obligations, we could be liable for damages and financial penalties, which may place existing pledged performance and payment bonds at risk as well as harm our ability to keep our existing contracts or obtain new contracts and future bonds.

Our failure to comply with our contractual obligations could, in addition to providing grounds for immediate termination of the contract for cause, negatively impact our financial performance and damage our reputation, which, in turn, could have a

material adverse effect on our ability to maintain current contracts or obtain new contracts. The termination of a contract for cause could, for instance, subject us to liabilities for excess costs incurred by a payer in obtaining similar services from another source. In addition, our contracts require us to indemnify payers for our failure to meet standards of care, and some of them contain liquidated damages provisions and financial penalties that we must pay if we breach these contracts.

Our failure to meet contractual obligations could also result in substantial actual and consequential financial damages. For example, on January 25, 2018, the MOJ released a report on reoffending statistics for certain offenders who entered probation services during the period October 2015 to March 2016. The report provides statistics for all providers of probation services, including our subsidiary RRP, which is in our WD Services segment. This information is the second data set that is utilized to determine performance payments under the various providers' transforming rehabilitation contracts with the MOJ, as the actual rates of recidivism are compared to benchmark rates established by the MOJ. Performance payments and penalties are linked to two separate measures of recidivism - the binary measure and the frequency measure. The binary measure defines the percentage of offenders within a cohort, formed quarterly, who reoffend in the following 12 months. The frequency measure defines the average number of offenses committed by reoffenders within the same 12-month measurement period. The performance for the frequency measure for most providers has been below the benchmarks established by the MOJ. As a result, RRP could be required to make payments to the MOJ and the amounts of such payments could be material. The amount of potential payments to the MOJ, if any, under RRP's contracts with the MOJ cannot be estimated at this time, as the MOJ is reviewing the data to understand the underlying reasons for the increase in certain rates of recidivism and other factors that could impact the contractual measure.

Any acquisition or integration that we undertake could disrupt our business, not generate anticipated results, dilute stockholder value or have a material adverse impact on our operating results.

We endeavor to ensure our acquisition strategy and alignment of resources serves to enhance shareholder value, which could result in changes to our strategy or to the way in which we deploy resources across Providence. We have made, and anticipate that we will continue to make, acquisitions. The Company typically incurs costs related to acquisitions and integrations, including third-party costs, whether or not the acquisition or integration is completed, which can have a material adverse impact on our operating results. The success of an acquisition depends in part on our ability to integrate an acquired company into our business operations. Integration of any acquired companies will place significant demands on our management, systems, internal controls and financial and physical resources. This could require us to incur significant expense for, among other things, hiring additional qualified personnel, retaining professionals to assist in developing the appropriate control systems and expanding our information technology infrastructure. The nature of our business is such that qualified management personnel can be difficult to find. Our inability to manage growth effectively could have a material adverse effect on our financial results.

There can be no assurance that the companies acquired will generate income or incur expenses at the historical or projected levels on which we based our acquisition decisions, that we will be able to maintain or renew the acquired companies' contracts, that we will be able to realize operating and economic efficiencies upon integration of acquired companies or that the acquisitions will not adversely affect our results of operations or financial condition.

We continually review opportunities to acquire other businesses that would complement our current services, expand our markets or otherwise offer prospects for growth. In connection with our acquisition strategy, we could issue stock that would dilute existing stockholders' percentage ownership, or we could incur or assume substantial debt or contingent liabilities. Acquisitions involve numerous risks, including, but not limited to, the following:

- challenges and unanticipated costs assimilating the acquired operations;
- known and unknown legal or financial liabilities associated with an acquisition;
- diversion of management's attention from our core businesses;
- adverse effects on existing business relationships with customers;
- entering markets in which we have limited or no experience;
- potential loss of key employees of purchased organizations;
- incurrence of excessive leverage in financing an acquisition;
- failure to maintain and renew contracts and other revenue streams of the acquired business;
- costs associated with litigation or other claims arising in connection with the acquired company;
- unanticipated operating, accounting or management difficulties in connection with an acquisition; and
- dilution to our earnings per share.

We cannot assure you that we will be successful in overcoming problems encountered in connection with any acquisition or integration and our inability to do so could disrupt our operations and adversely affect our business. Our failure to address these risks or other problems encountered in connection with past or future acquisitions and investments could cause us to fail

to realize the anticipated benefits of such acquisitions or investments, incur unanticipated liabilities and harm our business generally.

We may be unable to realize the benefits of any strategic initiatives that are adopted by the Company.

From time to time we may launch strategic initiatives in order to enhance shareholder value. For example, in 2017, NET Services pursued a strategic initiative to enhance member satisfaction and drive greater operational efficiencies. The implementation of the initiative is expected to be substantially completed by the end of 2018. Also in 2017, in order to build upon its leadership position in the UK employment services industry, enhance client satisfaction and drive greater operational efficiencies, WD Services substantially completed the Ingeus Futures program. In addition, we are actively evaluating the optimal industry sectors, such as the non-emergency medical transportation industry and others in which businesses complementary to our NET Services business operate, around which to focus our go-forward merger and acquisition activity, in an attempt to direct our capital towards those areas most likely to drive long-term value creation and generate the highest levels of return for our shareholders. The outcome of this active evaluation may impact the extent and manner in which we deploy resources across Providence, including strategic and administrative resources between Corporate and Other and our operating segments. There can be no assurance as to whether any strategic initiatives will be adopted as a result of this evaluation, and the outcome of any current or future strategic initiatives is uncertain.

Our investments in any joint ventures and unconsolidated entities could be adversely affected by our lack of sole decision-making authority, our reliance on our joint venture partners' financial condition, any disputes that may arise between us and our joint venture partners and our exposure to potential losses from the actions of our joint venture partners.

We currently hold a noncontrolling interest in Matrix, which constitutes 24.0% of our consolidated assets. We do not have unilateral power to direct the activities that most significantly impact such business' economic performance. Our future growth may depend, in part, on future similar arrangements, any of which could be material to our financial condition and results of operations. These arrangements involve risks not present with respect to our wholly-owned subsidiaries, which may negatively impact our financial condition and results of operations or make the arrangements less successful than anticipated, including the following:

- we may be unable to take actions that we believe are appropriate but are opposed by our joint venture partners under arrangements that require us to cede or share decision-making authority over major decisions affecting the ownership or operation of the joint venture and any property owned by the joint venture, such as the sale or financing of the business or the making of additional capital contributions for the benefit of the business;
- our joint venture partners may take actions that we oppose;
- we may be unable to sell or transfer our interest in a joint venture to a third party if we fail to obtain the prior consent of our joint venture partners;
- our joint venture partners may become bankrupt or fail to fund their share of required capital contributions, which could adversely impact the joint venture or increase our financial commitment to the joint venture;
- our joint venture partners may have business interests or goals with respect to a business that conflict with our business interests and goals, including with respect to the timing, terms and strategies for investment, which could increase the likelihood of disputes regarding the ownership, management or disposition of the business;
- disagreements with our joint venture partners could result in litigation or arbitration that increases our expenses, distracts our officers and directors, and disrupts the day-to-day operations of the business, including the delay of important decisions until the dispute is resolved; and
- we may suffer losses as a result of actions taken by our joint venture partners with respect to our joint venture investments.

We derive a significant amount of our revenues from a few payers, which puts our financial condition and results of operations at risk. Any changes in the funding, financial viability or our relationships with these payers could have a material adverse impact on our financial condition and results of operations.

We generate a significant amount of the revenues in our segments from a few payers under a small number of contracts. For example, for the years ended December 31, 2017, 2016 and 2015, we generated 46.7%, 47.9% and 54.6%, respectively, of our consolidated revenue from ten payers. Additionally, five payers related to NET Services represented, in the aggregate, 36.1%, 35.6% and 39.2%, respectively, of NET Services revenue for the years ended December 31, 2017, 2016 and 2015. A single payer related to WD Services represented 27.1%, 28.9% and 40.0% of our WD Services revenue for the years ended December 31, 2017, 2016 and 2015, respectively. Additionally, a single payer related to Matrix represented 30.9%, 27.8% and 31.1% of Matrix revenue for the years ended December 31, 2017, 2016 and 2015, respectively. The loss of, reduction in amounts generated by, or changes in methods or regulations governing payments for our services under these contracts could have a material adverse impact on our

revenue and results of operations. In addition, any consolidation of any of our private payers could increase the impact that any such risks would have on our revenue and results of operations.

If we fail to estimate accurately the cost of performing certain contracts, we may experience reduced or negative margins.

During 2017, 2016 and 2015, 77.9%, 78.3% and 83.6% of our NET Services revenue, respectively, was generated under capitated contracts with the remainder generated through FFS and flat fee contracts. WD Services also provides services under FFS and flat fee contracts. Under most of NET Services' capitated contracts, we assume the responsibility of managing the needs of a specific geographic population by contracting out transportation services to local transportation companies on a per ride or per mile basis. We use "pricing models" to determine applicable contract rates, which take into account factors such as estimated utilization, state specific data, previous experience in the state or with similar services, the medically covered programs outlined in the contract, identified populations to be serviced, estimated volume, estimated transportation provider rates and availability of mass transit. The amount of the fixed per-member, monthly fee is determined in the bidding process, but is predicated on actual historical transportation data for the subject geographic region as provided by the payer, actuarial work performed in-house as well as by third party actuarial firms and actuarial analysis provided by the payer. If the utilization of our services is more than we estimated, the contract may be less profitable than anticipated, or may not be profitable at all. Under our FFS contracts, we receive fees based on our interactions with government-sponsored clients. To earn a profit on these contracts, we must accurately estimate costs incurred in providing services. Our risk relating to these contracts is that our client population is not large enough to cover our fixed costs, such as rent and overhead. Our FFS contracts are not reimbursed on a cost basis and therefore, if we fail to estimate our costs accurately, we may experience reduced margins or losses on these contracts. Revenue under certain contracts may be adjusted prospectively if client volumes are below expectations. If the Company is unable to adjust its costs accordingly, our profitability may be negatively impacted. In addition, certain contracts with state Medicaid agencies are renewable at the state's option without an adjustment to pricing terms. If such renewed contracts require us to incur higher costs, including inflation or regulatory changes, than originally anticipated, our results of operations and financial condition may be adversely affected.

In WD Services, we often provide services to a client based on a unit price for delivery of a service or achievement of a defined outcome. If we fail to estimate costs accurately, we may have minimal ability to change the unit price to ensure profitability. While we may be able to alter our cost structure to reflect lower than anticipated volumes and other changes in service needs, there are certain fixed costs which are difficult to alter while still ensuring we can meet our contractual obligations. Further, many contracts require us to undertake significant onboarding projects, including making redundancies and changes to properties and IT. If we fail to anticipate the cost of these change programs, we may be unable to recover startup costs throughout the life of the contract. During the fourth quarter of 2016, WD Services recorded asset impairment charges of $19.6 million, which related, in part, to lower revenue and unanticipated costs for a recent contract. If WD Services continues to experience lower than expected volumes and unfavorable service mix shifts, it could result in additional impairment charges. For more information on the risks related to impairment of goodwill, see "Risk Factors—Risks Related to Our Business—Our reported financial results could suffer if there is an impairment of long-lived assets."

We may incur costs before receiving related revenues, which could impact our liquidity.

When we are awarded a contract to provide services, we may incur expenses before we receive any contract payments. These expenses include leasing office space, purchasing office equipment, instituting information technology systems, development of supply chains, hiring personnel and releasing certain personnel. As a result, in certain contracts where the government does not fund program start-up costs, we may be required to make significant investments before receiving any related contract payments or payments sufficient to cover start-up costs. For example, WD Services incurred start-up costs in 2017 related to the UK's Work and Health Programme, and in 2016 related to the offender rehabilitation program in the UK and start-up costs in France. In addition, payments due to us from payers may be delayed due to billing cycles or as a result of failures to approve government budgets in a timely manner, which may adversely affect our liquidity. Moreover, any resulting mismatch in expenses and revenue, especially under FFS arrangements, could be exacerbated if we fail either to invoice the payer correctly or to collect our fee in a timely manner. Such amounts may exceed our available cash, and any resulting liquidity shortages may require additional financing, which may not be available on satisfactory terms, or at all. This could have a material adverse impact on our ongoing operations and our financial position.

Our business is subject to risks of litigation.

The services we provide are subject to lawsuits and claims. A substantial award payable by the Company could have a material adverse impact on our operations and cash flows, and could adversely impact our ability to continue to purchase appropriate liability insurance. We can be subject to claims for negligence or intentional misconduct (in addition to professional liability type claims) by an employee or a third party we engage to assist with the provision of services, including but not limited to claims arising out of accidents involving vehicle collisions, workforce development placements or CHAs and various claims that could

result from employees or contracted third parties driving to or from interactions with clients or while providing direct client services. We can be subject to employee-related claims such as wrongful discharge, discrimination or a violation of equal employment laws and permitting issues. While we attempt to insure against for these types of claims, damages exceeding our insurance limits or outside our insurance coverage, such as a claim for fraud, certain wage and hour violations or punitive damages, could adversely affect our cash flow and financial condition.

We face risks related to attracting and retaining qualified employees and labor relations.

Our success depends to a significant degree on our ability to identify, attract, develop, motivate and retain highly qualified and experienced professionals who possess the skills and experience necessary to deliver high-quality services to our clients, with the continued contributions of our senior management being especially critical to our success. Our objective of providing the highest quality of service to our clients is a significant consideration when we evaluate the education, experience and qualifications of potential candidates for employment as direct care and administrative staff. A portion of our staff are professionals with requisite educational backgrounds and professional certifications. These employees are in great demand and are likely to remain a limited resource for the foreseeable future.

Our ability to attract and retain employees with the requisite experience and skills depends on several factors including, but not limited to, our ability to offer competitive wages, benefits and professional growth opportunities. While we have established programs to attract new employees and provide incentives to retain existing employees, particularly our senior management, we cannot assure you that we will be able to attract new employees or retain the services of our senior management or any other key employees in the future. In particular, we are currently seeking to fill several key management positions in our NET Services business, and we expect to continue to need to attract key employees to support the growth of our businesses. Some of the companies with which we compete for experienced personnel may have greater financial, technical, political and marketing resources, name recognition and a larger number of clients and payers than we do, which may prove more attractive to employment candidates. The inability to attract and retain experienced personnel could have a material adverse effect on our business.

The performance of each of our business segments also depends on the talents and efforts of our highly skilled information technology professionals. For example, technological improvement is a key component of the strategic initiative at NET Services to enhance member satisfaction and drive greater operational efficiencies and as NET Services expands our transportation network capacity beyond its traditional transportation provider network, increases on-time and on-demand performance, provides real time analytics and minimizes cancellations. Competition for skilled intellectual technology professionals can be intense. Our success depends on our ability to recruit, retain and motivate these individuals.

Effective succession planning is also important to our future success. If we fail to ensure the effective transfer of senior management knowledge and smooth transitions involving senior management, including the appointment of a new chief executive officer for the Company (as our chief executive officer terminated his role during the fourth quarter of 2017) and the transition of several key management positions, including the chief technology officer, in our NET Service business, our ability to execute short and long-term strategic, financial and operating goals, as well as our business, financial condition and results of operations generally, could be adversely affected.

In addition, our businesses rely on maintaining strong relationships with our employees and avoiding labor disputes. Certain of our UK employees are members of the NAPO and Unison unions and certain of our employees in France are members of the Confederation Generale du Travail. Unionized employees in both countries have collective bargaining rights. Participation in unions is confidential under European employment laws. While we believe we have good relationships with our employees, both unionized and non-unionized, in the U.S. and internationally, including the unions that represent some of our employees, a work stoppage due to our failure to renegotiate union contracts or for other reasons could have a significant negative effect on us. In addition, should additional portions of our workforce be subject to collective bargaining agreements, this could result in increased costs of doing business as we may be subject to mandatory, binding arbitration of labor scheduling, costs and standards and we may therefore have reduced operating flexibility.

We may have difficulty successfully completing divestitures or exiting businesses.

As demonstrated in 2017 with the sale of our interests in Mission Providence Pty Ltd to Konekt Limited, in 2016 with the Matrix Transaction and in 2015 with the Human Services Sale, we may dispose of all or a portion of our investments or exit businesses based on a variety of factors, including availability of alternative opportunities to deploy capital or otherwise maximize shareholder value as well as other strategic considerations. A divestiture or business termination could result in difficulties in the separation of operations, services, products and personnel, the diversion of management's attention, the disruption of our business and the potential loss of key employees and customers. A divestiture or business termination may be subject to the satisfaction of pre-closing conditions as well as to obtaining necessary regulatory and government approvals, which, if not satisfied or obtained,

may prevent us from completing the disposition or business termination, whether or not the disposition or business termination has been publicly announced. A divestiture or business termination may also involve continued financial involvement in the divested assets and businesses, such as indemnities or other financial obligations, including continuing obligations to employees, in which the performance of the divested assets or businesses could impact our results of operations. From time to time the Company guarantees the contractual payment or performance obligations of its segments. An inability to obtain waiver or termination of such guarantees may prevent us from completing a disposition or business termination, or may result in continued financial involvement in divested assets and businesses. Further, such divestitures may result in proceeds to us in an amount less than we expect or less than our assessment of the value of those assets. Any sale of our assets could result in a loss on divestiture. Any of the foregoing could adversely affect our financial condition and results of operations.

The indemnification provisions of acquisition and disposition agreements by which we have acquired or sold companies may result in liabilities.

We rely heavily on the representations and warranties and related indemnities provided to us by the sellers of acquired companies, including as they relate to creation, ownership and rights in intellectual property and compliance with laws and contractual requirements. However, the liability of the former owners is limited under the relevant acquisition agreements, and certain sellers may be unable to meet their indemnification responsibilities. Similarly, the purchasers of our divested operations may from time to time agree to indemnify us for operations of such businesses after the closing. We cannot be assured that any of these indemnification provisions will fully protect us, and as a result we may face unexpected liabilities that adversely affect our consolidated results of operations, financial condition and cash flows.

In addition, we have provided certain indemnifications in connection with the Human Services Sale in 2015 and the Matrix Transaction in 2016. To the extent we choose to divest other operations of our businesses in the future, we expect to provide certain indemnifications in connection with these divestitures. We may face liabilities in connection with these current or future indemnification obligations that may adversely affect our consolidated results of operation, financial condition and cash flows. We have entered into a settlement with Molina Healthcare Inc. (“Molina”), the purchaser of our former Human Services segment, regarding the settlement of certain potential indemnification claims. As of December 31, 2017, the accrual is $15.0 million with respect to an estimate of loss for such potential indemnification claims. Litigation is inherently uncertain, and the losses incurred in the event that the legal proceedings related to such claims were to result in unfavorable outcomes could have a material adverse effect on the Company’s business and financial performance. For more information on these potential indemnification obligations, see Note 18, Commitments and Contingencies, to our consolidated financial statements.

Our success depends on our ability to compete effectively in the marketplace.

We compete for clients and for contracts with a variety of organizations that offer similar services. Many organizations of varying sizes compete with us, including local not-for-profit organizations and community-based organizations, larger companies, organizations that currently provide or may begin to provide similar NET management services (including transportation network companies like Uber and Lyft), and large multi-national corporations that currently provide or may begin to provide workforce development services and CHA providers. Some of these companies may have greater financial, technical, political, marketing, name recognition and other resources and a larger number of clients or payers than we do. In addition, some of these companies offer more services than we do. To remain competitive, we must provide superior services and performance on a cost-effective basis to our customers.

The market in which we operate is influenced by technological developments that affect cost-efficiency and quality of services, and the needs of our customers change and evolve regularly. Accordingly, our success depends on our ability to develop services that address these changing needs and to provide technology needed to deliver these services on a cost-effective basis. Our competitors may better utilize technology to change the way services in our industry are designed and delivered and they may be able to provide our customers with different or greater capabilities than we can provide, including better contract terms, technical qualifications, price and availability of qualified professional personnel. In addition, new or disruptive technologies and methodologies by our competitors may make our services uncompetitive.

In conjunction with our initiatives to improve cost-efficiency, we incur substantial costs to develop technology, which may not ultimately serve our business purposes or lower costs. For example, in 2016, WD Services incurred a write-off of in-process technology of $3.1 million related to our legal offender rehabilitation services, as it was determined the system would not meet our business needs. As of December 31, 2017, NET Services has incurred $11.9 million of development in progress costs related to its LCAD NextGen technology system, which is a critical component of its initiative to progress towards an industry-leading call center and reservation scheduling platform, improve member communication, accessibility, and satisfaction, optimize the utilization of our extensive network of transportation providers and build the foundation for additional analytical capabilities.

The system has not been placed into service, and a review of the project is ongoing. In addition, we made a cost-method investment of $3.0 million during 2017, in Circulation, a technology-based transportation services provider.

We have experienced, and expect to continue to experience, competition from new entrants into the markets in which we operate. Increased competition may result in pricing pressures, loss of or failure to gain market share or loss of or failure to gain clients or payers, any of which could have a material adverse effect on our operating results. Our business may also be adversely affected by the consolidation of competitors, which may result in increased pricing pressure or negotiating leverage with payers, or by the provision of our services by payers or clients directly, including through the acquisition of competitors.

We may be adversely impacted by inadequacies in, or security breaches of, our information technology systems.

Our information technology systems are critically important to our operations and we must implement and maintain appropriate and sufficient infrastructure and systems to support growth and business processes. We provide services to individuals, including services that require us to maintain sensitive and personal client information, including information relating to their health, social security numbers and other identifying data. Therefore, our information technology systems store client information protected by numerous federal, state and foreign regulations. We also rely on our information technology systems (some of which are outsourced to third parties) to manage the data, communications and business processes for all other functions, including our marketing, sales, logistics, customer service, accounting and administrative functions. Further, our systems include interfaces to third-party stakeholders, often connected via the Internet. In addition, certain of our services or information related to our services are carried out or hosted within our customers' IT systems, and any failure or weaknesses in their IT systems may negatively impact our ability to deliver the services, for which we may not receive relief from contractual performance obligations or compensation for services provided. As a result of the data we maintain and third-party access, we are subject to increasing cybersecurity risks. The nature of our business, where services are often performed outside a secured location, adds additional risk.

If we do not allocate and effectively manage the resources necessary to build, sustain and protect an appropriate technology infrastructure, our business or financial results could be negatively impacted. Furthermore, computer hackers and data thieves are increasingly sophisticated and operate large scale and complex automated attacks and our information technology systems may be vulnerable to material security breaches (including the access to or acquisition of customer, employee or other confidential data), cyber-based attacks or other material system failures. Because the techniques used to obtain unauthorized access or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to implement adequate preventative measures sufficient to prevent a breach of our systems and protect sensitive data. Any breach of our data security could result in an unauthorized release or transfer of customer or employee information, or the loss of valuable business data or cause a disruption in our business. A failure to prevent, detect and respond in a timely manner to a major breach of our data security or to other cybersecurity threats could result in system disruption, business continuity issues or compromised data integrity. These events or any other failure to safeguard personal data could give rise to unwanted media attention, damage our reputation, damage our customer relationships and result in lost sales, fines or lawsuits. We may also be required to expend significant capital and other resources to protect against or respond to or alleviate problems caused by a security breach. If we are unable to prevent material failures, our operations may be impacted, and we may suffer other negative consequences such as reputational damage, litigation, remediation costs, a requirement not to operate our business until defects are remedied or penalties under various data privacy laws and regulations, any of which could detrimentally affect our business, financial condition and results of operations.

Failure to protect our client's privacy and confidential information could lead to legal liability, adversely affect our reputation and have a material adverse effect on our business, financial condition and results of operations.

We retain confidential information in our computer systems, including personal information about our customers, such as names, addresses, phone numbers, email addresses, identification numbers and payment account information. Malicious cyber attacks to gain access to personal information affect many companies across various industries, including ours. Pursuant to federal and state laws, various government agencies have established rules protecting the privacy and security of personal information. In addition, most states have enacted laws, which vary significantly from jurisdiction to jurisdiction, to safeguard the privacy and security of personal information. An increasing number of states require that customers be notified if a security breach results in the inappropriate disclosure of personally identifiable customer information. Any compromise of the security of our systems that results in the disclosure of personally identifiable customer or employee information or inadvertent disclosure of any clients' personal information could damage our reputation, deter people from using our services, expose us to litigation, increase regulatory scrutiny and require us to incur significant technical, legal and other expenses. In addition, data breaches impacting other companies, such as our vendors, may allow cybercriminals to obtain personally identifiable information about our customers. Cybercriminals may then use this information to, among other things, attempt to gain unauthorized access to our customers' accounts, which could have a material adverse effect on our reputation, business, results of operations or financial condition.

Failure to maintain or to develop further reliable, efficient and secure information technology systems would be disruptive to our operations and diminish our ability to compete and grow our business successfully.

We are highly dependent on efficient and uninterrupted performance of our information technology and business systems. These systems quote, process and service our business, and perform financial functions necessary for pricing and service delivery. These systems must also be able to undergo periodic modifications and improvements without interruptions or untimely delays in service. Additionally, our ability to integrate our systems with those of our clients is critical to our success. Our information systems rely on the commitment of significant financial and managerial resources to maintain and enhance existing systems as well as develop and create new systems to keep pace with continuing changes in information processing technology or evolving industry and regulatory requirements. However, we still rely on manual processes and procedures, including accounting, reporting and consolidation processes that may result in errors and may not scale proportionately with our business growth.

A failure or delay to achieve improvements in our information technology platforms could interrupt certain processes or degrade business operations and could place us at a competitive disadvantage. If we are unable to implement appropriate systems, procedures and controls, we may not be able to successfully offer our services and grow our business and account for transactions in an appropriate and timely manner, which could have an adverse effect on our business, financial condition and results of operations.

There are risks associated with our international operations that are different from the risks associated with our operations in the U.S., and our exposure to the risks of a global market could hinder our ability to maintain and expand international operations.

We have operation centers in Australia, Canada, France, Germany, Saudi Arabia, Singapore, South Korea, Switzerland, the UK and the U.S. and a noncontrolling interest in a joint venture in Spain. In implementing our international strategy, we may face barriers to entry and competition from local companies and other companies that already have established global businesses, as well as the risks generally associated with conducting business internationally. The success and profitability of international operations are subject to numerous risks and uncertainties, many of which are outside of our control, such as:

- political or economic instability;
- changes in governmental regulation or taxation;
- currency exchange fluctuations;
- difficulties and costs of staffing and managing operations in certain foreign countries, including potential pension and social plan liabilities;
- work stoppages or other changes in labor conditions; and
- taxes and other restrictions on repatriating foreign profits back to the U.S.

In addition, changes in policies or laws of the U.S. or foreign governments resulting in, among other changes, higher taxation, tariffs or similar protectionist laws could reduce the anticipated benefits of international operations and could have a material adverse effect on our results of operations and financial condition. We have currency exposure arising from both sales and purchases denominated in foreign currencies, including intercompany transactions outside the U.S., and we currently do not conduct hedging activities. The value of the U.S. dollar against other foreign currencies has seen significant volatility recently. Our financial condition and results of operations are reported in multiple currencies, and are then translated into U.S. dollars at the applicable exchange rate for inclusion in our consolidated financial statements. Appreciation of the U.S. dollar against these other currencies will have a negative impact on our reported net revenue and operating income while depreciation of the U.S. dollar against such currencies will have a positive effect on reported net revenue and operating income. We cannot predict with precision the effect of future exchange-rate fluctuations on our business and operating results, and significant rate fluctuations could have a material adverse effect on our results of operations and financial condition.

Our results of operations will continue to fluctuate due to seasonality.

NET Services operating results and operating cash flows normally fluctuate as a result of seasonal variations in our business. Due to higher demand in the summer months and lower demand in the winter months, coupled with a primarily fixed revenue stream based on a per-member, per-month payment structure, NET Services normally experiences lower operating margins during the summer season and higher operating margins during the winter season. WD Services typically does not experience seasonal fluctuations in operating results. However, volatility in revenue and earnings is common in the case of WD Services due to the timing of commencement and expiration of certain major contracts as well as fluctuations in referrals provided by its customers.

Our reported financial results could suffer if there is an impairment of long-lived assets.

Goodwill may be impaired if the estimated fair value of one or more of our reporting units is less than the carrying value of the respective reporting unit. As a result of our growth, in part through acquisitions, goodwill and other intangible assets represent a significant portion of our assets. We perform an analysis on our goodwill balances to test for impairment on an annual basis. Interim impairment tests may also be required in advance of our annual impairment test if events occur or circumstances change that would more likely than not reduce the fair value, including goodwill, of one or more of our reporting units below the reporting unit's carrying value. Such circumstances could include but are not limited to: (1) loss of significant contracts, (2) a significant adverse change in legal factors or in the climate of our business, (3) unanticipated competition, (4) an adverse action or assessment by a regulator or (5) a significant decline in our stock price. In the fourth quarter of 2016, we recorded asset impairment charges of $19.6 million related to WD Services and an asset impairment of $1.4 million for Corporate and Other related to the sale of a building, as discussed below in Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations - Critical Accounting Policies and Estimates". As of December 31, 2017, the carrying value of goodwill, intangibles and property and equipment, net is $121.7 million, $43.9 million and $50.4 million, respectively. In addition, property and equipment as of December 31, 2017 includes $13.4 million of construction and development in progress, primarily related to NET Services' LCAD NextGen technology system, as discussed above. We continue to monitor the carrying value of these long-lived assets. Any future impairment charges could have a material adverse impact on our results of operations and financial position.

Our use of a reinsurance program and insurance programs to cover certain claims for losses suffered and costs or expenses incurred could negatively impact our business.

We reinsured a substantial portion of our automobile, general liability, professional liability and workers' compensation insurance policies through May 15, 2017. Upon renewal of the policies, we made the decision to no longer reinsure these risks, although we continue to resolve claims under the historical policy years. Through February 15, 2011, one of our subsidiaries also insured certain general liability, automobile liability, and automobile physical damage coverage for independent third-party transportation providers. In the event that actual reinsured losses increase unexpectedly and substantially exceed actuarially determined estimated reinsured losses under the program, the aggregate of such losses could materially increase our liability and adversely affect our financial condition, liquidity, cash flows and results of operations.

In addition, under our current insurance policies, we are subject to deductibles, and thus retain exposure within these limits. In the event that actual losses within our deductible limits increase unexpectedly and substantially exceed our expected losses, the aggregate of such losses could materially increase our liability and adversely affect our financial condition, liquidity, cash flows and results of operations.

As the availability to us of certain traditional insurance coverage diminishes or increases in cost, we will continue to evaluate the levels and types of insurance coverage we include in our reinsurance and self-insurance programs, as well as the deductible limits within our traditional insurance programs. Any increase to these reinsurance and self-insurance programs or increases in deductible limits increases our risk exposure and therefore increases the risk of a possible material adverse effect on our financial condition, liquidity, cash flows and results of operations.

Inaccurate, misleading or negative media coverage could damage our reputation and harm our ability to maintain or procure contracts.

There is sometimes media coverage regarding services that we or our competitors provide or contracts that we or our competitors are a party to. Inaccurate, misleading or negative media coverage about us could harm our reputation and, accordingly, our ability to maintain our existing contracts or procure new contracts. In addition, negative media coverage could influence government officials to slow the pace of privatizing or retendering government services.

Regulatory Risks

Our U.S. Healthcare Segments conduct business in a heavily regulated healthcare industry. Compliance with existing Laws is costly, and changes in Laws or violations of Laws may result in increased costs or sanctions that could reduce our segments' revenue and profitability.

The U.S. healthcare industry is subject to extensive federal and state Laws relating to, among other things:

- professional licensure;
- conduct of operations;
- addition of facilities, equipment and services, including certificates of need;
- coding and billing related to our services; and
- payment for services.

Both federal and state government agencies have increased coordinated civil and criminal enforcement efforts related to the healthcare industry. Regulations related to the healthcare industry are extremely complex and, in many instances, the industry does not have the benefit of significant regulatory or judicial interpretation of those laws. The Patient Protection and Affordable Care Act, as well as the anticipated attempts to repeal all or portions of those laws by the President and Congress, has also introduced some degree of regulatory uncertainty as the industry does not know how the changes it introduced or changes to it will affect many aspects of the industry. Medicare and Medicaid anti-fraud and abuse laws prohibit certain business practices and relationships related to items and services reimbursable under Medicare, Medicaid and other governmental healthcare programs, including the payment or receipt of remuneration to induce or arrange for referral of patients or recommendation for the provision of items or services covered by Medicare or Medicaid or any other federal or state healthcare program. Federal and state Laws prohibit the submission of false or fraudulent claims, including claims to obtain reimbursement under Medicare and Medicaid. Our U.S. Healthcare Segments have implemented compliance policies to help assure their compliance with these regulations as they become effective; however, different interpretations or enforcement of these laws and regulations in the future could subject our practices to allegations of impropriety or illegality or could require such segments to make changes in their facilities, equipment, personnel, services or the manner in which they conduct our business.

Changes in budgetary priorities of the government entities that fund the services our segments provide could result in our segments' loss of contracts or a decrease in amounts payable to them under their contracts.

Our segments' revenue is largely derived from contracts that are directly or indirectly paid or funded by government agencies. All of these contracts are subject to legislative appropriations and state or national budget approval. The availability of funding under NET Services' contracts with state governments is dependent in part upon federal funding to states. Changes in Medicaid methodology may further reduce the availability of federal funds to states in which our U.S. Healthcare Segments provide services. The President of the United States and Congress have proposed various changes to the Medicaid program, including considering converting the Medicaid program to a block grant format or capping the federal contribution to state Medicaid programs to a fixed amount per beneficiary. The Centers for Medicare and Medicaid Services ("CMS") has the ability to grant waivers to states relative to the parameters of their Medicaid programs. Such changes, individually or in the aggregate could have a material adverse effect on our U.S. Healthcare Segments operations.

Among the alternative Medicaid funding approaches that states have explored are provider assessments as tools for leveraging increased Medicaid federal matching funds. Provider assessment plans generate additional federal matching funds to the states for Medicaid reimbursement purposes, and implementation of a provider assessment plan requires approval by CMS in order to qualify for federal matching funds. These plans usually take the form of a bed tax or a quality assessment fee, which were historically required to be imposed uniformly across classes of providers within the state, except that such taxes only applied to Medicaid health plans.

Changes to provider assessment opportunities, the Medicaid programs in states in which our U.S. Healthcare Segments operate or in the structure of the federal government's support for those programs can impact the amount of funds available in the programs our U.S. Healthcare Segments support. Such segments cannot make any assurances that these Medicaid changes will not negatively affect the funding under their contracts. As funding under U.S. Healthcare Segments' contracts is dependent in part upon federal funding, such funding changes could have a significant effect upon such segments' businesses.

Currently, many of the U.S. states and overseas countries in which our segments operate are facing budgetary shortfalls or changes in budgetary priorities. While many of these states are dealing with budgetary concerns by shifting costs from institutional care to home and community based care such as we provide, there is no assurance that this trend will continue.

Likewise, in many of the overseas countries addressed by WD Services, particularly the UK, a continued focus following the global financial crisis on austerity measures to reduce national and local budget deficits could lead to further spending cuts or changes to welfare arrangements. This may make availability of funding for outsourcing of such services more difficult to obtain from relevant government departments, which may lead to more challenging terms and conditions, including pressure on prices or volumes of services provided.

In the UK, the low unemployment rate has led to a change in the government prioritizing employability services, and a consequent reduction in scale of the Work and Health Programme, the successor program to the Work Programme. While we have the ability to alter a portion of our cost structure to reflect the decreasing volume of these contracts during their term, there may be significant redundancy costs and management time additionally invested to reflect these changes, particularly if programs are discontinued.

Consequently, a significant decline in government expenditures, shift of expenditures or funding away from programs that call for the types of services that we provide, or change in government contracting or funding policies could cause payers to terminate their contracts with our segments or reduce their expenditures under those contracts, either of which could have a negative impact on our segments' operating results.

Our segments are subject to regulations relating to privacy and security of patient and service user information. Failure to comply with privacy and security regulations could result in a material adverse impact on our segments' operating results.

There are numerous federal and state regulations addressing patient information privacy and security concerns. In particular, the federal regulations issued under HIPAA contain provisions that:

- protect individual privacy by limiting the uses and disclosures of patient information;
- require the implementation of security safeguards to ensure the confidentiality, integrity and availability of individually identifiable health information in electronic form; and
- prescribe specific transaction formats and data code sets for certain electronic healthcare transactions.

Compliance with state and federal laws and regulations is costly and requires our segment management to expend substantial time and resources which could negatively impact our segments' results of operations. Further, the HIPAA regulations and state privacy laws expose our segments to increased regulatory risk, as the penalties associated with a failure to comply or with information security breaches, even if unintentional, could have a material adverse effect on our segments' results of operations.

Our WD Services segment has operations in many countries in Europe, and internationally, and these operations have access to significant amounts of sensitive personal information about individuals. In Europe, these operations are subject to European and national data privacy legislation which imposes significant obligations on data processors and controllers with respect to such personal information. Similar regimes exist in other WD Service jurisdictions such as Australia, Canada and South Korea. Some countries, such as Spain, France and Germany, have particularly strong privacy laws which impose even greater obligations on people handling personal information. Data protection and privacy law within the EU is changing effective May 25, 2018, from which date the EU General Data Protection Regulation ("GDPR") must be complied with. Amongst other changes the GDPR brings about an increase in the potential fines for certain breaches of the GDPR, of up to the higher of 4% of an undertaking's global turnover or €20,000,000. In addition to fining powers, data protection authorities in Europe have significant powers to require organizations that breach regulations to put in place measures to ensure that such breaches do not occur again, and require businesses to stop processing personal information until the required measures are in place. Such orders could significantly impact our business given that we are required to handle personal information as part of our service delivery model. The GDPR and other similar laws and regulations, as well as any associated inquiries or investigations or any other government actions, may be costly to comply with, result in negative publicity, increase our operating costs, require significant management time and attention, and subject us to remedies that may harm our business, including fines or demands or orders that we modify or cease existing business practices.

Our segments could be subject to actions for false claims or recoupment of funds pursuant to certain audits if they do not comply with government coding and billing rules, which could have a material adverse impact on our segments' operating results.

If our segments fail to comply with federal and state documentation, coding and billing rules, our segments could be subject to criminal or civil penalties, loss of licenses and exclusion from the Medicare and Medicaid programs, which could have a material adverse impact on our segments' operating results. In billing for our segments' services to third-party payers, our segments must follow complex documentation, coding and billing rules. These rules are based on federal and state laws, rules and regulations, various government pronouncements, and industry practice. In the U.S., failure to follow these rules could result in

potential criminal or civil liability under the federal False Claims Act, under which extensive financial penalties can be imposed or under various state statutes which prohibit the submission of false claims for services covered. Compliance failure could further result in criminal liability under various federal and state criminal or civil statutes. Our segments may be subject to audits conducted by our clients or their proxies that may result in recoupment of funds. In addition, our segments' clients may be subject to certain audits that may result in recoupment of funds from our clients that may, in turn, implicate our segments' services. Our segments' businesses could be adversely affected in the event such an audit results in negative findings and recoupment from or penalties to their customers.

Our segment contracts are subject to stringent claims and invoice processing regimes which vary depending on the customer and nature of the payment mechanism. Government entities in the U.S. may take the position that if a transport cannot be matched to a healthcare event, or is conducted inconsistently with contractual, regulatory or even policy requirements, payment for such transport may be recouped by such customer. Under European procurement legislation which has been implemented in each EU member state, any conviction for fraud can result in a ban from participating in public procurement tenders for up to five years, or until the organization in question has put in place "self clean" measures to the satisfaction of the procuring authority. This could significantly affect our business given that most of our customers in Europe are governmental organizations. Any such breaches or deficiencies in paperwork associated with billing may also be subject to contractual clawback regimes and penalties, which can be enforced many years after the revenue has been paid by the relevant authority.

While our segments carefully and regularly review their documentation, coding and billing practices, the rules are frequently vague and confusing and they cannot assure that governmental investigators, private insurers or private whistleblowers will not challenge their practices. Such a challenge could result in a material adverse effect on our segments' financial position and results of operations.

Our segments' business could be subject to civil penalties and loss of business if we fail to comply with applicable bribery, corruption and other regulations governing business with governments.

Our U.S. Healthcare Segments are subject to the federal Anti-Kickback Statute, which prohibits the offer, payment, solicitation or receipt of any form of remuneration in return for referring, ordering, leasing, purchasing or arranging for or recommending the ordering, purchasing or leasing of items or services payable by a federally funded healthcare program. Any of our U.S. Healthcare Segments' financial relationships with healthcare providers will be potentially implicated by this statute to the extent Medicare or Medicaid referrals are implicated. Violations of the Anti-Kickback Statute could result in substantial civil or criminal penalties, including criminal fines of up to $25,000 per violation, imprisonment of up to five years, civil penalties under the Civil Monetary Penalties Law of up to $50,000 per violation, plus three times the remuneration involved, civil penalties under the False Claims Act of up to $11,000 for each claim submitted, plus three times the amounts paid for such claims and exclusion from participation in the Medicaid and Medicare programs. Any such penalties could have a significant negative effect on our U.S. Healthcare Segments' operations. Furthermore, the exclusion, if applied to such segments, could result in significant reductions in our revenues, which could materially and adversely affect such segments' businesses, financial condition and results of their operations. In addition, many states have adopted laws similar to the federal Anti-Kickback Statute with similar penalties.

As an international business whose customers are largely in the public sector, the WD Services segment generally wins work through public tender processes. Various statutes, such as the UK's Bribery Act and the Foreign Corrupt Practices Act in the U.S., generally require organizations to prohibit bribery by or for the organization and demand the implementation of systems to counter bribery, including risk management, training and guidance and the maintenance of adequate record-keeping and internal accounting practices. These statutes also, among other things, prohibit us from providing anything of value to foreign officials for the purposes of influencing official decisions or obtaining or retaining business or otherwise obtaining favorable treatment. In addition, many countries in which we operate have antitrust or competition regulations which, among other things, prohibit collusive tendering or bid-rigging behavior. Policies and procedures we implement to prevent bribery, corruption and anti-competitive conduct may not effectively prevent us from violating these regulations in every transaction in which we may engage, and such a violation could adversely affect our reputation, business, financial condition and results of operations. Any breach of bribery, corruption and collusive tendering laws could also expose our operations in Europe to a ban from participating in public procurement tenders for up to 5 years, or until the organization in question has put in place "self clean" measures to the satisfaction of the procuring authority.

In WD Services, we conduct business in several countries, each with its own system of regulation. Compliance with existing regulations is costly, and changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce our revenue and profitability.

As of December 31, 2017, our WD Services segment operated in the U.S and 10 countries outside the U.S. Each of these countries has its own national and municipal laws and regulations, and some countries such as Australia, Germany and Switzerland,

have both federal and state regulations. In the UK, certain law making powers are being devolved to Scotland, Wales and Northern Ireland. These laws can differ significantly from country to country. In addition, in Europe, countries (including the UK) are subject to European Union ("EU") laws and rules. We have implemented compliance policies to help assure our compliance with these laws and regulations as they become effective; however, different interpretations or enforcement of these laws and regulations in the future could subject our practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services or the manner in which we conduct our business.

Our segments' businesses could be adversely affected by future legislative changes that hinder or reverse the privatization of non-emergency transportation services or workforce development services.

The market for certain of our segments' services depends largely on government sponsored programs. These programs can be modified or amended at any time. Moreover, part of our growth strategy includes aggressively pursuing opportunities created by government initiatives to privatize the delivery of non-emergency transportation services and workforce development services. However, there are opponents to the privatization of these services and, as a result, future privatization is uncertain. In the UK, opposition to the government's outsourcing of the services provided by WD Services to private companies may increase in light of recent events in the UK, including the liquidation of the UK government contractor Carillion plc. In 2017, legislation was proposed in the U.S. Congress, but not passed, which would reduce or eliminate certain non-emergency medical transportation services provided by NET Services as a required Medicaid benefit. If additional privatization initiatives are not proposed or enacted, or if previously enacted privatization initiatives are challenged, repealed or invalidated, there could be a material adverse impact on our segments' operating results.

Our business could be adversely affected by the referendum on the UK's exit from the European Union.

On June 23, 2016, the UK held a referendum in which eligible persons voted in favor of a proposal that the UK leave the EU, also known as "Brexit". The result of the referendum increases political and economic uncertainty in the UK for the foreseeable future, in particular during any period where the terms of any UK exit from the EU are negotiated. In turn, Brexit could cause disruptions to and create uncertainty surrounding our business, including affecting our relationships with our existing and future payers and employees, which could have an adverse effect on our financial results, operations and prospects, including being adversely affected in ways that cannot be anticipated at present. The impact of Brexit on our business is not yet clear, and will depend on any agreements the UK makes to retain access to EU markets. Such agreements could potentially disrupt and/or destabilize the markets we serve and the tax jurisdictions in which we operate and adversely change tax benefits or liabilities in these or other jurisdictions. The terms of any UK exit from the EU could generate restriction on the movement of capital and the mobility of personnel. Depending on the outcome of negotiations between the UK and the European Union regarding the terms of Brexit (which will be negotiated over a period which may extend at least until March 2019), we may decide to alter the group's European operations to respond to new business, legal, regulatory, tax and trade environments that may result. In addition, Brexit could lead to legal uncertainty and potentially divergent national laws and regulations as the UK determines which EU laws to replace, modify or replicate.

Following the referendum, there was significant volatility in global stock markets and currency exchange rate fluctuations that resulted in the strengthening of the U.S. dollar against foreign currencies in which we conduct business. The strengthening of the U.S. dollar relative to the British pound and other currencies may adversely affect our results of operations as we translate sales and other results denominated in foreign currency into U.S. dollars for our financial statements. During periods of a strengthening dollar, our reported international sales and earnings could be reduced because foreign currencies may translate into fewer U.S. dollars. For the year ended December 31, 2017, revenue denominated in British pound represented 11.6% of our revenue.

Brexit may also create global economic uncertainty, which may cause our payers to closely monitor their costs and reduce their spending budget on our services. Additionally, changes in governmental personnel may impact our current relationships with our payers. Any of these effects and the uncertainties of Brexit, among others, could materially adversely affect our business, business opportunities, results of operations, financial condition, future growth and cash flows.

Changes to the regulatory landscape applicable to Matrix could have a material adverse effect on our results of operations and financial condition.

The CHA services industry is primarily regulated by federal and state healthcare Laws and the requirements of participation and reimbursement of the MA Program established by CMS. From time to time, CMS considers changes to regulatory guidelines with respect to prospective CHAs or the risk adjusted payment system applicable to Matrix's Medicare Advantage plan customers. CMS could adopt new requirements or guidelines that may, for example, increase the costs associated with CHAs, limit the opportunities and settings available to administer CHAs, or otherwise change the risk adjusted payment system in a way that would

adversely impact our business. Further, changes in or adoption of new state laws governing the scope of practice of mid-level practitioners, or more restrictive interpretations of such laws, may restrict Matrix's ability to provide services using nurse practitioners. Any such implementation of additional regulations on the CHA industry by CMS or other regulatory bodies or further regulation of mid-level practitioners could have a material adverse impact on Matrix's revenues and margins, which could have a material adverse impact on our consolidated results of operations.

If our U.S. Healthcare Segments fail to comply with physician self-referral laws, to the extent applicable to our operations, they could experience a significant loss of reimbursement revenue.

Our U.S. Healthcare Segments may be subject to federal and state statutes and regulations banning payments for referrals of patients and referrals by physicians to healthcare providers with whom the physicians have a financial relationship and billing for services provided pursuant to such referrals if any occur. Violation of these federal and state laws and regulations, to the extent applicable to our U.S. Healthcare Segments' operations, may result in prohibition of payment for services rendered, loss of licenses, fines, criminal penalties and exclusion from Medicaid and Medicare programs. To the extent such segments do maintain such financial relationships with physicians, they rely on certain exceptions to self-referral laws that they believe will be applicable to such arrangements. Any failure to comply with such exceptions could result in the penalties discussed above.

As government contractors, our segments are subject to an increased risk of litigation and other legal actions and liabilities.

As government contractors, our segments are subject to an increased risk of investigation, criminal prosecution, civil fraud, whistleblower lawsuits and other legal actions and liabilities that are not as frequently experienced by companies that do not provide government sponsored services. Companies providing government sponsored services can also become involved in public inquiries which can lead to negative media speculation or potential cancellation or termination of contracts. In WD Services in Europe, European procurement regulations in force in each European Union member state require public procurement authorities to impose a ban from participating in public procurement tenders for up to five years, or until the organization in question has put in place "self clean" measures to the satisfaction of the procuring authority, where companies are found guilty of fraud or certain other criminal offenses. Authorities can also exercise their discretion to blacklist companies for up to two years where they believe they have been involved in acts of gross misconduct or until the organization in question has put in place "self clean" measures to the satisfaction of the procuring authority. The occurrence of any of these actions, regardless of the outcome, could disrupt our operations and result in increased costs, and could limit our ability to obtain additional contracts in other jurisdictions. Further, government tenders in the U.S., the European Union and other countries can be subject to challenge where the procurer has not followed the correct processes, or where they seek to make material amendments to contracts after award. Consequently, it can be very difficult to convince government customers to amend their contracts, even where circumstances have changed significantly, because they are concerned that if challenged they may have to re-procure the entire service. This can pose significant risks in terms of cost management and profitability.

Our segments' businesses are subject to licensing regulations and other regulatory provisions, including provisions governing surveys and audits. Changes to, or violations of, these regulations could negatively impact our segments' revenues.

In many of the locations where our segments operate, they are required by local laws (both U.S. and foreign) to obtain and maintain licenses. The applicable state and local licensing requirements govern the services our segments provide, the credentials of staff, record keeping, treatment planning, client monitoring and supervision of staff. The failure to maintain these licenses or the loss of a license could have a material adverse impact on our segments' businesses and could prevent them from providing services to clients in a given jurisdiction. Our segments' contracts are subject to surveys or audit by their payers or their clients. Our segments are also subject to regulations that restrict their ability to contract directly with a government agency in certain situations. Such restrictions could affect our segments' ability to contract with certain payers and clients, and could have a material adverse impact on our segments' results of operations.

Our segments' contracts are subject to audit and modification by the payers with whom our segments contract, at their sole discretion.

Our segments' businesses depend on their ability to successfully perform under various government funded contracts. Under the terms of these contracts, payers, government agencies or their proxy contractors can review our segments' compliance or performance, as well as our segments' records and general business practices at any time, and may, in their discretion:

- suspend or prevent our segments from receiving new contracts or extending existing contracts because of violations or suspected violations of procurement laws or regulations;
- terminate or modify our segments' existing contracts;
- reduce the amount our segments are paid under our existing contracts; or
- audit and object to our segments' contract related fees.

Any increase in the number or scope of audits could increase our segments' expenses, and the audit process may disrupt the day-to-day operations of our segments' businesses and distract their management. If payers have significant audit findings, or if they make material modifications to our segments' contracts, it could have a material adverse impact on our segments' results of operations.

Contract profitability may decline due to actions by governmental agencies or penalties that are based on government generated statistical information that may not be known to us in advance.

WD Services' operating costs and profitability may be significantly impacted by actions required by a government agency, such as the availability of information systems maintained by the government to streamline enrollment into our service programs. Government generated performance statistics, such as the MOJ reoffending report, may not be known to us prior to its release by the government agencies. WD Services may be subject to penalties that are based on such government generated statistics, and we could be required to make material payments, the amounts of which we may not be able to estimate and which could have an adverse effect on our financial condition and results of operations.

In addition, certain contracts may require that we hire former government employees, in relation to offering our service programs, or develop new information technology systems which would serve to replace legacy systems operated by the government. Lastly, revenue under certain contracts may be adjusted prospectively if client volumes are below expectations or client profiles change materially, which may also lead to cost or productivity changes. If the Company is unable to adjust its costs accordingly, profitability is negatively impacted.

Our estimated income taxes could be materially different from income taxes that we ultimately pay.

We are subject to income taxation in both the U.S. and 10 foreign countries, including specific states or provinces where we operate. Our overall effective income tax rate is a function of applicable local tax rates and the geographic mix of our income from continuing operations before taxes, which is itself impacted by currency movements. Consequently, the isolated or combined effects of unfavorable movements in tax rates, geographic mix, or foreign exchange rates could reduce our after-tax income.

Our annual tax rate is based on our income and the tax laws in the various jurisdictions in which we operate. Significant judgment and estimation is required in determining our annual income tax expense and in evaluating our tax positions and related matters. In the ordinary course of our business, there are many transactions and calculations for which the ultimate tax determinations are uncertain or otherwise subject to interpretation. Although we believe our tax estimates are reasonable, the final determination of tax audits and any related disputes could be materially different from our historical income tax provisions and accruals. In addition, we make judgments regarding the applicability of tax treaties and the appropriate application of transfer pricing regulations. In the event one taxing jurisdiction disagrees with another taxing jurisdiction with respect to the amount or applicability of a particular type of tax, or the amount or availability of a particular type of tax refund or credit, we could experience temporary or permanent double taxation and increased professional fees to resolve such taxation matters. Our determination of our income tax liability is always subject to review by applicable tax authorities, and we have been audited by various jurisdictions in prior years. Although we believe our income tax estimates and related determinations are reasonable and appropriate, relevant taxing authorities may disagree. The ultimate outcome of any such audits and reviews could be materially different from the estimates and determinations reflected in our historical income tax provisions and accruals. Any adverse outcome of any such audit or review could have an adverse effect on our financial condition and the results of our operations.

The Tax Cuts and Jobs Act ("Tax Reform Act"), which was signed into law on December 22, 2017, significantly affected U.S. income tax law by changing how the U.S. imposes income tax on multinational corporations. We have recorded in our consolidated financial statements provisional amounts based on our current estimates of the effects of the Tax Reform Act in

accordance with our current understanding of the Tax Reform Act and currently available guidance. For additional information regarding the Tax Reform Act and the provisional tax amounts recorded in our consolidated financial statements, see "Management's Discussion and Analysis of Financial Condition and Results of Operations – Critical Accounting Policies". The final amounts may be significantly affected by regulations and interpretive guidance expected to be issued by the tax authorities, clarifications of the accounting treatment of various items, our additional analysis, and our refinement of our estimates of the effects of the Tax Reform Act and, therefore, such final amounts may be materially different than our current provisional amounts, which could materially affect our tax obligations and effective tax rate.

Risks Related to Our Indebtedness

Restrictive covenants in our Credit Agreement may limit our current and future operations, particularly our ability to respond to changes in our business or to pursue our business strategies.

The terms contained in the agreements that govern certain of our indebtedness, including our Amended and Restated Credit and Guaranty Agreement (as amended, supplemented, or modified, the "Credit Agreement"), and the agreements that govern any future indebtedness of ours, may include a number of restrictive covenants that impose significant operating and financial restrictions, including restrictions on our ability to take actions that we believe may be in our best interest. These agreements, among other things, limit our ability to:

- incur additional debt;
- provide guarantees in respect of obligations of other persons;
- issue redeemable stock and preferred stock;
- pay dividends or distributions or redeem or repurchase capital stock;
- make loans, investments and capital expenditures;
- enter into transactions with affiliates;
- create or incur liens;
- make distributions from our subsidiaries;
- sell assets and capital stock of our subsidiaries;
- make acquisitions; and
- consolidate or merge with or into, or sell substantially all of our assets to, another person.

A breach of the covenants or restrictions could result in a default under the applicable agreements that govern our indebtedness. Such default may preclude us from drawing from our senior secured credit facility (the "Credit Facility") or allow the creditors to accelerate the related debt and may result in the acceleration of any other debt that we may incur to which a cross acceleration or cross-default provision applies. In the event our lenders accelerate the repayment of our borrowings, we cannot assure that we and our subsidiaries would have sufficient assets to repay such indebtedness.

Loss of available financing or an inability to renew, repay or refinance our debt could have an adverse effect on our financial condition and results of operations.

At December 31, 2017, our available credit under the Credit Facility was $188.9 million. The Credit Facility matures on August 2, 2018. If our cash on hand is insufficient, or we are unable to generate sufficient cash flows in the future, to cover our cash flow and liquidity needs and service our debt, we may be required to seek additional sources of funds, including refinancing all or a portion of our existing or future debt, incurring additional debt to maintain sufficient cash flow to fund our ongoing operating needs, pay interest and fund anticipated expenditures. There can be no assurance that any refinancing will be possible or that any additional financing could be obtained on acceptable terms. If we are unable to obtain additional financing, we may (i) be unable to satisfy our obligations under our outstanding indebtedness, (ii) be unable to pursue future business opportunities or fund acquisitions, (iii) find it more difficult to fund future operating costs, tax payments or general corporate expenditures and (iv) become vulnerable to adverse general economic, capital markets and industry conditions. Any of these circumstances could have a material adverse effect on our financial position, liquidity and results of operations.

We may incur substantial additional indebtedness in the future, which could impair our financial condition.

We may incur substantial additional indebtedness in the future to fund activities including but not limited to share repurchases, acquisitions, cash dividends and business expansion. Any existing and future indebtedness increases the risk that we may be unable to generate cash sufficient to pay amounts due in respect of such indebtedness. Future substantial indebtedness could have other important consequences on our business. For example, it could:

- make it more difficult for us to satisfy our obligations;
- make it more difficult to renew or enter into new contracts with existing and potential future clients;
- limit our ability to borrow additional amounts to fund working capital, capital expenditures, debt service requirements, execution of our business strategy or acquisitions and other purposes;
- require us to dedicate a substantial portion of our cash flow from operations to pay principal and interest on our debt, which would reduce the funds available to us for other purposes;
- restrict our ability to dispose of assets and use the proceeds from any such dispositions;
- restrict our ability to raise debt or equity capital to be used to repay other indebtedness when it becomes due;
- make us more vulnerable to adverse changes in general economic, industry and competitive conditions, as well as in government regulation and to our business;
- expose us to risks inherent in interest rate fluctuations because some of our borrowings are at variable rates of interest, which could result in higher interest expenses in the event of increases in interest rates; and
- make it more difficult to satisfy our financial obligations.

Our ability to satisfy and manage our debt obligations depends on our ability to generate cash flow and on overall financial market conditions. To some extent, this is subject to prevailing economic and competitive conditions and to certain financial, business and other factors, many of which are beyond our control. Our business may not generate sufficient cash flow from operations to permit us to pay principal, premium, if any, or interest on our debt obligations. If we are unable to generate sufficient cash flow from operations to service our debt obligations and meet our other cash needs, we may be forced to reduce or delay capital expenditures, sell or curtail assets or operations, seek additional capital, or seek to restructure or refinance our indebtedness. If we must sell or curtail our assets or operations, it may negatively affect our ability to generate revenue.

Risks Related to Our Capital Stock

Our annual operating results and stock price may be volatile or may decline significantly regardless of our operating performance.

Our annual operating results and the market price for our Common Stock may fluctuate significantly in response to a number of factors, many of which we cannot control, including:

- changes in rates or coverage for services by payers;
- changes in Medicaid, Medicare or other U.S. federal or state rules, regulations, policies or applicable foreign regulations, policies and technical guidance, including UK health, employment and criminal justice legislation and guidance, Saudi Arabian licensing and Saudization rules, as well as other foreign laws applicable to our business;
- price and volume fluctuations in the overall stock market;
- market conditions or trends in our industry or the economy as a whole;
- increased competition in any of our segments, including through insourcing of services by our clients and new entrants to the market;
- other events or factors, including those resulting from war, incidents of terrorism, natural disasters or responses to these events;
- changes in tax law; and
- changes in accounting principles.

In addition, the stock markets, and in particular the NASDAQ Global Select Market, have experienced considerable price and volume fluctuations that have affected and continue to affect the market prices of equity securities of many companies. In the past, stockholders have instituted securities class action litigation following periods of market volatility. If we become involved in securities litigation, we could incur substantial costs, and our resources and the attention of management could be diverted from our business.

The Company depends on its subsidiaries for cash to fund all of its operations and expenses, including to make future dividend payments, if any.

Our operations are conducted entirely through our subsidiaries and our ability to generate cash to fund all of our operations and expenses, to pay dividends or to meet any debt service obligations is highly dependent on the earnings and the receipt of funds from our subsidiaries via dividends or intercompany loans. We do not currently expect to declare or pay dividends on our Common Stock for the foreseeable future; however, to the extent that we determine in the future to pay dividends on our Common Stock, none of our subsidiaries will be obligated to make funds available to us for the payment of dividends. Further, the agreement governing our Credit Agreement significantly restricts the ability of our subsidiaries to pay dividends, make loans or otherwise transfer assets to us. In addition, Delaware law may impose requirements that may restrict our ability to pay dividends to holders of our Common Stock.

If securities or industry analysts do not publish research or publish misleading or unfavorable research about our business, our stock price and trading volume could decline.

The trading market for our Common Stock will depend in part on the research and reports that securities or industry analysts publish about us or our business. If one or more analysts downgrade our stock or publish misleading or unfavorable research about our business, our stock price would likely decline. If one or more of these analysts ceases coverage of our company or fails to publish reports on us regularly, demand for our stock could decrease, which could cause our stock price or trading volume to decline.

Future sales of shares by existing stockholders could cause our stock price to decline.

Sales of substantial amounts of our Common Stock in the public market, or the perception that these sales could occur, could cause the market price of our Common Stock to decline. As of March 5, 2018, we had 12,866,551 outstanding shares of Common Stock which are freely transferable without restriction or further registration under the Securities Act of 1933, as amended (the "Securities Act"), unless held by or purchased by our "affiliates" as that term is defined in Rule 144 under the Securities Act. Shares of our Common Stock held by or purchased by our affiliates are restricted securities within the meaning of Rule 144 under the Securities Act, but will be eligible for resale subject to applicable volume, means of sale, holding period and other limitations of Rule 144 under the Securities Act.

As of March 5, 2018, shares of our convertible preferred stock were convertible into 2,014,042 shares of Common Stock, all of which are subject to registration rights. In addition, as of March 5, 2018, 1,653,755 shares of Common Stock are beneficially owned by entities for which Coliseum Capital Management acts as investment adviser.

In August 2016, we filed a registration statement under the Securities Act to register additional shares of Common Stock to be issued under our equity compensation plans and, as a result, all shares of Common Stock acquired upon exercise of stock options granted under our plans will also be freely tradable under the Securities Act, unless purchased by our affiliates. As of December 31, 2017, there were stock options outstanding to purchase a total of 606,695 shares of our Common Stock and there were 111,157 shares of our Common Stock subject to restricted stock awards. In addition, 1,938,666 shares of our Common Stock are reserved for future issuances under the plan.

The terms of our Preferred Stock contain restrictive covenants that may impair our ability to conduct business and we may not be able to maintain compliance with the obligations under our outstanding Preferred Stock which could have a material adverse effect on our future results of operations and our stock price.

On February 11, 2015 and March 12, 2015, we issued $65.5 million and $15.8 million, respectively, of Preferred Stock. The terms of the Preferred Stock require us to pay mandatory quarterly dividends, either in cash or through an increase in the stated principal value of such stock. Our ability to satisfy and manage our obligations under our outstanding Preferred Stock depends, in part, on our ability to generate cash flow and on overall financial market conditions. Additionally, the terms of our Preferred Stock contain operating and financial covenants that limit management's discretion with respect to certain business matters. Among other things, these covenants, subject to certain limitations and exceptions, restrict our ability to incur additional debt, sell or otherwise dispose of our assets, make acquisitions, and merge or consolidate with other entities. As a result of these covenants and restrictions, we may be limited in how we conduct our business, which could have a material adverse effect on our future results of operations and our stock price.

Future offerings of debt or equity securities that would rank senior to our Common Stock, may adversely affect the market price of our Common Stock.

If, in the future, we decide to issue debt or equity securities that rank senior to our Common Stock, it is likely that such securities will be governed by an indenture or other instrument containing covenants restricting our operating flexibility. Additionally, any convertible or exchangeable securities that we issue in the future may have rights, preferences and privileges more favorable than those of our Common Stock and may result in dilution to owners of our Common Stock. We and, indirectly, our stockholders, will bear the cost of issuing and servicing such securities. Because our decision to issue debt or equity securities in any future offering will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing or nature of our future offerings. Thus, holders of our Common Stock will bear the risk of our future offerings reducing the market price of our Common Stock and diluting the value of their stock holdings in us.

Fulfilling our obligations incident to being a public company, including with respect to the requirements of and related rules under the Sarbanes-Oxley Act of 2002, is expensive and time-consuming, and any delays or difficulties in satisfying these obligations could have a material adverse effect on our future results of operations and our stock price.

We are subject to the reporting and corporate governance requirements, under the listing standards of the NASDAQ Global Select Market ("NASDAQ") and the Sarbanes-Oxley Act of 2002 (the "Sarbanes-Oxley Act"), that apply to issuers of listed equity, which impose certain significant compliance costs and obligations upon us. Being a publicly listed company requires a significant commitment of additional resources and management oversight resulting in increased operating costs. These requirements also place additional demands on our finance and accounting staff and on our financial accounting and information systems. Other expenses associated with being a public company include increases in auditing, accounting and legal fees and expenses, investor relations expenses, increased directors' fees and director and officer liability insurance costs, registrar and transfer agent fees and listing fees, as well as other expenses. As a public company, we are required, among other things, to define and expand the roles and the duties of our Board of Directors ("Board") and its committees and institute more comprehensive compliance and investor relations functions.

If we fail to maintain effective internal control over financial reporting in the future, the accuracy and timing of our financial reporting may be adversely affected. Preparing our consolidated financial statements involves a number of complex manual and automated processes, which are dependent upon individual data input or review and require significant management judgment. One or more of these elements may result in errors that may not be detected and could result in a material misstatement of our consolidated financial statements. If a material misstatement occurs in the future, we may fail to meet our future reporting obligations. For example, we may fail to file periodic reports in a timely manner or may need to restate our financial results, either of which may cause the price of our common stock to decline. In addition, our WD Services business is subject to the European Union's and other countries' data security and protection laws and regulations, which may make it more difficult for the Company to maintain the records and internal accounting practices necessary to ensure the appropriate operation of our internal controls or to detect corruption or increasing the Company's costs to maintain appropriate controls.

If the accounting estimates we make, and the assumptions on which we rely, in preparing our financial statements prove inaccurate, our actual results may be adversely affected.

Our financial statements have been prepared in accordance with accounting principles generally accepted in the United States, or GAAP. The preparation of these financial statements requires us to make estimates and judgments about, among other things, taxes, revenue recognition, contingent obligations, NET Services transportation expense, recoverability of long-lived assets and doubtful accounts. In addition, our foreign operations report their results pursuant to International Financial Reporting Standards, or IFRS, or local accounting standards, which requires judgment to convert into GAAP. Lastly, the implementation of ASU No. 2014-09, Revenue from Contracts with Customers (Topic 606), which is effective for the Company beginning January 1, 2018, requires a significant level of judgment and estimation, especially in regards to contingent or success-based payments, such as those prevalent at WD Services. These estimates and judgments affect the reported amounts of our assets, liabilities, revenue and expenses, the amounts of charges accrued by us, and related disclosure of contingent assets and liabilities. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances and at the time they are made. If our estimates or the assumptions underlying them are not correct, we may need to accrue additional charges or reduce the value of assets that could adversely affect our results of operations, leading to a loss in investor confidence in our ability to manage our business and our stock price could decline.

Anti-takeover provisions in our second amended and restated certificate of incorporation and amended and restated by-laws could discourage, delay or prevent a change of control of our company and may affect the trading price of our Common Stock.

Our second amended and restated certificate of incorporation and amended and restated bylaws include a number of provisions that may be deemed to have anti-takeover effects, which include when and by whom special meetings of our stockholders may be called, and may discourage, delay or prevent a change in our management or control over us that stockholders may consider favorable. Such provisions may prevent our stockholders from receiving the benefit from any premium to the market price of our Common Stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our Common Stock if the provisions are viewed as discouraging takeover attempts in the future. Our second amended and restated certificate of incorporation and amended and restated by-laws may also make it difficult for stockholders to replace or remove our management. These provisions may facilitate management entrenchment that may delay, deter, render more difficult or prevent a change in our control, which may not be in the best interests of our stockholders.

We do not expect to pay dividends on our Common Stock and, consequently, your ability to achieve a return on your investment will depend on appreciation in the price of our Common Stock.

We currently do not expect to declare and pay dividends on our Common Stock for the foreseeable future. We currently intend to invest our future earnings, if any, to fund our growth, to develop our business, for working capital needs and for general corporate purposes. Therefore, you are not likely to receive any dividends on your Common Stock for the foreseeable future and the success of an investment in shares of our Common Stock will depend upon any future appreciation in their value. There is no guarantee that shares of our Common Stock will appreciate in value or even maintain the price at which stockholders have purchased their shares.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

Our principal executive office is located in Stamford, Connecticut, and we lease additional office space in Tucson, Arizona. As of March 2, 2018, NET Services leases space in approximately 40 locations, WD Services leases space in approximately 220 locations, and Matrix leases space in five locations. The lease terms vary and we believe are generally at market rates. We believe that our properties are adequate for our current business needs, and believe that we can obtain adequate space, if needed, to meet our foreseeable business needs.

Item 3. Legal Proceedings.

On June 15, 2015, a putative stockholder class action derivative complaint was filed in the Court of Chancery of the State of Delaware (the "Court"), captioned Haverhill Retirement System v. Kerley et al., C.A. No. 11149-VCL (the "Haverhill Litigation"). The complaint named Richard A. Kerley, Kristi L. Meints, Warren S. Rustand, Christopher Shackelton (the "Individual Defendants") and Coliseum Capital Management, LLC ("Coliseum Capital Management") as defendants, and the Company as a nominal defendant. The complaint purported to allege that the dividend rate increase term originally in the Company's outstanding Preferred Stock was an impermissibly coercive measure that impaired the voting rights of the Company's stockholders in connection with the vote on the removal of certain voting and conversion caps previously applicable to the Preferred Stock (the "Caps"), and that the Individual Defendants breached their fiduciary duties by approving the dividend rate increase term and attempting to coerce the stockholder vote relating to the Company's Preferred Stock, and by failing to disclose all material information necessary to allow the Company's stockholders to cast an informed vote on the Caps. The complaint also purported to allege derivative claims alleging that the Individual Defendants breached their fiduciary duties to the Company by entering into the subordinated note and standby agreement with Coliseum Capital Management, and granting Coliseum Capital Management certain stock options. The complaint further alleged that Coliseum Capital Management aided and abetted the Individual Defendants in breaching their fiduciary duties. The complaint sought, among other things, an injunction prohibiting the stockholder vote relating to the dividend rate increase, corporate governance reforms, unspecified damages and other relief.

On August 31, 2015, after arms' length negotiations, the parties reached an agreement in principle and executed a Memorandum of Understanding ("MOU") providing for the settlement of claims concerning the dividend rate increase term and stockholder vote and related disclosure. The MOU stated that the Defendants had entered into the partial settlement of the litigation solely to eliminate the distraction, burden, expense, and potential delay of further litigation involving claims that have been settled. Pursuant to the partial settlement, the Company agreed to supplement the disclosures in its definitive proxy statement on Schedule

14A (the "2015 Proxy Statement"), Coliseum Capital Management and certain of its affiliates and the Company entered into an amendment to that certain Series A Preferred Stock Exchange Agreement, by and among Coliseum Capital Partners, L.P., Coliseum Capital Partners II, L.P., Coliseum Capital Co-Invest, L.P., Blackwell Partners, LLC, and The Providence Service Corporation dated as of February 11, 2015 described in the 2015 Proxy Statement, and the Board agreed to adopt a policy related to the Board's determination each quarter as to whether the Company should pay cash dividends or allow dividends to be paid in the form of PIK dividends on the Preferred Stock, as further described in the supplemental proxy disclosures. On September 2, 2015, Providence issued supplemental disclosures through a supplement to the 2015 Proxy Statement. On September 16, 2015, Providence stockholders approved the removal of the Caps. The Company provided notice of the proposed partial settlement to Providence's stockholders by December 11, 2015. At a hearing on February 9, 2016, the court denied approval of the settlement. The Court indicated that plaintiff's counsel could petition the Court for a mootness fee, and that defendants would have the opportunity to oppose any such application.

On January 12, 2016, the plaintiff filed a verified amended class action and derivative complaint (the "first amended complaint"). In addition to the defendants named in the earlier complaint, the first amended complaint named David Shackelton, Coliseum Capital Partners, L.P., Coliseum Capital Partners II, L.P., Blackwell Partners, LLC, Coliseum Capital Co-Invest, L.P. (collectively, and together with Coliseum Capital Management, LLC, "Coliseum") and RBC Capital Markets, LLC ("RBC Capital Markets") as additional defendants. The first amended complaint purported to allege direct and derivative claims for breach of fiduciary duty against some or all of the Individual Defendants and David Shackelton (collectively, the "Amended Individual Defendants") regarding the approval of the subordinated note, the rights offering, the standby agreement with Coliseum Capital Management, and the grant to Coliseum Capital Management of certain stock options. The first amended complaint also purported to allege an additional derivative claim for unjust enrichment against Coliseum and further alleged that Coliseum and RBC Capital Markets aided and abetted the Amended Individual Defendants in breaching their fiduciary duties. The first amended complaint sought, among other things, revision or rescission of the terms of the subordinated note and Preferred Stock, corporate governance reforms, unspecified damages and other relief.

On May 6, 2016, the plaintiff filed a verified second amended class action and derivative complaint (the "second amended complaint"). In addition to the defendants named in the earlier complaint, the second amended complaint named Paul Hastings LLP ("Paul Hastings") and Bank of America, N.A. ("BofA") as additional defendants. In addition to previously asserted claims, the second amended complaint purported to assert direct and derivative claims for breach of fiduciary duties against Coliseum Capital Management, in its capacity as the controlling stockholder of the Company, in connection with the subordinated note, the Company's rights offering of Preferred Stock and the standby purchase agreement with Coliseum Capital Management (the "Financing Transactions"). The second amended complaint also alleged that Paul Hastings breached their fiduciary duties as counsel to the Company in connection with the Financing Transactions and that BofA and Paul Hastings aided and abetted certain of the Amended Individual Defendants in breaching their fiduciary duties in connection with the Financing Transactions. The second amended complaint sought, among other things, revision or rescission of the terms of the subordinated note and Preferred Stock, corporate governance reforms, disgorgement of fees paid to RBC Capital Markets, Paul Hastings and BofA for work relating to the Financing Transactions, unspecified damages and other relief.

On May 20, 2016, the Court granted a six-month stay of the proceeding (which was subsequently extended) to allow a special litigation committee, created by the Board, sufficient time to investigate, review and evaluate the facts, circumstances and claims asserted in or relating to this action and determine the Company's response thereto. On January 20, 2017, the special litigation committee advised the Court that the parties to the litigation and the special litigation committee had reached an agreement in principle to settle all of the claims in the litigation. The parties then entered into a proposed settlement agreement which was submitted to the Court for approval. On September 28, 2017, the Court approved the proposed settlement agreement among the parties that provided for a settlement amount of $10 million less plaintiff's legal fees and expenses (the "Settlement Amount"), with 75% of the Settlement Amount to be paid to the Company and 25% of the Settlement Amount to be paid to holders of the Company's Common Stock other than certain excluded parties. On November 16, 2017, the Company, as a nominal defendant, received a payment of $5.4 million from the Settlement Amount.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

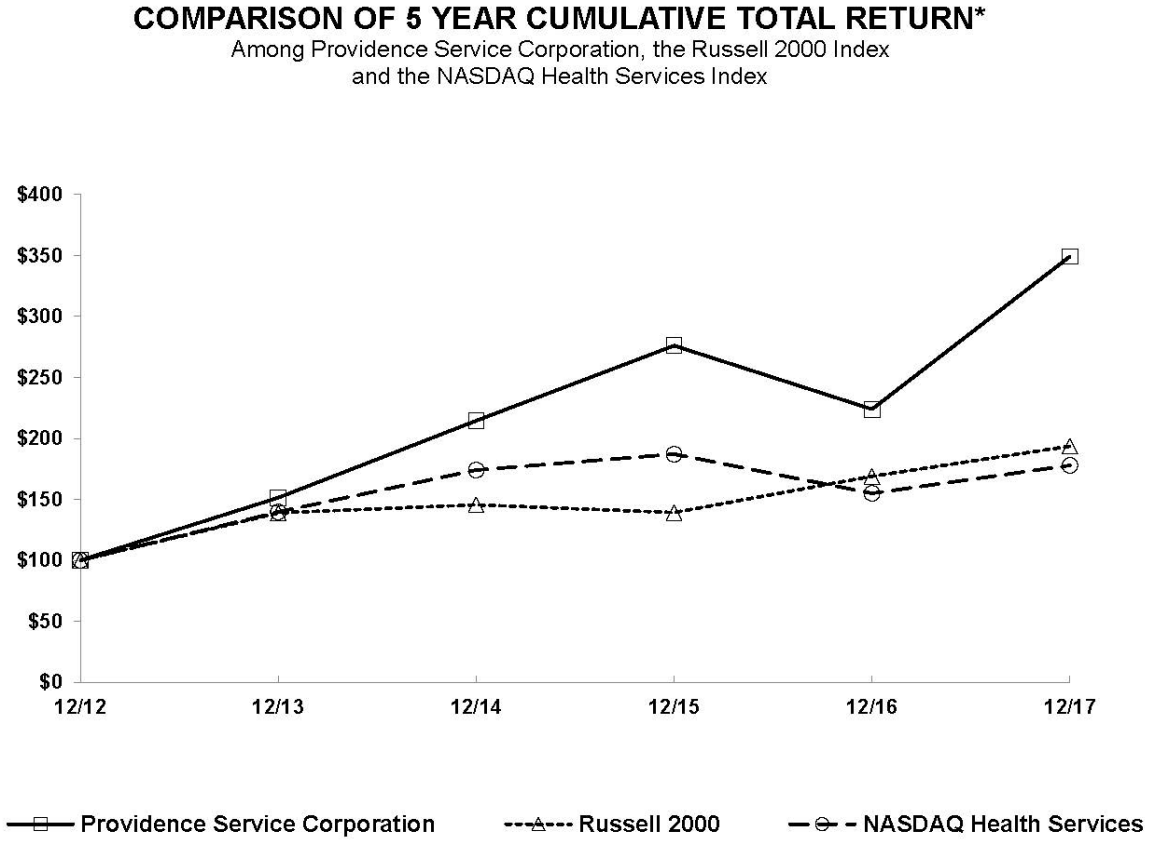
Market for our Common Stock

Our Common Stock, our only class of common equity, has been quoted on NASDAQ under the symbol "PRSC" since August 19, 2003. Prior to that time there was no public market for our Common Stock. As of March 5, 2018, there were 22 holders of record of our Common Stock. The following table sets forth the high and low sales prices per share of our Common Stock for the period indicated, as reported on NASDAQ Global Select Market:

	High	Low
2017		
Fourth Quarter	$ 60.59	$ 53.84
Third Quarter	$ 54.99	$ 49.77
Second Quarter	$ 47.47	$ 43.73
First Quarter	$ 41.80	$ 37.65
2016		
Fourth Quarter	$ 49.97	$ 34.89
Third Quarter	$ 50.30	$ 43.01
Second Quarter	$ 53.38	$ 43.77
First Quarter	$ 55.28	$ 42.03

Stock Performance Graph

The following graph shows a comparison of the cumulative total return for our Common Stock, NASDAQ Health Services Index and Russell 2000 Index assuming an investment of $100 in each on December 31, 2012.



*$100 invested on 12/31/12 in stock or index, including reinvestment of dividends.
Fiscal year ending December 31.

Dividends

We have not paid any cash dividends on our Common Stock and currently do not expect to pay dividends on our Common Stock. In addition, our ability to pay dividends on our Common Stock is limited by the terms of our Credit Agreement and our Preferred Stock. The payment of future cash dividends, if any, will be reviewed periodically by the Board and will depend upon, among other things, our financial condition, funds from operations, the level of our capital and development expenditures, any restrictions imposed by present or future debt or equity instruments, and changes in federal tax policies, if any.

Issuer Purchases of Equity Securities

Period	Total Number of Shares of Common Stock Purchased (1)	Average Price Paid per Share	Total Number of Shares of Common Stock Purchased as Part of Publicly Announced Program (2)	Maximum Dollar Value of Shares of Common Stock that May Yet Be Purchased Under Program (2) (in thousands)
Fourth quarter:				
October 1, 2017 to October 31, 2017	—	$ —	—	$ 69,640
November 1, 2017 to November 30, 2017	247	$ 56.74	—	$ 69,640
December 1, 2017 to December 31, 2017	181,714	$ 58.27	180,270	$ 59,137
Total	181,961	$ 58.26	180,270	

(1) Includes (i) shares that were acquired from employees in connection with the settlement of income tax and related benefit withholding obligations arising from vesting in restricted stock awards; and (ii) the repurchase of shares under the repurchase program authorized by the Board on November 2, 2017. For more information on these repurchases, see Note 11, Stockholders' Equity, to our consolidated financial statements.

(2) On October 26, 2016, our Board authorized a new repurchase program, under which the Company may repurchase up to $100.0 million in aggregate value of the Company's Common Stock during the twelve-month period following October 26, 2016. Through October 26, 2017, a total of 770,808 shares were purchased through this plan for $30.4 million, excluding commission payments.

On November 2, 2017, our Board approved the extension of the Company's prior stock repurchase program, authorizing the Company to engage in a repurchase program to repurchase up to $69.6 million (the amount remaining from the $100.0 million repurchase amount authorized in 2016) in aggregate value of our Common Stock through December 31, 2018. Purchases under the repurchase program may be made from time-to-time through a combination of open market repurchases (including Rule 10b5-1 plans), privately negotiated transactions, and accelerated share repurchase transactions, at the discretion of the Company's officers, and as permitted by securities laws, covenants under existing bank agreements, and other legal requirements. As of December 31, 2017, a total of 180,270 shares were purchased through the extended plan approved on November 2, 2017, for $10.5 million, excluding commission payments. For additional information, see Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations – Liquidity and capital resources".

Equity Compensation Plan Information

The following table provides certain information as of December 31, 2017 with respect to our equity based compensation plans.

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	(b) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
Equity compensation plans approved by security holders (1)	606,695	$ 48.70	1,938,666
Equity compensation plans not approved by security holders	—	—	—
Total	606,695	48.70	1,938,666

(1) The number of shares shown in column (b) represents the number of shares available for issuance pursuant to stock options and other stock-based awards that could be granted in the future under the Company's 2006 Long-Term Incentive Plan, as amended (the "2006 Plan").

Item 6. Selected Financial Data.

We have derived the following selected financial data from the consolidated financial statements and related notes. The information set forth below is not necessarily indicative of future results. This information should be read in conjunction with our consolidated financial statements and the related notes, and Item 7. “Management’s Discussion and Analysis of Financial Condition and Results of Operations”, all of which are included elsewhere in this Annual Report on Form 10-K.

Significant transactions which occurred during the periods presented include the acquisition of Ingeus effective May 30, 2014, which primarily comprises our WD Services segment, the investment in Mission Providence, a joint venture in Australia, which commenced operations in 2014 but was sold on September 29, 2017, and our equity interest in Matrix effective October 19, 2016. Matrix, which was originally acquired on October 23, 2014, comprised our HA Services segment through October 19, 2016. The operations of HA Services and Human Services, which was sold effective November 1, 2015, have been presented as discontinued operations for all periods presented.

	Year Ended December 31,				
	2017	2016	2015	2014	2013
	(1)(2)(3)(4)(8)(9)	(3)(5)(6)(8)(9)	(7)(8)(9)(11)	(8)(10)(11)	
	(dollars and shares in thousands, except per share data)				
Statement of operations data:					
Service revenue, net	$ 1,623,882	$ 1,578,245	$ 1,478,010	$ 1,092,880	$ 798,766
Operating expenses:					
Service expense	1,489,044	1,452,110	1,381,154	988,600	736,669
General and administrative expense	72,336	69,911	70,986	44,080	25,590
Asset impairment charge	—	21,003	—	—	—
Depreciation and amortization	26,469	26,604	23,998	17,213	9,331
Total operating expenses	1,587,849	1,569,628	1,476,138	1,049,893	771,590
Operating income	36,033	8,617	1,872	42,987	27,176
Non-operating expense:					
Interest expense, net	1,278	1,583	1,853	10,224	6,921
Other income	(5,363)	—	—	—	—
Loss on extinguishment of debt	—	—	—	—	525
Equity in net (gain) loss of investees	(12,054)	10,287	10,970	—	—
Gain on sale of investment	(12,377)	—	—	—	—
Loss (gain) on foreign currency transactions	345	(1,375)	(857)	(37)	—
Income (loss) from continuing operations, before income taxes	64,204	(1,878)	(10,094)	32,800	19,730
Provision for income taxes	4,401	17,036	14,583	8,289	6,625
Income (loss) from continuing operations, net of tax	59,803	(18,914)	(24,677)	24,511	13,105
Discontinued operations, net of tax	(5,983)	108,760	107,871	(4,236)	6,333
Net income	53,820	89,846	83,194	20,275	19,438
Net (gain) loss attributable to noncontrolling interests	(451)	2,082	502	—	—
Net income attributable to Providence	$ 53,369	$ 91,928	$ 83,696	$ 20,275	$ 19,438
Diluted earnings (loss) per common share:					
Continuing operations	$ 3.50	$ (1.45)	$ (1.83)	$ 1.63	$ 0.95
Discontinued operations	(0.44)	6.52	6.09	(0.28)	0.46
Total	$ 3.06	$ 5.07	$ 4.26	$ 1.35	$ 1.41
Weighted-average number of common shares outstanding:					
Diluted	13,673	14,667	15,961	15,019	13,810

	As of December 31,				
	2017	2016	2015	2014	2013
	(9)	(5)(6)			
	(dollars in thousands)				
Balance sheet data:					
Cash and cash equivalents	$ 95,310	$ 72,262	$ 79,756	$ 121,538	$ 75,156
Total assets	704,090	685,279	1,050,202	1,168,934	425,954
Long-term obligations, including current portion	2,984	3,611	300,071	574,613	123,500
Other liabilities	287,543	306,428	382,423	372,907	151,817
Convertible preferred stock	77,546	77,565	77,576	—	—
Total stockholders' equity	336,017	297,675	290,132	221,414	150,637

(1) Other income for the year ended December 31, 2017 includes the receipt of the Haverhill Litigation settlement of $5.4 million, see Item 3. Legal Proceedings for further information on the settlement.

(2) Gain on sale of equity investment of $12.4 million relates to the sale of the Company's equity interest in Mission Providence in 2017. The investment in Mission Providence was part of the WD Services segment.

(3) Discontinued operations, net of tax, for the years ended December 31, 2017 and 2016 include losses of $6.0 million and $5.6 million, respectively, related to potential indemnification claims for our historical Human Services segment.

(4) The year ended December 31, 2017 includes a net tax benefit of $16.0 million related to the enactment of the Tax Reform Act during the fourth quarter of 2017 due to the re-measurement of deferred tax liabilities by Providence as a result of the reduction in the U.S. corporate tax rate. Providence realized a benefit of $19.4 million, partially offset by $3.4 million of increased tax expense resulting from additional equity in net gain of Matrix, due to Matrix's re-measurement of its deferred tax liabilities. In addition, the tax provision was adversely impacted by tax expense of $3.6 million related to the Company's 2015 Holding Company LTI Program (the "HoldCo LTIP"), for which expense was incurred for financial reporting purposes, but no shares were issued due to the market condition of the award not being satisfied and thus no tax deduction was realized.

(5) On October 19, 2016, we completed the Matrix Transaction. Included in discontinued operations, net of tax, for 2016 is a gain on the transaction, net of tax, totaling $109.4 million. In conjunction with the completion of this transaction, we fully repaid the amounts outstanding on our term loans and Credit Facility in 2016.

(6) During the fourth quarter of 2016, WD Services recorded long-lived asset impairment charges of $10.0 million, $4.4 million and $5.2 million to its property and equipment, intangible assets and goodwill, respectively, primarily due to lower than expected volumes and unfavorable service mix shifts under a large contract in the UK impacting future projections; additional clarity into the anticipated size and structure of the Work and Health Programme in the UK; and the absence of additional details regarding the restructuring of the offender rehabilitation contract in the UK.

(7) On November 1, 2015, we completed the sale of our Human Services segment. Included in discontinued operations, net of tax, for 2015 is a gain on the sale of the Human Services segment, net of tax, totaling $100.3 million.

(8) The Company incurred $20.9 million of accelerated expense in 2015 related to restricted shares and cash placed into escrow at the time of the Ingeus acquisition. The shares and cash were placed into escrow concurrent with the payments of the acquisition consideration paid in 2014 for Ingeus; however, because two sellers of Ingeus remained employees post acquisition, the value of the shares and cash was recognized as compensation expense over the escrow term. Acceleration was triggered in 2015 when the two sellers separated from the Company. In addition, in 2015 and 2014, respectively, the Company incurred $5.9 million and $4.5 million of expense related to the separation of these two employees. Benefits of $2.0 million, $2.5 million and $16.1 million associated with the favorable resolution of acquisition contingencies and reductions in the fair value of Ingeus contingent consideration are included in general and administrative expenses for 2017, 2015 and 2014, respectively. 2017, 2016 and 2015 expenses also include $2.6 million, $8.5 million and $12.2 million, respectively, of WD Services' redundancy costs.

(9) Equity in net (gain) loss of investees primarily relates to our investment in Mission Providence during 2015, 2016 and 2017 and Matrix for the period of October 19, 2016 through December 31, 2017. Matrix became an equity investment upon the completion of the Matrix Transaction. For Mission Providence, we recorded net loss in investee of $1.4 million, $8.5 million and $11.0 million in 2017, 2016 and 2015, respectively. For Matrix, we recorded $13.4 million in equity in net gain of investee and $1.8 million in equity in net loss of investee related to our equity method investment in Matrix in 2017 and for the period of October 19, 2016 through December 31, 2016, respectively. The equity in net gain from Matrix for the year ended December 31, 2017 includes a benefit of $13.6 million related to the re-measurement of deferred tax liabilities arising from a lower U.S. corporate tax rate as a result of the Tax Reform Act. As a result of the increased equity income, Providence incurred higher tax expense of $3.4 million, which is reflected as a component of “Provision for income taxes” in the table above. The investment in Matrix at December 31, 2017 of $169.7 million is included in “Equity investments” in our consolidated balance sheet.

(10) 2014 includes $4.5 million of financing fees that were deferred and fully expensed within interest expense in the fourth quarter of 2014 in relation to bridge financing commitments and $3.0 million of third-party financing fees that are included in general and administrative expense.

(11) 2015 includes $2.4 million in Ingeus transaction-related expenses and 2014 includes $11.8 million in acquisition costs primarily related to the acquisitions of Ingeus and Matrix.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with Item 6. "Selected Financial Data" and our consolidated financial statements and related notes included in Item 8. "Financial Statements and Supplementary Data" of this report. This discussion and analysis contains forward-looking statements that involve risks, uncertainties and other factors that may cause actual results to differ materially from those projected in any forward-looking statements, as discussed in "Disclosure Regarding Forward-Looking Statements". These risks and uncertainties include but are not limited to those set forth in Item 1A. "Risk Factors".

Overview of Our Business

Please refer to Item 1. "Business" of this Annual Report on Form 10-K for a discussion of our services and corporate strategy.

Providence owns subsidiaries and investments primarily engaged in the provision of healthcare services in the United States and workforce development services internationally. The subsidiaries and other investments in which we hold interests comprise the following segments:

- NET Services – Nationwide manager of non-emergency medical transportation programs for state governments and managed care organizations.
- WD Services – Global provider of employment preparation and placement services, legal offender rehabilitation services, youth community service programs and certain health related services to eligible participants of government sponsored programs.
- Matrix Investment – Minority interest in Matrix, a nationwide provider of in-home care optimization and management solutions, including CHAs, to members of managed care organizations, accounted for as an equity method investment. On February 16, 2018, Matrix acquired HealthFair, expanding its service offerings to include mobile health assessments, advanced diagnostic testing, and additional care optimization services.

In addition to its segments' operations, the Corporate and Other segment includes the Company's activities at its corporate office that include executive, accounting, finance, internal audit, tax, legal, public reporting, certain strategic and corporate development functions and the results of the Company's captive insurance company. We are actively monitoring these activities as they relate to our capital allocation and acquisition strategy to ensure alignment with Providence's overall strategic objectives and its goal of enhancing shareholder value.

Business Outlook and Trends

Our performance is affected by a number of trends that drive the demand for our services. In particular, the markets in which we operate are exposed to various trends such as healthcare industry and demographic dynamics in the U.S. and international government outsourcing and employment dynamics. Over the long term, we believe there are numerous factors that could affect growth within the industries in which we operate, including:

- an aging population, which will increase demand for healthcare services;
- a movement towards value-based versus fee for service care and budget pressure on governments, both of which may increase the use of private corporations to provide necessary and innovative services;
- increasing demand for in-home care provision, driven by cost pressures on traditional reimbursement models and technological advances enabling remote engagement;
- technological advancements, which may be utilized by us to improve service and lower costs, but also by others which may increase industry competitiveness;
- changes in UK government policy driven by opposition to the government's outsourcing of the services provided by WD Services to private companies, which opposition may increase in light of recent events in the UK, including the liquidation of the UK government contractor Carillion plc;
- the results of the referendum on the UK's exit from the European Union and related political and economic uncertainty in the UK; and
- proposals by the President of the United States and Congress to change the Medicaid program, including considering converting the Medicaid program to a block grant format or capping the federal contribution to state Medicaid programs

to a fixed amount per beneficiary, and CMS' grant of waivers to states relative to the parameters of their Medicaid programs. Enactment of adverse legislation, regulation or agency guidance, may reduce the demand for our services, our ability to conduct some or all of our business and/or reimbursement rates for services performed within our segments.

Historically, our segments have grown through organic expansion into new markets and service lines, organic expansion within existing markets and service lines, increases in the number of members served under contracts we have been awarded, the securing of new contracts, and acquisitions. With respect to acquisitions, we are actively evaluating the optimal industry sectors, such as the non-emergency medical transportation industry and others in which businesses complementary to our NET Services business operate, around which to focus our merger and acquisition activity. This ongoing evaluation takes into consideration and balances a number of factors, including the strategic goals, competitive landscape, and growth opportunities of our current segments, in an attempt to direct our capital towards those areas most likely to drive long-term value creation and generate the highest levels of return for our shareholders. In addition, as evidenced by the 2016 Matrix Transaction, we may also enter into strategic partnerships if we feel this provides the best opportunity to maximize shareholder value. The pursuit of our strategy may also result in the disposition of current businesses, as demonstrated in 2017 with our sale of our equity investment in Mission Providence and in 2015 with the sale of our Human Services segment. In making these determinations, we base our decisions on a variety of factors, including the availability of alternative opportunities to deploy capital, maximize shareholder value or other strategic considerations. The outcome of our active evaluation of the optimal industry sectors around which to focus our merger and acquisition activity as well as the potential future entry into strategic partnerships or potential disposition of businesses may impact the extent and manner in which we deploy resources across Providence, including strategic and administrative resources between Corporate and Other and our operating segments, and we may incur incremental costs in pursuing these efforts.

Revenues and Expenses

NET Services

NET Services primarily contracts with state Medicaid agencies and managed care organizations for the coordination of their members' non-emergency transportation needs. Most contracts are capitated, which means we are paid on a per-member, per-month basis for each eligible member. For most contracts, we arrange for transportation of members through our network of independent transportation providers, whereby we negotiate rates and remit payment to the transportation providers. However, for certain contracts, we assume no risk for the transportation network, credentialing and/or payments to these providers. For these contracts, we only provide administrative management services to support the customers efforts to serve its clients.

WD Services

WD Services primarily provides workforce development and offender rehabilitation services on a global basis that include employment preparation and placement, legal offender rehabilitation services, youth community service programs and certain health related services to eligible participants of government sponsored programs. Populations served by WD Services are broad and include the disabled, recently and long-term unemployed and individuals seeking new skills, as well as individuals that are coping with medical illnesses, are newly graduated from educational institutions, or are being released from incarceration. We contract primarily with national and regional government entities that seek to reduce the unemployment and recidivism rates.

The revenue earned by WD Services under its contracts is often derived through a combination of different revenue channels including, but not limited to, fees contingent upon: (1) the volume of WD end-users referred to or admitted into a specific program, (2) the achievement of defined outcomes for specific individuals, such as a job placement or continued employment, and (3) the achievement of defined outcomes for a population of individuals over a specific time period, such as aggregate employment or recidivism rates. The relative contributions of different revenue channels under a specific contract can fluctuate meaningfully over the life of a contract and thus contribute to significant earnings volatility. Revenue recognition related to our NCS youth programs can be particularly volatile due to the timing of services provided, which typically occur in the second and third quarters of each year. WD Services also earns revenue under fixed FFS arrangements, based upon contractual rates established at the outset of the applicable contract year, although the rate may be prospectively adjusted during the contract year based upon actual volumes. Volume levels are typically not guaranteed under contracts. We bill according to contractual terms, typically after proof of services have been demonstrated, although certain contracts allow for ratable billings based upon expected levels of services, and require reconciliation at the conclusion of the contract year.

As described above, when WD Services enters into new markets and service lines, it often experiences significant costs, which are expensed as incurred, whereas revenue may not be realized until a later date. As a result, WD Services experiences significant variability in its financial results and we therefore believe the results of WD Services are best viewed over a multi-year period.

Classification of Operating Expenses

Our "Service expense" line item includes the majority of the operating expenses of NET Services and WD Services as well as our captive insurance company, with the exception of certain costs which are classified as "General and administrative expense". Service expense also excludes asset impairment charges and depreciation and amortization expenses. In the discussion below, we present the breakdown of service expense by the following major categories: purchased services, payroll and related costs, other operating expenses and stock-based compensation. Purchased services includes the amounts we pay to third-party service providers and are typically dependent upon service volume. Payroll and related costs include all personnel costs of our segments. Other operating expenses include general overhead costs, excluding facilities and related charges, of our segments. Stock-based compensation represents the stock-based compensation expense associated with stock grants to employees of our segments as well as the expense related to restricted stock placed into escrow at the time of the Ingeus acquisition.

Our "General and administrative expense" primarily includes the operating expenses of our corporate office, excluding depreciation and amortization, as well as facilities and related charges of our segments and contingent consideration and acquisition related adjustments, as applicable.

Critical Accounting Policies and Estimates

Critical accounting policies and estimates are those that we believe are important in the preparation of our consolidated financial statements because they require that we use judgment and estimates in applying those policies. We prepare our consolidated financial statements and accompanying notes in accordance with GAAP. Preparation of the consolidated financial statements and accompanying notes requires that we make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities as of the date of the consolidated financial statements as well as revenue and expenses during the periods reported. We base our estimates on historical experience, where applicable, and other assumptions that we believe are reasonable under the circumstances. Actual results may differ from our estimates under different assumptions or conditions.

There are certain critical estimates that we believe require significant judgment in the preparation of our consolidated financial statements. We consider an accounting estimate to be critical if:

- it requires us to make an assumption because information was not available at the time or it included matters that were highly uncertain at the time the estimate is made; and
- changes in the estimate or different estimates that could have been selected may have had a material impact on our financial condition or results of operations.

For more information on each of these policies, see Note 2, Significant Accounting Policies and Recent Accounting Pronouncements, to our consolidated financial statements. We discuss information about the nature and rationale for our critical accounting estimates below.

Transportation Accrual

We accrue the cost of transportation expense within NET Services based on request for services and the amount we expect to be billed by transportation providers, as we generally only pay transportation providers for completed trips based upon documentation submitted after services have been provided. The transportation accrual requires significant judgment, as the accrual is based upon contractual rates and mileage estimates, as well as an estimated rate for unknown cancellations, as members may have requested transportation but not notified us of cancellation. Based upon historical experience and contract terms, we estimate the amount of expense incurred for invoices which have not yet been submitted as of period end. Actual expense could be greater or less than the amounts estimated due to changes in member or transportation provider behavior.

Business Combinations

We assign the value of the consideration transferred to acquire a business to the tangible assets and identifiable intangible assets acquired and liabilities assumed on the basis of their fair values at the date of acquisition. Any excess purchase price paid over the fair value of the net tangible and intangible assets acquired is allocated to goodwill. When determining the fair values of assets acquired and liabilities assumed, management makes significant estimates and assumptions, especially with respect to intangible assets. Critical estimates in valuing certain intangible assets include but are not limited to future expected cash flows from customer relationships and trade names, and discount rates. Management's estimates of fair value are based upon assumptions believed to be reasonable, but which are inherently uncertain and unpredictable. As a result, actual results may differ significantly from estimates.

Recoverability of Goodwill and Definite-Lived Intangible Assets

Goodwill. In accordance with ASC 350, Intangibles-Goodwill and Other, we review goodwill for impairment annually, or more frequently, if events and circumstances indicate that an asset may be impaired. Such circumstances could include, but are not limited to: (1) the loss or modification of significant contracts, (2) a significant adverse change in legal factors or in business climate, (3) unanticipated competition, (4) an adverse action or assessment by a regulator, or (5) a significant decline in the Company's stock price. We perform the annual goodwill impairment test for all reporting units as of October 1.

First, we perform qualitative assessments for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If the qualitative assessment suggests that it is more likely than not that the fair value of a reporting unit is less than its carrying value amount, we then perform a quantitative assessment and compare the fair value of the reporting unit to its carrying value.

We adopted ASU No. 2017-04, Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment ("ASU 2017-04") effective April 1, 2017. ASU 2017-04 removes the requirement to compare the implied fair value of goodwill with its carrying amount as part of step two of the goodwill impairment test. Instead, if we deem it necessary to perform the quantitative goodwill impairment test in an annual or interim period, we recognize an impairment charge equal to the excess, if any, of a reporting unit's carrying amount over its fair value, not to exceed the total amount of goodwill allocated to the reporting unit.

Long-Lived Assets Including Intangibles. In accordance with ASC 360, Property, Plant, and Equipment, we review the carrying value of long-lived assets or groups of assets to be used in operations whenever events or changes in circumstances indicate that the carrying amount of the assets may be impaired. Factors that may necessitate an impairment assessment include, among others, significant adverse changes in the extent or manner in which an asset or group of assets is used, significant adverse changes in legal factors or the business climate that could affect the value of an asset or group of assets or significant declines in the observable market value of an asset or group of assets. The presence or occurrence of those events indicates that an asset or group of assets may be impaired. In those cases, we assess the recoverability of an asset or group of assets by determining whether the carrying value of the asset or group of assets exceeds the sum of the projected undiscounted cash flows expected to result from the use and eventual disposition of the assets over the remaining economic life of the asset or the primary asset in the group of assets. If such testing indicates the carrying value of the asset or group of assets is not recoverable, we estimate the fair value of the asset or group of assets using appropriate valuation methodologies, which would typically include an estimate of discounted cash flows. If the fair value of those assets or groups of assets is less than carrying value, we record an impairment loss equal to the excess of the carrying value over the estimated fair value.

The use of different estimates or assumptions in determining the fair value of our goodwill and intangible assets may result in different values for those assets, which could result in an impairment or, in the period in which an impairment is recognized, could result in a materially different impairment charge.

During the fourth quarter of 2016, the Company reviewed WD Services for impairment, as there were several negative factors impacting the segment, primarily due to lower than expected volumes and unfavorable service mix shifts under a large contract in the UK impacting future projections; additional clarity into the anticipated size and structure of the Work and Health Programme in the UK; the absence of additional details regarding the restructuring of the offender rehabilitation contract in the UK; and a change in senior management at WD Services during the fourth quarter. As a result, the Company performed a quantitative test comparing the fair value of the asset groupings comprising WD Services with their carrying amounts and recorded an asset impairment charge of $10.0 million to property and equipment and $4.4 million to definite-lived customer relationship intangible assets, which is recorded in "Asset impairment charge" on the Company's consolidated statement of operations for the year ended December 31, 2016. In addition, the Company reviewed the carrying value of goodwill of WD Services, noting the carrying value exceeded the fair value. Therefore, the Company performed the second step of the impairment test, in which the fair value of the reporting unit is allocated to all of the assets and liabilities, on a fair value basis, with any excess representing the implied value of goodwill of the reporting unit. The fair value was determined using an income approach, which estimates the present value of future cash flows based on management's forecast of revenue growth rates and operating margins, working capital requirements and capital expenditures. Based on this analysis, the carrying value of goodwill of the WD Services reporting unit exceeded the implied fair value and the Company recorded an impairment charge of $5.2 million, which is included in "Asset impairment charge" on the Company's consolidated statement of operations for the year ended December 31, 2016. No impairment charges were incurred during the year ended December 31, 2017.

Income Taxes

We record income taxes under the liability method. Deferred tax assets and liabilities reflect our estimation of the future tax consequences of temporary differences between the carrying amounts of assets and liabilities for book and tax purposes. We determine deferred income taxes based on the differences in accounting methods and timing between financial statement and income tax reporting. Accordingly, we determine the deferred tax asset or liability for each temporary difference based on the enacted tax rates expected to be in effect when we realize the underlying items of income and expense. We consider many factors when assessing the likelihood of future realization of our deferred tax assets, including our recent earnings experience by jurisdiction, expectations of future taxable income, and the carryforward periods available to us for tax reporting purposes, as well as other relevant factors. We may establish a valuation allowance to reduce deferred tax assets to the amount we believe is more likely than not to be realized. Due to inherent complexities arising from the nature of our businesses, future changes in income tax law, tax sharing agreements or variances between our actual and anticipated operating results, we make certain judgments and estimates. Therefore, actual income taxes could materially vary from these estimates.

We record liabilities to address uncertain tax positions we have taken in previously filed tax returns or that we expect to take in a future tax return. The determination for required liabilities is based upon an analysis of each individual tax position, taking into consideration whether it is more likely than not that our tax position, based on technical merits, will be sustained upon examination. For those positions for which we conclude it is more likely than not it will be sustained, we recognize the largest amount of tax benefit that is greater than 50 percent likely of being realized upon ultimate settlement with the taxing authority. The difference between the amount recognized and the total tax position is recorded as a liability. The ultimate resolution of these tax positions may be greater or less than the liabilities recorded.

On December 22, 2017, the Tax Reform Act was enacted, which significantly changes U.S. tax law by, among other things, lowering corporate income tax rates, implementing a territorial tax system and imposing a repatriation tax on deemed repatriated earnings of foreign subsidiaries. The Tax Reform Act permanently reduces the U.S. corporate income tax rate from a maximum of 35% to a flat 21% rate, effective January 1, 2018. The Tax Reform Act also provides for a one-time deemed repatriation of post-1986 undistributed foreign subsidiary earnings and profits through the year ended December 31, 2017.

On December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118 (“SAB 118”) to address the application of GAAP in situations when a registrant does not have the necessary information available, prepared, or analyzed (including computations) in reasonable detail to complete the accounting for certain income tax effects of the Tax Reform Act. We have recognized the provisional tax impacts related to deemed repatriated earnings and the benefit for the revaluation of deferred tax assets and liabilities, and included these amounts in our consolidated financial statements for the year ended December 31, 2017. The final impact may differ from these provisional amounts, possibly materially, due to, among other things, additional analysis, changes in interpretations and assumptions we made, additional regulatory guidance that may be issued, and actions we may take as a result of the Tax Reform Act. In accordance with SAB 118, the financial reporting impact of the Tax Reform Act will be completed no later than the fourth quarter of 2018.

Reinsurance and Self-Insurance Liabilities

We historically reinsured a substantial portion of our automobile, general and professional liability and workers’ compensation costs under reinsurance programs through our wholly-owned subsidiary, Social Services Providers Captive Insurance Company (“SPCIC”), a licensed captive insurance company domiciled in the State of Arizona. In conjunction with the policy renewals on May 16, 2017, SPCIC did not renew the expiring policies. However, SPCIC continues to resolve claims under the historical policy years. In addition, under the current policies, the Company retains liability up to the policy deductibles. In addition, we maintain self-funded health insurance programs for U.S. based employees with a stop-loss umbrella policy with a third party insurer to limit the maximum potential liability for individual claims and for a maximum potential claim liability based on member enrollment. We utilize independent actuarial reports to determine the expected losses and in order to record the appropriate entries associated with our historical reinsurance programs, our retained exposure for the deductibles under our current policies, and self-funded health insurance programs. We regularly analyze our reserves for incurred but not reported claims, and for reported but not paid claims related to our reinsurance and self-funded insurance programs. We believe our reserves are adequate. However, significant judgment is involved in assessing these reserves such as evaluating historical paid claims, average lag times between the claims’ incurred date, reported dates and paid dates, and the frequency and severity of claims. There may be differences between actual settlement amounts and recorded reserves and any resulting adjustments are recorded once a probable amount is known.

Revenue Recognition

NET Services

Capitated contracts. The majority of NET Services revenue is generated under capitated contracts with customers where we assume the responsibility of meeting the covered transportation requirements of a specific geographic population based on per-member per-month fees for the number of members in the customer's program. Revenue is recognized based on the population served during the period. In some capitated contracts, partial payment is received as a prepayment during the month service is provided. These partial payments may be due back to the customer, or additional payments may be due to the Company, after each reconciliation period, based on a reconciliation of actual utilization and cost compared to the prepayment made.

FFS contracts. Revenues earned under FFS contracts are based upon contractually established billing rates. Revenues are recognized when the service is provided based upon contractual amounts.

Flat fee contracts. Revenues earned under flat fee contracts are recognized ratably over the covered service period based upon contractually established rates which do not fluctuate with any changes in the membership population who are eligible to receive the transportation services.

For most contracts, we arrange for transportation of members through our network of independent transportation providers, whereby we remit payment to the transportation providers; however, for certain contracts, we only provide administrative management services to support the customers efforts to serve its clients. The amount of revenue recognized is based upon the management fee earned.

WD Services

WD Services revenues are primarily generated from providing workforce development and offender rehabilitation services which include employment preparation and placement, apprenticeship and training, and certain health related services to clients on behalf of governmental and private entities. While the specific terms vary by contract and country, we primarily receive four types of revenue streams under contracts with government entities: referral/attachment fees, job placement and job outcome fees, sustainment fees and incentive fees. Referral/attachment fees are typically upfront payments that are payable when a client is referred by the contracting government entity or that client enters the program. Job placement fees are typically payable when a client is employed. Job outcome fees are typically payable when a client attains and holds employment for a specified minimum period of time. Sustainment fees are typically payable when clients maintain a job outcome past specified employment tenure milestones. Incentive fees are generally based upon a calculation that includes a variety of factors and inputs, such as average sustainment rates and client referral rates. Incentive fees vary greatly by contract.

Referral/attachment fee revenue is recognized ratably over the period of service, based upon an estimated period of time general services will be provided (i.e., the person is placed in a job or reaches the maximum time period for the program). The estimated period of time for which services will be rendered is based upon historical data. Job placement, job outcome and sustainment fee revenue is recognized when certain milestones are achieved, and amounts become billable. Incentive fee revenue is generally recognized when fixed and determinable, frequently at the end of the cumulative calculation period, unless contractual terms allow for earned payments on a fixed or ratable basis.

Revenue is also earned under fixed FFS arrangements, based upon contractual rates established at the outset of the contract or the applicable contract year, although the rate may be prospectively adjusted during the contract year based upon actual volumes.

If the rate is adjusted but the Company is unable to adjust its costs accordingly, or if the volume or types of referrals are lower than estimated, our profitability may be negatively impacted. Volume levels are typically not guaranteed under contracts.

Deferred Revenue

At times we may receive funding for certain services in advance of services being rendered. These amounts are reflected in the consolidated balance sheets as "Deferred revenue" until the services are rendered.

Stock Based Compensation

Our primary forms of employee stock-based compensation are stock option awards and restricted stock awards, including certain awards which vest based upon performance conditions. We measure the value of stock option awards on the date of grant at fair value using the appropriate valuation techniques, including the Black-Scholes and Monte Carlo option-pricing models. We

recognize the fair value as stock-based compensation expense on a straight-line basis over the requisite service period, which is typically the vesting period. The pricing models require various highly judgmental assumptions including volatility and expected option term. If any of the assumptions used in the models change significantly, stock-based compensation expense may differ materially in the future from that recorded in the current period.

As a result of the adoption of Accounting Standards Update ("ASU") No. 2016-09, Compensation – Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting ("ASU 2016-09"), effective January 1, 2017, we no longer record stock-based compensation expense net of estimated forfeitures and the tax effects of awards are treated as discrete items in the period in which tax windfalls or shortfalls occur. The adoption also impacted the presentation of cash flows and the computation of earnings per share.

The adoption of ASU 2016-09 will subject our tax rate to quarterly volatility from the effects of stock award exercises and vesting activities, including the adverse impact on our income tax provision for awards which result in a tax deduction less than the amount recorded for financial reporting purposes based upon the fair value of the award at the grant date. See additional discussion included in Note 2, Significant Accounting Policies and Recent Accounting Pronouncements, to our consolidated financial statements.

Restructuring, Redundancy and Related Reorganization Costs

We have engaged in employee headcount optimization actions within WD Services which require management to estimate the timing and amount of severance and other employee separation costs for workforce reduction. We accrue for severance and other employee separation costs under these actions when it is probable that a liability has been incurred and the amount is reasonably estimable. The amounts used in determining severance accruals are based on an estimate of the salaries and related benefit costs payable under existing plans for the number of employees impacted, but the final determination of the actual employees to be terminated is subject to a customary consultation process. The estimate of costs that will ultimately be paid requires significant judgment and to the extent that actual results or updated results differ from our current estimates, such amounts will be recorded as a cumulative adjustment in the period such amounts are determined.

Results of operations

Segment reporting. Our operations are organized and reviewed by management along our segment lines. We operate in two principal business segments: NET Services and WD Services. Our investment in Matrix is also a reportable segment referred to as the "Matrix Investment". Segment results are based on how our chief operating decision maker manages our business, makes operating decisions and evaluates operating performance. The operating results of the two principal business segments include revenue and expenses incurred by the segment, as well as an allocation of direct expenses incurred by our corporate division on behalf of the segment, which primarily relate to insurance and stock-based compensation allocations. Indirect expenses, including unallocated corporate functions and expenses, such as executive, finance, accounting, human resources, information technology and legal, as well as the results of our captive insurance company (the "Captive") and elimination entries recorded in consolidation are reflected in "Corporate and Other".

Discontinued operations. Effective October 19, 2016, we completed the Matrix Transaction resulting in our ownership of a noncontrolling interest in our historical HA Services segment. The HA Services segment results of operations for the periods through October 19, 2016 are separately discussed in the "Discontinued operations, net of tax" section set forth below. For periods subsequent to the transaction, the results of the Matrix Investment are separately discussed in the "Equity in net loss of investees" section set forth below. Additionally, effective November 1, 2015, we completed the sale of our Human Services segment. The Human Services segment results of operations are separately discussed in the "Discontinued operations, net of tax" section set forth below.

Year ended December 31, 2017 compared to year ended December 31, 2016

The following table sets forth results of operations and the percentage of consolidated total revenues represented by items in our consolidated statements of income for 2017 and 2016 (in thousands):

	Year ended December 31,			
	2017		2016	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	1,623,882	100.0 %	1,578,245	100.0 %
Operating expenses:				
Service expense	1,489,044	91.7 %	1,452,110	92.0 %
General and administrative expense	72,336	4.5 %	69,911	4.4 %
Asset impairment charge	—	— %	21,003	1.3 %
Depreciation and amortization	26,469	1.6 %	26,604	1.7 %
Total operating expenses	1,587,849	97.8 %	1,569,628	99.5 %
Operating income	36,033	2.2 %	8,617	0.5 %
Non-operating expense:				
Interest expense, net	1,278	0.1 %	1,583	0.1 %
Other income	(5,363)	(0.3)%	—	— %
Equity in net (gain) loss of investees	(12,054)	(0.7)%	10,287	0.7 %
Gain on sale of equity investment	(12,377)	(0.8)%	—	— %
Loss (gain) on foreign currency transactions	345	— %	(1,375)	(0.1)%
Income (loss) from continuing operations before income taxes	64,204	4.0 %	(1,878)	(0.1)%
Provision for income taxes	4,401	0.3 %	17,036	1.1 %
Income (loss) from continuing operations	59,803	3.7 %	(18,914)	(1.2)%
Discontinued operations, net of tax	(5,983)	(0.4)%	108,760	6.9 %
Net income	53,820	3.3 %	89,846	5.7 %
Net (gain) loss attributable to noncontrolling interest	(451)	— %	2,082	0.1 %
Net income attributable to Providence	53,369	3.3 %	91,928	5.8 %

Service revenue, net. Consolidated service revenue, net for 2017 increased $45.6 million, or 2.9%, compared to 2016. Revenue for 2017 compared to 2016 includes an increase in revenue of NET Services of $84.5 million, which was partially offset by a decrease in revenue of WD Services of $38.7 million. Excluding the effects of changes in currency exchange rates, consolidated service revenue increased 3.4% in 2017 compared to 2016.

Total operating expenses. Consolidated operating expenses for 2017 increased $18.2 million, or 1.2%, compared to 2016. Operating expenses for 2017 compared to 2016 included an increase in expenses attributable to NET Services of $95.8 million and Corporate and Other of $2.5 million. Partially offsetting these expense increases was a decrease in WD Services' operating expenses of $80.2 million. 2016 operating expenses include asset impairment charges of $19.6 million at WD Services and $1.4 million at Corporate and Other.

Operating income. Consolidated operating income for 2017 increased $27.4 million compared to 2016 due to a decrease in the operating loss of WD Services in 2017 of $41.4 million, as compared to 2016. This change was partially offset by a decrease in operating income of NET Services in 2017 as compared to 2016 of $11.3 million and an increase in the operating loss for Corporate and Other of $2.7 million in 2017 as compared to 2016.

Interest expense, net. Consolidated interest expense, net for 2017 decreased $0.3 million, or 19.3%, compared to 2016, and remained consistent as a percentage of revenue.

Other income. Other income in 2017 of $5.4 million represents the settlement received from the Haverhill Litigation, see Item 3. Legal Proceedings for further information on the settlement.

Equity in net (gain) loss of investees. Our equity in net (gain) loss of investees for 2017 of $12.1 million includes an equity in net loss for Mission Providence of $1.4 million through the sale date on September 29, 2017, and an equity in net gain for Matrix of $13.4 million. Our equity in net loss of investees for 2016 of $10.3 million includes an equity in net loss for Mission Providence of $8.5 million and Matrix of $1.8 million. We began reporting Matrix as an equity investment effective October 19, 2016, upon the completion of the Matrix Transaction, and we record our ownership percentage of Matrix's profit or loss in net loss or gain of investees. Included in Matrix's 2017 full standalone net income of $26.7 million (which is not consolidated with Providence's) are depreciation and amortization of $33.5 million, interest expense of $14.8 million, transaction bonuses and other transaction related costs of $3.5 million, equity compensation of $2.6 million, management fees paid to Matrix's shareholders of $2.3 million, merger and acquisition diligence related costs of $0.7 million and income tax benefit of $29.6 million. Matrix's significant income tax benefit in 2017 primarily related to the re-measurement of deferred tax liabilities arising from a lower U.S. corporate tax rate as a result of the Tax Reform Act. Included in Matrix's 2016 full standalone net loss of $4.2 million (which is not consolidated with Providence's) are depreciation and amortization of $6.4 million, interest expense of $2.9 million, transaction bonuses and other transaction related costs of $6.4 million, equity compensation of $0.4 million, management fees paid to Matrix's shareholders of $0.4 million and income tax benefit of $2.8 million.

Gain on sale of equity investment. The gain on sale of equity investment of $12.4 million relates to the sale of the Company's equity interest in Mission Providence in 2017. The investment in Mission Providence was part of the WD Services segment. The sale of Mission Providence is not included as a discontinued operation as the disposition did not represent a strategic shift that has a major effect on our operations and financial results.

Loss (gain) on foreign currency transactions. The foreign currency loss of $0.3 million and gain of $1.4 million for 2017 and 2016, respectively, were primarily due to translation adjustments of our foreign subsidiaries.

Provision for income taxes. Our effective tax rate from continuing operations for 2017 was 6.9%. The effective tax rate was lower than the U.S. federal statutory rate of 35% primarily due to the impact of the Tax Reform Act. The tax provision includes a benefit of $16.0 million related to the enactment of the Tax Reform Act during the fourth quarter of 2017, consisting of a net tax benefit of $19.4 million from the re-measurement of deferred tax liabilities from the lower U.S. corporate tax rate, partially offset by additional tax expense of $3.4 million due to an increase in our equity in net gain of Matrix as a result of Matrix's re-measurement of deferred tax liabilities. In addition, the Company incurred tax expense of $3.6 million related to the HoldCo LTIP, for which expense was recorded for financial reporting purposes based upon fair value of the award at the grant date, but no shares will be issued due to the market condition of the award not being satisfied. This tax expense was the result of the adoption of ASU 2016-09, which subjects our tax rate to quarterly volatility from the effects of stock award exercises and vesting activities, including the adverse impact on our income tax provision for awards which result in a tax deduction less than the amount recorded for financial reporting purposes.

During 2016, we recognized an income tax provision despite having a loss from continuing operations before income taxes. Because of foreign net operating losses (including equity investee losses) for which the future income tax benefit could not be recognized, and non-deductible expenses, the Company recognized taxable income for this year upon which the income tax provision for financial reporting is calculated.

Discontinued operations, net of tax. Discontinued operations, net of tax, includes the activity of our former Human Services segment and our former HA Services segment, composed entirely of our 100% ownership in Matrix until the completion of the Matrix Transaction on October 19, 2016. For 2017, discontinued operations, net of tax for our Human Services segment was a loss of $6.0 million, which primarily related to the accrual of a contingent liability of $9.0 million related to the settlement of indemnification claims and associated legal costs of $0.7 million, partially offset by a related tax benefit. Discontinued operations, net of tax for our Human Services segment was a loss of $5.6 million in 2016, which included an accrual of $6.0 million with respect to potential indemnification claims, legal costs of $1.1 million related to these potential claims and transaction related expenses of $0.8 million, partially offset by a related tax benefit. Discontinued operations, net of tax for our HA Services segment was income of $114.3 million for 2016, which included a gain on disposition, net of tax, of $109.4 million. See Note 20, Discontinued Operations, to our consolidated financial statements for additional information.

Net (income) loss attributable to noncontrolling interests. Net (income) loss attributable to noncontrolling interests primarily relates to a minority interest held by a third-party operating partner in our company servicing the offender rehabilitation contract in our WD Services segment.

Segment Results. The following analysis includes discussion of each of our segments.

NET Services

NET Services financial results are as follows for 2017 and 2016 (in thousands):

	Year Ended December 31,			
	2017		2016	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	1,318,220	100.0%	1,233,720	100.0%
Service expense	1,227,426	93.1%	1,132,857	91.8%
General and administrative expense	11,779	0.9%	11,406	0.9%
Depreciation and amortization	13,275	1.0%	12,375	1.0%
Operating income	65,740	5.0%	77,082	6.2%

Service revenue, net. Service revenue, net for NET Services in 2017 increased $84.5 million, or 6.8%, compared to 2016. The increase was related to net increased revenue from existing contracts, including successfully renewed contracts, of $82.5 million, due to the net impact of membership and rate changes. Included within net rate changes are the positive impacts of final agreements on rate adjustments related to existing contracts that experienced increased utilization in 2017 as well as the release of previously accrued revenue hold-backs based on certain contract performance requirements on a significant contract. Additionally, the impact of new contracts, including new managed care organization contracts in Florida and New York, contributed $93.8 million of revenue for 2017. These increases were partially offset by the $91.8 million impact on revenue of contracts we no longer serve, including a contract with the state of New York.

Service expense. Service expense is comprised of the following for 2017 and 2016 (in thousands):

	Year Ended December 31,			
	2017		2016	
	$	Percentage of Revenue	$	Percentage of Revenue
Purchased services	1,009,518	76.6%	927,321	75.2%
Payroll and related costs	165,666	12.6%	162,000	13.1%
Other operating expenses	51,720	3.9%	42,478	3.4%
Stock-based compensation	522	—%	1,058	0.1%
Total service expense	1,227,426	93.1%	1,132,857	91.8%

Service expense for 2017 increased $94.6 million, or 8.3%, compared to 2016. The increase in service expense was primarily attributable to the impact of new managed care organization contracts in California, Florida and New York. Purchased services as a percentage of revenue increased from 75.2% in 2016 to 76.6% in 2017 primarily attributable to an increase in utilization across multiple contracts. The higher utilization was in part driven by increased Medicaid reimbursement in New Jersey for certain medical services, increasing the demand for transportation services, and increased utilization across multiple managed care contracts in California. Additionally, due to milder winter weather conditions during the first quarter of 2017, we experienced above expected utilization; however, we experienced lower utilization for contracts in the third quarter of 2017 due in part to the impact of Hurricane Irma. The increase in purchased services as a percentage of revenue caused by increased utilization was partially offset by the successful implementation of initiatives aimed at lowering transportation costs on a per trip and per mile basis as well as the release of a reserve based upon the finalization of a contract amendment with a state customer.

Payroll and related costs as a percentage of revenue decreased from 13.1% in 2016 to 12.6% in 2017 due to efficiencies gained from multiple process improvement initiatives, including those aimed at lowering payroll expense across our reservation

and operation center networks, as well as a decrease in chief executive officer compensation expense due to the transition of the chief executive officer position during 2017. Other operating expenses increased for 2017 as compared to 2016 primarily attributable to an incremental $4.1 million of value enhancement and related costs incurred for external resources used in the design and implementation of NET Services member experience and value enhancement initiatives in 2017, as well as increased software and hardware maintenance costs associated with increased use of information technology.

General and administrative expense. General and administrative expenses in 2017 increased $0.4 million, or 3.3%, as compared to 2016, due to increased facility costs resulting from the overall growth of our operations. As a percentage of revenue, general and administrative expense remained constant at 0.9%.

Depreciation and amortization expense. Depreciation and amortization expenses increased $0.9 million primarily due to the addition of long-lived assets relating to information technology projects. As a percentage of revenue, depreciation and amortization remained constant at 1.0%. At December 31, 2017, NET Services has $11.9 million of construction and development in progress related to its LCAD NextGen technology system, which is expected to be placed into service in 2018.

WD Services

WD Services financial results are as follows for 2017 and 2016 (in thousands):

	Year Ended December 31,			
	2017		2016	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	305,662	100.0%	344,403	100.0 %
Service expense	265,417	86.8%	320,147	93.0 %
General and administrative expense	25,438	8.3%	30,300	8.8 %
Asset impairment charge	—	—%	19,588	5.7 %
Depreciation and amortization	12,851	4.2%	13,824	4.0 %
Operating income (loss)	1,956	0.6%	(39,456)	(11.5)%

Service revenue, net. Service revenue, net in 2017 decreased $38.7 million, or 11.2%, compared to 2016. Excluding the effects of changes in currency exchange rates, service revenue decreased 8.9% in 2017 compared to 2016, which was primarily related to the anticipated decline of referrals under the segment's Work Programme contracts in the UK, as well as decreased revenue under our offender rehabilitation program. While WD Services has successfully secured contracts under the UK's new Work and Health Programme, the successor program to the Work Programme, with a combined total value of approximately $195 million over 5 years, revenues under these new contracts were negligible in 2017 and did not offset declines in revenue experienced under the Work Programme contracts. These decreases were partially offset by increases across various employability contracts outside the UK, including in Australia, France, Germany and the U.S., as well as increased revenue from our health services contract in the UK. 2017 includes the impact of $5.2 million of revenue recognized under the offender rehabilitation program related to the finalization of a contractual adjustment for the contract year ended March 31, 2017, whereas 2016 includes $5.4 million of revenue recognized under the offender rehabilitation program related to the finalization of a contractual adjustment for the prior contract years ended March 31, 2015 and 2016.

Service expense. Service expense is comprised of the following for 2017 and 2016 (in thousands):

	Year Ended December 31,			
	2017		2016	
	$	Percentage of Revenue	$	Percentage of Revenue
Payroll and related costs	177,195	58.0%	210,293	61.1 %
Purchased services	49,491	16.2%	65,363	19.0 %
Other operating expenses	38,675	12.7%	44,502	12.9 %
Stock-based compensation	56	—%	(11)	— %
Total service expense	265,417	86.8%	320,147	93.0 %

Service expense in 2017 decreased $54.7 million, or 17.1%, compared to 2016. Payroll and related costs decreased primarily as a result of declining referrals under the segment's primary employability program in the UK as well as redundancy plans that better aligned headcount with service delivery volumes, resulting in a decrease of payroll and related costs as a percentage of revenue. Payroll and related costs include $2.6 million and $8.5 million in 2017 and 2016, respectively, of termination benefits related to redundancy plans. Purchased services decreased in 2017 compared to 2016 primarily as a result of a decline in client referrals under our primary employability program in the UK, which resulted in a decline in the use of outsourced services. Other operating expenses decreased in 2017 compared to 2016 primarily as a result of a decline in consulting related costs and information technology maintenance costs.

General and administrative expense. General and administrative expense in 2017 decreased $4.9 million compared to 2016. The decrease was due to office closures associated with the restructuring of the UK operations, as well as lower rent for certain offices. Additionally, $2.0 million of the decrease related to the impact of acquisition related contingencies that were favorably resolved in 2017, resulting in a benefit to general and administrative expense.

Asset impairment charge. During the fourth quarter of 2016, WD Services recorded asset impairment charges of $10.0 million, $4.4 million and $5.2 million to its property and equipment, intangible assets and goodwill, respectively, primarily due to lower than expected volumes and unfavorable service mix shifts under a large contract in the UK impacting future projections; additional clarity into the anticipated size and structure of the Work and Health Programme in the UK; and the absence of additional details regarding the restructuring of the offender rehabilitation contract in the UK. No impairment charges were incurred in 2017.

Depreciation and amortization expense. Depreciation and amortization expense for 2017 decreased $1.0 million compared to 2016, primarily due to the asset impairment charges incurred during the fourth quarter of 2016, which decreased the value of our intangible assets and certain property and equipment.

Corporate and Other

Corporate and Other includes the headcount and professional service costs incurred at the Providence corporate level, our captive insurance company, and elimination entries to account for inter-segment transactions. Corporate and Other financial results are as follows for 2017 and 2016 (in thousands):

	Year Ended December 31,	
	2017	2016
	$	$
Service revenue, net	—	122
Service expense (a)	(3,799)	(894)
General and administrative expense	35,119	28,205
Asset impairment charge	—	1,415
Depreciation and amortization	343	405
Operating loss	(31,663)	(29,009)

(a) Negative amounts are present for this line item due to changes in estimate for claims incurred but not reported, as well as elimination entries that are included in Corporate and Other. Certain offsetting amounts are reflected in the financial results of our operating segments.

Operating loss. Corporate and Other operating loss in 2017 increased by $2.7 million, or 9.1%, as compared to 2016 primarily due to an increase in cash settled stock-based compensation expense of $3.6 million, primarily as a result of an increase in the Company's stock price in 2017 as compared to a decrease in 2016, an increase in share settled stock-based compensation expense of $2.7 million, primarily related to an increase in expense for the HoldCo LTIP despite this program expiring with no shares due to any employees, expense for stock options issued to a former chief executive officer upon separation from the Company, and a benefit recorded in 2016 for performance based units, with no corresponding benefit in 2017, as well as an increase of $3.8 million of professional costs due to activities associated with our increased focus on strategic initiatives. This increase was partially offset by a reduction in insurance loss reserves of $3.5 million in 2017, versus $2.5 million in 2016, due to favorable claims history of our Captive reinsurance programs, as well as decreased costs of the Captive operations due to no longer writing new policies as of May 2017, which is included in "Service expense", decreased accounting, legal and professional fees included in "General and administrative expense", and decreased asset impairment charges, as $1.4 million was recorded in 2016 in relation to the sale of a building.

General and administrative expense includes stock-based compensation for the HoldCo LTIP of $4.7 million and $3.3 million for 2017 and 2016, respectively. No shares will be distributed under the HoldCo LTIP as the volume weighted average of Providence's stock price over the 90-day trading period ended on December 31, 2017 was less than $56.79. As such, as of December 31, 2017, we accelerated all remaining unrecognized compensation expense for the Holdco LTIP as there was no further requisite service period associated with the award resulting in an acceleration of expense of $1.1 million. General and administrative expense also includes $0.4 million and $1.6 million for 2017 and 2016, respectively, related to a shareholder lawsuit.

Costs associated with the resignation of Mr. Lindstrom during the year ended December 31, 2017 include cash compensation related items of $0.9 million, stock-based compensation of $0.7 million, and other costs of $0.2 million. These costs are recorded as part of "General and administrative expense".

Year ended December 31, 2016 compared to year ended December 31, 2015

The following table sets forth results of operations and the percentage of consolidated total revenues represented by items in our consolidated statements of income for 2016 and 2015 (in thousands):

	Year ended December 31,			
	2016		2015	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	1,578,245	100.0 %	1,478,010	100.0 %
Operating expenses:				
Service expense	1,452,110	92.0 %	1,381,154	93.4 %
General and administrative expense	69,911	4.4 %	70,986	4.8 %
Asset impairment charge	21,003	1.3 %	—	— %
Depreciation and amortization	26,604	1.7 %	23,998	1.6 %
Total operating expenses	1,569,628	99.5 %	1,476,138	99.9 %
Operating income	8,617	0.5 %	1,872	0.1 %
Non-operating expense:				
Interest expense, net	1,583	0.1 %	1,853	0.1 %
Equity in net loss of investees	10,287	0.7 %	10,970	0.7 %
Gain on foreign currency transactions	(1,375)	(0.1)%	(857)	(0.1)%
Income (loss) from continuing operations before income taxes	(1,878)	(0.1)%	(10,094)	(0.7)%
Provision for income taxes	17,036	1.1 %	14,583	1.0 %
Income (loss) from continuing operations	(18,914)	(1.2)%	(24,677)	(1.7)%
Discontinued operations, net of tax	108,760	6.9 %	107,871	7.3 %
Net income	89,846	5.7 %	83,194	5.6 %
Net loss attributable to noncontrolling interest	2,082	0.1 %	502	— %
Net income attributable to Providence	91,928	5.8 %	83,696	5.7 %

Service revenue, net. Consolidated service revenue, net for 2016 increased $100.2 million, or 6.8%, compared to 2015. Revenue for 2016 compared to 2015 included an increase in revenue of NET Services of $150.7 million, which was partially offset by a decrease in revenue of WD Services of $50.7 million. Excluding the effects of changes in currency exchange rates, consolidated service revenue increased 8.8% in 2016 compared to 2015.

Total operating expenses. Consolidated operating expenses for 2016 increased $93.5 million, or 6.3%, compared to 2015. Operating expenses for 2016 compared to 2015 included an increase in expenses attributable to NET Services of $144.8 million and Corporate and Other of $2.2 million. Partially offsetting these expense increases was a decrease in WD Services' operating expenses of $53.6 million. Operating expenses included asset impairment charges of $19.6 million at WD Services and $1.4 million at Corporate and Other during 2016, while no such charges were incurred in 2015.

Operating income. Consolidated operating income for 2016 increased $6.7 million compared to 2015 due to an increase in operating income of NET Services in 2016 as compared to 2015 of $5.9 million and a decrease in the operating loss of WD Services in 2016 as compared to 2015 of $2.9 million, although WD Services' new offender rehabilitation program incurred an operating loss in 2016 as compared to operating income in 2015. In addition, France continued to experience a significant operating loss in 2016, consistent with 2015. These changes were partially offset by an increase in the operating loss for Corporate and Other of $2.0 million, driven primarily by the asset impairment charge of $1.4 million in 2016.

Interest expense, net. Consolidated interest expense, net for 2016 decreased $0.3 million, or 14.6%, compared to 2015. The decrease is primarily related to the repayment of the related party note during 2015, which was partially offset by higher commitment fees on our Credit Facility for 2016 as compared to 2015.

Equity in net loss of investees. Equity in net loss of investees primarily relates to our investments in Mission Providence and Matrix. Mission Providence, which is part of WD Services, began providing services in July 2015. We record 75% of Mission Providence's profit or loss in equity in net loss of investees. We began reporting Matrix as an equity investment effective October 19, 2016, upon the completion of the Matrix Transaction. Our equity in net loss of investees related to WD Services and Matrix totaled $8.5 million and $1.8 million, respectively, for 2016. Included in Matrix's results (which are not consolidated with Providence's) is interest expense of $2.9 million and transaction related expenses of $6.0 million, which includes $4.0 million of transaction incentive compensation payable to the Matrix management team.

Gain on foreign currency transactions. The foreign currency gains of $1.4 million and $0.9 million for 2016 and 2015, respectively, were primarily due to translation adjustments of our foreign subsidiaries.

Provision for income taxes. We recognized an income tax provision for 2016 and 2015 despite having losses from continuing operations before income taxes. Because of foreign net operating losses (including equity investee losses) for which the future income tax benefit currently cannot be recognized, and non-deductible expenses such as amortization of deferred consideration related to the Ingeus acquisition, the Company recognized taxable income for these years upon which the income tax provision for financial reporting is calculated.

Discontinued operations, net of tax. Discontinued operations, net of tax, includes the activity of our former Human Services segment and our former HA Services segment, composed entirely of our 100% equity interest in Matrix until the completion of the Matrix Transaction on October 19, 2016. Discontinued operations, net of tax for our Human Services segment was a loss of $5.6 million in 2016 and income of $101.8 million in 2015, respectively. 2016 Human Services results include an accrual of $6.0 million with respect to potential indemnification claims, legal costs of $1.1 million related to these potential claims and transaction related expenses of $0.8 million. 2015 Human Services segment results include a gain on disposition, net of tax, of $100.3 million. Discontinued operations, net of tax for our HA Services segment was income of $114.3 million and $6.1 million for 2016 and 2015, respectively. 2016 HA Services segment results include a gain on disposition, net of tax, of $109.4 million. See Note 20, Discontinued Operations, to our consolidated financial statements for additional information.

Net loss attributable to noncontrolling interest. Net loss attributable to noncontrolling interests primarily relates to the minority interest associated with our company servicing the offender rehabilitation contract in our WD Services segment. As this contract is currently experiencing losses, as further discussed below, we have a net loss attributable to noncontrolling interests.

Segment Results. The following analysis includes discussion of each of our segments.

NET Services

NET Services financial results are as follows for 2016 and 2015 (in thousands):

	Year Ended December 31,			
	2016		2015	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	1,233,720	100.0%	1,083,015	100.0%
Service expense	1,132,857	91.8%	991,659	91.6%
General and administrative expense	11,406	0.9%	10,704	1.0%
Depreciation and amortization	12,375	1.0%	9,429	0.9%
Operating income	77,082	6.2%	71,223	6.6%

Service revenue, net. Service revenue, net for NET Services in 2016 increased $150.7 million, or 13.9%, compared to 2015. The increase related to the impact of new contracts which contributed $76.4 million of revenue in 2016, including contracts in California and Florida, and an increase in revenue associated with existing contracts of $119.8 million due to the net impact of membership and rate changes, partially offset by the loss of certain contracts that resulted in a decrease in revenue of $45.5 million.

Service expense. Service expense is comprised of the following for 2016 and 2015 (in thousands):

	Year Ended December 31,			
	2016		2015	
	$	Percentage of Revenue	$	Percentage of Revenue
Purchased services	927,321	75.2%	814,632	75.2%
Payroll and related costs	162,000	13.1%	141,669	13.1%
Other operating expenses	42,478	3.4%	34,634	3.2%
Stock-based compensation	1,058	0.1%	724	0.1%
Total service expense	1,132,857	91.8%	991,659	91.6%

Service expense for 2016 increased $141.2 million, or 14.2%, compared to 2015. The increase in service expense was primarily attributable to an increase in purchased transportation services due primarily to higher transportation volume. Purchased services as a percentage of revenue remained constant at 75.2%. Additionally, our payroll and related costs increased for 2016 as compared to 2015 primarily due to the hiring of employees to support new contracts and increased call volume associated with increased utilization, as well as an increase of $1.2 million in expense for the long-term incentive plan for management put into place in the fourth quarter of 2015 and separation related charges for NET Services' former chief executive officer during 2016 of $0.8 million. Our other operating expenses also increased for 2016 as compared to 2015. The increase was primarily attributable to increased bad debt expense, including $2.1 million of expense related to one specific customer, and costs incurred for external resources used in the design and implementation of NET Services member experience and value enhancement initiatives of $2.0 million. Stock-based compensation increased $0.3 million in 2016 as compared to 2015 primarily due to the expense associated with new stock-based compensation awards granted in 2016 that vested in January 2017.

General and administrative expense. General and administrative expenses in 2016 increased $0.7 million, or 6.6%, as compared to 2015, due to increased facility costs resulting from the overall growth of our operations. As a percentage of revenue, general and administrative expense decreased slightly from 1.0% for 2015 to 0.9% for 2016.

Depreciation and amortization expense. Depreciation and amortization expenses increased $2.9 million primarily due to the addition of long-lived assets in our call centers. As a percentage of revenue, depreciation and amortization increased slightly from 0.9% for 2015 to 1.0% for 2016.

WD Services

WD Services financial results are as follows for 2016 and 2015 (in thousands):

	Year Ended December 31,			
	2016		2015	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	344,403	100.0 %	395,059	100.0 %
Service expense	320,147	93.0 %	393,803	99.7 %
General and administrative expense	30,300	8.8 %	29,846	7.6 %
Asset impairment charge	19,588	5.7 %	—	— %
Depreciation and amortization	13,824	4.0 %	13,776	3.5 %
Operating income (loss)	(39,456)	(11.5)%	(42,366)	(10.7)%

Service revenue, net. Service revenue, net in 2016 decreased $50.7 million, or 12.8%, compared to 2015. Excluding the effects of changes in currency exchange rates, service revenue decreased 5.1% in 2016 compared to 2015, which was primarily related to revenue declines associated with declining referrals and an altered pricing structure under the segment's primary employability

program in the UK and a revised bidding strategy in certain markets. Implemented in late 2015, the overhauled bidding process emphasized the pursuit of only those contracts that meet certain investment criteria, including risk-weighted return

on capital thresholds, and involve the provision of services where we believe our experience will allow us to deliver differentiated and improved outcomes for our clients. As a result of this enhanced criteria and a challenging UK outsourcing industry, new contracts have been more infrequent and smaller in nature. The decrease was partially offset by two new contracts in France that began in 2015 and growth of NCS youth programs in 2016. WD Services additionally recognized revenue of $5.4 million for 2016 under its offender rehabilitation program related to the finalization of a contractual adjustment for contract years ended March 31, 2015 and 2016, which partially offset the decline in revenue under this contract for 2016.

Service expense. Service expense is comprised of the following for 2016 and 2015 (in thousands):

	Year Ended December 31,			
	2016		2015	
	$	Percentage of Revenue	$	Percentage of Revenue
Payroll and related costs	210,293	61.1 %	249,130	63.1%
Purchased services	65,363	19.0 %	78,498	19.9%
Other operating expenses	44,502	12.9 %	45,418	11.5%
Stock-based compensation	(11)	— %	20,757	5.3%
Total service expense	320,147	93.0 %	393,803	99.7%

Service expense in 2016 decreased $73.7 million, or 18.7%, compared to 2015. Payroll and related costs decreased primarily as a result of the redundancy plans implemented in the fourth quarter of 2015 that were designed to better align headcount with service delivery volumes as well as declining referrals under the segment's primary employability program in the UK. Partially offsetting these decreases was increased payroll and related costs associated with a significant new offender rehabilitation program that began in 2015 and higher payroll expenses in France associated with new programs implemented in 2015 and 2016. As referenced above, both the segment's new offender rehabilitation program and operations in France had significant operating losses in 2016. In addition, $8.5 million in termination benefits related to three redundancy plans contributed to losses in 2016. Purchased services decreased in 2016 compared to 2015 primarily as a result of a decline in client referrals under our primary employability program in the UK which required less use of outsourced services. Stock-based compensation decreased $20.8 million in 2016 as compared to 2015 primarily due to expenses totaling $16.1 million related to the settlement of outstanding awards in the fourth quarter of 2015 in relation to the separation of two executives, who were also sellers of Ingeus to Providence, as further described in Note 13, Stock-Based Compensation and Similar Arrangements, to our consolidated financial statements.

General and administrative expense. General and administrative expense in 2016 increased $0.5 million compared to 2015. $2.5 million of the increase relates to the impact of the reduction in the fair value of contingent consideration that was recorded in 2015. Offsetting this increase were decreased facility costs of $2.0 million primarily due to the closure of numerous sites in the UK, partially offset by the opening of new sites in France during 2016.

Asset impairment charge. During the fourth quarter of 2016, WD Services recorded asset impairment charges of $10.0 million, $4.4 million and $5.2 million to its property and equipment, intangible assets and goodwill, respectively, primarily due to lower than expected volumes and unfavorable service mix shifts under a large contract in the UK impacting future projections; additional clarity into the anticipated size and structure of the Work and Health Programme in the UK; and the absence of additional details regarding the restructuring of the offender rehabilitation contract in the UK. No impairment charges were incurred in 2015.

Depreciation and amortization expense. Depreciation and amortization expense for 2016 was flat compared to 2015.

Corporate and Other

Corporate and Other includes the headcount and professional service costs incurred at the Providence corporate level, our captive insurance company, and elimination entries to account for inter-segment transactions. Corporate and Other financial results are as follows for 2016 and 2015 (in thousands):

	Year Ended December 31,	
	2016	2015
	$	$
Service revenue, net (a)	122	(64)
Service expense (a)	(894)	(4,308)
General and administrative expense	28,205	30,436
Asset impairment charge	1,415	—
Depreciation and amortization	405	793
Operating loss	(29,009)	(26,985)

(a) Negative amounts are present for this line item due to elimination entries that are included in Corporate and Other. Offsetting amounts are reflected in the financial results of our operating segments.

Operating loss. Corporate and Other operating loss in 2016 increased by $2.0 million, or 7.5%, as compared to 2015 primarily due to a $4.5 million decrease in benefits associated with favorable claims experiences on our reinsurance and self-insured programs, an asset impairment charge of $1.4 million in 2016 and a $0.4 million net increase in compensation related expenses. The $0.4 million net increase in compensation expenses in 2016 was primarily due to an increase in short-term incentives and $1.0 million of compensation related to the sale of the Company's Human Services segment in 2015. Also included in 2016 were $1.6 million of expenses related to a shareholder lawsuit, an increase of $0.8 million from 2015. These increases in expense were partially offset by a decrease in various professional fees of $4.0 million. The Company anticipates continued reductions in multiple Corporate and Other expense categories in 2017.

Seasonality

Our quarterly operating results and operating cash flows normally fluctuate due in part to seasonal factors, uneven demand for services and the timing of new contracts, which impact the amount of revenues earned and expenses incurred. NET Services experiences fluctuations in demand during the summer and winter seasons. Due to higher demand in the summer months, lower demand during the winter months, and a primarily fixed revenue stream based on a per-member, per-month payment structure, NET Services normally experiences lower operating margins during the summer season and higher operating margins during the winter. WD Services is impacted by both the timing of commencement and expiration of major contracts. Under many of WD Services' contracts, we invest significant sums of money in personnel, leased office space, purchased or developed technology, and other costs, and generally incur these costs prior to commencing services and receiving payments. This results in significant variability in financial performance and cash flows between quarters and for comparative periods. It is expected that future contracts will be structured in a similar fashion. However, the Company does not expect a large variability in financial performance upon the commencement of WD Service's newly secured Work and Health Programme contracts as the upfront implementation investments needed for these contracts are expected to be significantly less than those associated with other large contract commencements undertaken in the past, such as the offender rehabilitation program in 2016. In addition, under the majority of WD Services' contracts, the Company relies on its customers, which include government agencies, to provide referrals, for which the Company can provide services and earn revenue. The timing and magnitude of referrals can fluctuate significantly, leading to volatility in revenue.

Liquidity and capital resources

Short-term capital requirements consist primarily of recurring operating expenses and new contract start-up costs, including workforce restructuring costs. We expect to meet any cash requirements through available cash on hand, cash generated from our operating segments, and borrowing capacity under our Credit Facility (as defined below).

Cash flow from operating activities was our primary source of cash during 2017, and included $5.4 million received from the settlement of the Haverhill Litigation. Additionally, 2017 included $15.6 million in proceeds from the sale of our equity investment in Mission Providence which is included in cash provided by investing activities. Our balance of cash and cash equivalents was $95.3 million and $72.3 million at December 31, 2017 and 2016, respectively, including $40.1 million and $21.4 million held in foreign countries, respectively. The December 31, 2017 foreign cash balance includes the proceeds from the sale of Mission Providence of $15.6 million. Such cash held in foreign countries is generally used to fund foreign operations, although it may also be used to repay intercompany indebtedness existing between Providence and its foreign subsidiaries. As of March 5, 2018, the Company transferred $13.9 million from its foreign operations to its domestic operations since December 31, 2017.

We had restricted cash of $6.3 million and $14.1 million at December 31, 2017 and 2016, respectively, primarily related to contractual obligations and activities of our captive insurance subsidiary. Given expiring policies under our captive insurance subsidiary were not renewed upon expiration in May 2017, we expect our restricted cash balances to decline over time. These restricted cash amounts are not included in our balance of cash and cash equivalents. At both December 31, 2017 and 2016, we had no amounts outstanding under our credit facility.

We may, from time to time, access capital markets to raise equity or debt financing for various business reasons, including acquisitions. We may also raise debt financing to fund future repurchases of our Common Stock. The timing, term, size, and pricing of any such financing will depend on investor interest and market conditions, and there can be no assurance that we will be able to obtain any such financing. Our current credit facility expires on August 2, 2018. On November 2, 2017, the Company's Board approved the extension of the Company's existing stock repurchase program, authorizing the Company to engage in a repurchase program to repurchase up to $69.6 million (the amount remaining from the $100.0 million repurchase amount authorized in 2016) in aggregate value of our Common Stock through December 31, 2018. Through December 31, 2017, the Company repurchased 180,270 shares, for $10.5 million, and $59.1 million was available under the plan to repurchase shares. During the period January 1, 2018 to March 5, 2018, the Company repurchased an additional 527,825 shares for $33.3 million, and $25.8 million was available under the plan to repurchase shares.

The cash flow statement for all periods presented includes both continuing and discontinued operations. Discontinued operations includes the activity of our Human Services and HA Services segments. The loss from discontinued operations totaled $6.0 million for the year ended December 31, 2017, while income from discontinued operations totaled $108.8 million and $107.9 million for the years ended December 31, 2016 and 2015, respectively. For 2017, the loss from discontinued operations primarily related to the accrual of a contingent liability of $9.0 million related to the future settlement of indemnification claims associated with our former Human Services segment, partially offset by a related tax benefit. The significant income from discontinued operations during the years ended December 31, 2016 and 2015 related to the gains on sale of our HA Services segment and Human Services segment, respectively. Significant non-cash items of our discontinued operations in 2016 and 2015 included $3.7 million and $5.7 million of depreciation expense, respectively, $17.5 million and $28.6 million of amortization expense, respectively, and $52.3 million and negative $5.0 million of deferred taxes, respectively. Our discontinued operations also purchased property and equipment totaling $9.2 million and $10.3 million during 2016 and 2015.

2017 cash flows compared to 2016

Operating activities. Cash provided by operating activities was $55.0 million for 2017, an increase of $13.3 million compared with 2016. 2017 and 2016 cash flow from operations was driven by net income of $53.8 million and $89.8 million, respectively, non-cash adjustments to reconcile net income to net cash provided by operating activities of negative $11.1 million and negative $32.9 million, respectively, and changes in working capital of $12.3 million and negative $15.2 million, respectively.

The change in non-cash adjustments to reconcile net income to net cash provided by operating activities was due primarily to the impact of:

- the disposition of HA Services, resulting in decreased gain on sale of business, depreciation, amortization and deferred taxes in 2017 as compared to 2016;
- the asset impairment charge incurred in 2016 of $21.0 million;
- the impact on deferred taxes as a result of the Tax Reform Act passed in 2017;
- the gain on sale of Mission Providence of $12.4 million in 2017; and
- the impact of the change in equity in net (gain) loss of investees, which was a gain of $12.1 million in 2017 as compared to a loss of $10.3 million in 2016.

The change in working capital was primarily driven by the following:

- Accounts receivable generated a cash inflow in 2017 of $5.7 million as compared to an outflow of $19.3 million in 2016. The increase in cash inflow of $25.0 million was primarily attributable to NET Services due to the timing of collections as well as an outflow of $3.1 million of HA Services in 2016. These changes were partially offset by cash outflows in 2017 related to an increase in WD Services' receivables in Germany, Saudi Arabia, South Korea and the UK.
- Prepaid expenses and other generated a cash inflow of $15.5 million in 2017, as compared to a cash outflow of $4.1 million in 2016. The increase in cash inflow of $19.5 million was primarily attributable to a decrease in other receivables related to amounts receivable from insurance carriers in respect to certain claims paid by the Company, but reimbursable from the respective insurance carrier, decreased receivables related to our captive insurance company insurance policy rewrite, decreased prepaid value added taxes in the UK, decreased prepayments in WD Services in relation to certain contracts and changes in income tax payments.
- Accounts payable and accrued expenses generated a cash outflow of $9.1 million in 2017, as compared to a cash inflow of $33.4 million in 2016. The decrease in cash inflow of $42.4 million is due primarily to the impact of NET Services accrued contract payments of $21.5 million, as well as the disposition of HA Services, which generated a cash inflow of $10.6 million in 2016. Partially offsetting these impacts is the impact of the increase in the accrued settlement related to our former Human Services segment of $9.0 million during 2017 as compared to an increase of $6.0 million in 2016.
- Accrued transportation costs of NET Services generated a cash inflow of $11.2 million in 2017, as compared to a cash inflow of $8.7 million in 2016. The increase in cash inflow of $2.6 million is due primarily to the timing of payments to NET Services transportation providers and increased volume.
- Income taxes payable on sale of business for 2016 includes a cash outflow of $30.2 million related to the sale of our Human Services segment.

Investing activities. Net cash provided by investing activities of $0.8 million in 2017 decreased by $323.1 million as compared to 2016. The decrease was primarily attributable to $371.6 million of proceeds on the Matrix Transaction recorded in 2016, which was partially offset by the impact of $15.6 million in proceeds from the sale of our equity investment in Mission Providence in 2017. Additionally in 2017, we made a cost method investment in Circulation, a technology-based service provider, for $3.0 million. There was also a decrease in funding of our equity investment in Mission Providence of $13.7 million and a decrease in the purchase of property and equipment of $21.3 million. 2016 included purchases of property and equipment of $9.2 million by our discontinued operations.

Financing activities. Net cash used in financing activities of $33.8 million in 2017 decreased $343.0 million as compared to 2016. During 2016, there was a net repayment of debt of $305.0 million, primarily related to the repayment of debt upon the completion of the Matrix Transaction. Additionally, during 2017, we repurchased $41.0 million less of our Common Stock than in 2016. In addition, there was a decrease in proceeds from Common Stock issued pursuant to stock option exercises of $2.2 million.

2016 cash flows compared to 2015

Operating activities. Cash provided by operating activities was $41.8 million for 2016, an increase of $25.7 million compared with 2015. 2016 and 2015 cash flow from operations was driven by net income of $89.8 million and $83.2 million, respectively, non-cash adjustments to reconcile net income to net cash provided by operating activities of negative $32.9 million and negative $1.2 million, respectively, and changes in working capital of negative $15.2 million and negative $65.9 million, respectively. The change in adjustments to reconcile net income to net cash provided by operating activities was due primarily to the impact of the disposition of HA Services in 2016 and Human Services in 2015, as well as, significant stock-based compensation in 2015 and an asset impairment charge in 2016. The change in working capital is primarily driven by the following:

- Accounts receivable generated a cash outflow for 2016 of $19.3 million as compared to an outflow of $86.6 million for 2015. The decrease in cash outflow of $67.3 million was primarily attributable to timing of significant receivable collections of NET Services, increases in WD Services accounts receivable in 2015 related to additional revenue contracts in place during 2015 as compared to 2014, and a cash outflow related to Human Services in 2015.
- Accounts payable and accrued expenses generated a cash inflow of $33.4 million in 2016, as compared to a cash outflow of $21.9 million in 2015. The increase in cash flow of $55.3 million was primarily attributable to our Human Services segment activity included in 2015, but not in 2016, due to the sale effective November 1, 2015, as well as a decreased change in accrued compensation between periods.
- Deferred revenue generated a cash outflow of $4.0 million in 2016, as compared to a cash inflow of $19.0 million in 2015. The significant cash inflow in 2015 primarily related to WD Services in association with cash received in advance of services being rendered for two large contracts.

- Income taxes payable on sale of business for 2016 includes a cash outflow of $30.2 million related to the sale of our Human Services segment.

Investing activities. Net cash provided by investing activities of $323.9 million in 2016 increased by $180.6 million as compared to 2015. The increase was primarily attributable to $371.6 million of proceeds on the Matrix Transaction recorded in 2016, which was partially offset by the impact of $199.9 million in proceeds from the sale of our Human Services segment in 2015. There was also an increase in the purchase of property and equipment of $6.1 million from 2015 to 2016.

Financing activities. Net cash used in financing activities of $376.8 million in 2016 increased $142.7 million as compared to 2015. During 2016, there was a net repayment of debt of $305.0 million, primarily related to the repayment of debt upon the completion of the Matrix Transaction, compared to a net repayment of debt of $271.1 million in 2015 upon the sale of our Human Services segment. Additionally, during 2016, we repurchased $33.5 million more of our Common Stock than in 2015. 2015 includes $80.7 million received from the issuance of preferred stock as well as a contingent consideration payment of $7.5 million associated with our purchase of Ingeus UK Holdings Limited and its wholly and partly-owned subsidiaries and associates.

Obligations and commitments

Current Credit Facility

The Credit Agreement provides for a revolving credit facility of $200.0 million, $25.0 million of which is available for letters of credit. As of December 31, 2017 we had no borrowings outstanding under the Credit Facility and seven letters of credit in the aggregate amount of $11.1 million outstanding. At December 31, 2017, our available credit under the Credit Facility was $188.9 million. The Credit Facility matures on August 2, 2018.

Under the Credit Agreement, we have an option to request an increase in the amount of the revolving credit facility and/or the term loan facility from time to time (on substantially the same terms as apply to the existing facilities) in an aggregate amount of up to $75.0 million with either additional commitments from lenders under the Credit Agreement at such time or new commitments from financial institutions acceptable to the administrative agent in its reasonable discretion, so long as no default or event of default exists at the time of any such increase. We may not be able to access additional funds under this increase option as no lender is obligated to participate in any such increase under the Credit Facility.

We may prepay any outstanding principal under the Credit Facility in whole or in part, at any time without premium or penalty, subject to reimbursement of the lenders' breakage and redeployment costs in connection with prepayments of London Interbank Offered Rate, or LIBOR, loans. The unutilized portion of the commitments under the Credit Facility may be irrevocably reduced or terminated by us at any time without penalty.

Interest on the outstanding principal amount of any loans accrues, at our election, at a per annum rate equal to LIBOR, plus an applicable margin or the base rate plus an applicable margin. The applicable margin ranges from 2.25% to 3.25% in the case of LIBOR loans and 1.25% to 2.25% in the case of the base rate loans, in each case, based on our consolidated leverage ratio as defined in the Credit Agreement. Interest on any loans is payable quarterly in arrears. In addition, we are obligated to pay a quarterly commitment fee based on a percentage of the unused portion of each lender's commitment under the Credit Facility and quarterly letter of credit fees based on a percentage of the maximum amount available to be drawn under each outstanding letter of credit. The commitment fee and letter of credit fee range from 0.25% to 0.50% and 2.25% to 3.25%, respectively, in each case, based on our consolidated leverage ratio.

The Credit Facility also requires us (subject to certain exceptions as set forth in the Amended and Restated Credit Agreement) to prepay the outstanding loans in an aggregate amount equal to 100% of the net cash proceeds received from certain asset dispositions, debt issuances, insurance and casualty awards and other extraordinary receipts.

The Credit Agreement contains customary affirmative and negative covenants and events of default. The negative covenants include restrictions on our ability to, among other things, incur additional indebtedness, create liens, make investments, give guarantees, pay dividends, repurchase shares, sell assets, and merge and consolidate. We are subject to financial covenants, including consolidated net leverage and consolidated interest coverage covenants. The Company's consolidated net leverage ratio may not be greater than 3.00:1.00 as of the end of any fiscal quarter and the Company's consolidated interest coverage ratio may not be less than 3.00:1.00 as of the end of any fiscal quarter. We were in compliance with all covenants as of December 31, 2017.

Our obligations under the Credit Facility are guaranteed by all of our present and future domestic subsidiaries, excluding certain domestic subsidiaries, which includes our insurance captive. Our obligations under, and each guarantor's obligations under its

guaranty of, the Credit Facility are secured by a first priority lien on substantially all of our respective assets, other than our

equity investment in Matrix, including a pledge of 100% of the issued and outstanding stock of our domestic subsidiaries, excluding our insurance captive, and 65% of the issued and outstanding stock of our first tier foreign subsidiaries.

Credit Facility Background

On August 2, 2013, we entered into the Credit Agreement with Bank of America, N.A., as administrative agent, swing line lender and letter of credit issuer, SunTrust Bank, as syndication agent, Merrill Lynch, Pierce, Fenner & Smith Incorporated and SunTrust Robinson Humphrey, Inc., as joint lead arrangers and joint book managers and other lenders party thereto. The Credit Agreement provided us with a senior secured credit facility, in aggregate principal amount of $225.0 million, comprised of a $60.0 million term loan facility and a $165.0 million revolving credit facility. The Credit Facility includes sublimits for swingline loans and letters of credit in amounts of up to $10.0 million and $25.0 million, respectively. On August 2, 2013, we borrowed the entire amount available under the term loan facility and $16.0 million under our revolving credit facility and used the proceeds thereof to refinance certain of our existing indebtedness.

On May 28, 2014, we entered into the first amendment to the Credit Agreement (the "First Amendment"). The First Amendment provided for, among other things, an increase in the aggregate amount of the Credit Facility from $165.0 million to $240.0 million and other modifications in connection with the consummation of the acquisition of Ingeus.

On October 23, 2014, we entered into the Second Amendment to the Credit Agreement (the "Second Amendment") to (i) add a new term loan tranche in aggregate principal amount of up to $250.0 million to partly finance the acquisition of Matrix and make certain other modifications in connection with the consummation of the acquisition of Matrix and (ii) add an excess cash flow mandatory prepayment provision.

On September 3, 2015, we entered into the Third Amendment to the Credit Agreement (the "Third Amendment"). Pursuant to the Third Amendment, the lenders under the Credit Agreement consented to Providence's sale of the Human Services segment and certain other amendments to the terms of the Credit Agreement to reflect such consents.

On August 28, 2016, we entered into the Fourth Amendment and Consent (the "Fourth Amendment") to the Credit Agreement. In accordance with the Fourth Amendment, which provided for the lenders' consent to the Matrix Transaction, a portion of the net cash proceeds received by the Company in connection with the Matrix Transaction were applied to the prepayment of outstanding term loans and revolving loans. Additionally, effective following the repayment of the outstanding term loans in full on October 20, 2016, the Fourth Amendment further (i) reduced the aggregate revolving commitments under the Credit Agreement to $200.0 million, (ii) amended the consolidated net leverage ratio covenant such that the Company's consolidated net leverage ratio may not be greater than 3.00:1.00 as of the end of any fiscal quarter and (iii) replaced the existing consolidated fixed charge coverage ratio covenant with a covenant that the Company's consolidated interest coverage ratio may not be less than 3.00:1.00 as of the end of any fiscal quarter.

Rights Offering

We completed a rights offering on February 5, 2015, allowing all of the Company's existing common stockholders the non-transferrable right to purchase their pro rata share of $65.5 million of Preferred Stock at a price equal to $100.00 per share (the "Rights Offering"). The Preferred Stock was convertible into shares of our Common Stock at a conversion price equal to $39.88, which was the closing price of our Common Stock on the NASDAQ Global Select Market on October 22, 2014.

Stockholders exercised subscription rights to purchase 130,884 shares of the Company's Preferred Stock. Pursuant to the terms and conditions of the Standby Purchase Agreement between Coliseum Capital Partners, L.P., Coliseum Capital Partners II, L.P., Coliseum Capital Co-Invest, L.P. and Blackwell Partners, LLC (collectively, the "Standby Purchasers") and the Company, the remaining 524,116 shares of the Company's Preferred Stock was purchased by the Standby Purchasers at the $100.00 per share subscription price. The Standby Purchasers beneficially owned approximately 94% of our outstanding Preferred Stock after giving effect to the Rights Offering and the Standby Purchase Agreement. The Company received $65.5 million in aggregate gross proceeds from the consummation of the Rights Offering and Standby Purchase Agreement, which it used to repay the related party unsecured subordinated bridge note that was outstanding as of December 31, 2014.

Additionally, on March 12, 2015, the Standby Purchasers exercised their right to purchase an additional 150,000 shares of the Company's convertible preferred stock at a $105 per share subscription price.

We may pay a noncumulative cash dividend on each share of convertible preferred stock, when, as and if declared by a committee of our Board, at the rate of 5.5% per annum on the liquidation preference then in effect. Following the issue date of the convertible preferred stock, on or before the third business day immediately preceding each fiscal quarter, we determine our

intention whether or not to pay a cash dividend with respect to that ensuing quarter and give notice of our intention to each holder of convertible preferred stock as soon as practicable thereafter.

In the event we do not declare and pay a cash dividend, the liquidation preference will be increased to an amount equal to the liquidation preference in effect at the start of the applicable dividend period, plus an amount equal to such then applicable liquidation preference multiplied by 8.5% per annum, computed on the basis of a 365-day year and the actual number of days elapsed from the start of the applicable dividend period to the applicable date of determination.

Cash dividends are payable quarterly in arrears on January 1, April 1, July 1 and October 1 of each year, and, if declared, will begin to accrue on the first day of the applicable dividend period. Payment in kind ("PIK") dividends, if applicable, will accrue and be cumulative on the same schedule as set forth above for cash dividends and will also be compounded at the applicable annual rate on each applicable subsequent dividend date. PIK dividends are paid upon the occurrence of a liquidation event, conversion or redemption in accordance with the terms of the convertible preferred stock. Cash dividends were declared each quarter for the years ended December 31, 2017 and 2016 and totaled $4.4 million each year.

Reinsurance and Self-Funded Insurance Programs

Reinsurance

We historically reinsured a substantial portion of our automobile, general and professional liability and workers' compensation costs under reinsurance programs primarily through our wholly-owned captive insurance subsidiary, Social Services Providers Captive Insurance Company, or SPCIC. As of May 16, 2017, SPCIC did not renew the expiring reinsurance policies. SPCIC will continue to resolve claims under the historical policy years.

At December 31, 2017, the cumulative reserve for expected losses since inception of these historical automobile, general and professional liability and workers' compensation reinsurance programs was $1.1 million, $0.7 million and $5.0 million, respectively. Based on an independent actuarial report, our expected losses related to workers' compensation, automobile and general and professional liability in excess of our liability under our associated historical reinsurance programs at December 31, 2017 was $5.7 million. We recorded a corresponding receivable from third-party insurers and liability at December 31, 2017 for these expected losses, which would be paid by third-party insurers to the extent losses are incurred.

Further, we had restricted cash of $6.3 million and $14.1 million at December 31, 2017 and December 31, 2016, respectively, which was primarily restricted to secure the reinsured claims losses under the historical automobile, general and professional liability and workers' compensation reinsurance programs.

Health Insurance

We offer our NET Services, U.S. based WD Services, and corporate employees an option to participate in self-funded health insurance programs. Additionally, we historically offered this option to our HA Services and Human Services segments' employees. During the year ended December 31, 2017, health claims were self-funded with a stop-loss umbrella policy with a third-party insurer to limit the maximum potential liability for individual claims generally to $275,000 per person, subject to an aggregating stop-loss limit of $400,000. In addition, the program has a total stop-loss limit for total claims, in order to limit our exposure to catastrophic claims.

Health insurance claims are paid as they are submitted to the plan administrator. We maintain accruals for claims that have been incurred but not yet reported to the plan administrator, and therefore, have not been paid. The incurred but not reported reserve is based on an established cap and current payment trends of health insurance claims. The liability for the self-funded health plan of $2.2 million and $3.0 million as of December 31, 2017 and 2016, respectively, was recorded in "Reinsurance liability and related reserve" in our consolidated balance sheets.

We charge our employees a portion of the costs of our self-funded group health insurance programs. We determine this charge at the beginning of each plan year based upon historical and projected medical utilization data. Any difference between our projections and our actual experience is borne by us, up to the stop-loss limit. We estimate potential obligations for liabilities under this program to reserve what we believe to be a sufficient amount to cover liabilities based on our past experience. Any significant increase in the number of claims or costs associated with claims made under this program above what we reserve could have a material adverse effect on our financial results.

Contractual cash obligations.

The following is a summary of our future contractual cash obligations as of December 31, 2017:

	At December 31, 2017				
Contractual cash obligations (000's)	Total	Less than 1 Year	1-3 Years	3-5 Years	After 5 Years
Capital Leases	$ 2,984	$ 2,400	$ 584	$ —	$ —
Interest (1)	467	467	—	—	—
Purchased services commitments (2)	8,448	2,966	5,482	—	—
Guarantees (3)	43,287	42,768	519	—	—
Letters of credit (3)	11,074	11,074	—	—	—
Operating Leases (4)	62,092	20,875	23,114	14,164	3,939
Total	$ 128,352	$ 80,550	$ 29,699	$ 14,164	$ 3,939

(1) Future interest payments have been calculated at the current rates as of December 31, 2017.

(2) Our purchase obligations represent the minimum obligations we have under agreements with certain of our vendors. These minimum obligations are less than our projected use for those periods. Payments may be more than the minimum obligations based on actual use.

(3) Guarantees and letters of credit ("LOCs") are commitments that represent funding responsibilities that may require our performance in the event of third-party demands or contingent events. Guarantees include surety bonds we provide to certain customers to protect against potential non-delivery of our non-emergency transportation services. Of the outstanding balance of our stand-by LOCs, $11.1 million directly reduces the amount available to us from our Credit Facility. The surety bonds and LOC amounts in the above table represent the amount of commitment expiration per period.

(4) The operating leases are for office space and related office equipment. We account for these leases on a monthly basis. Certain leases contain periodic rent escalation adjustments and renewal options.

Other than the items described above, we do not have any off-balance sheet arrangements as of December 31, 2017.

Stock repurchase programs

On November 4, 2015, our Board authorized us to engage in a repurchase program to repurchase up to $70.0 million in aggregate value of our Common Stock during the twelve-month period following November 4, 2015. This plan terminated on November 3, 2016. A total of 1,360,249 shares were purchased through this plan for $63.0 million, excluding commission payments.

On October 26, 2016, our Board authorized us to engage in a repurchase program to repurchase up to $100.0 million in aggregate value of our Common Stock during the twelve-month period following October 26, 2016. As of October 26, 2017, we spent $30.4 million, excluding commission payments, to purchase 770,808 shares of our Common Stock under this plan.

On November 2, 2017, the Board approved the extension of the Company's existing stock repurchase program, authorizing the Company to engage in a repurchase program to repurchase up to $69.6 million (the amount remaining from the $100.0 million repurchase amount authorized in 2016) in aggregate value of our Common Stock through December 31, 2018. As of December 31, 2017, 180,270 shares were purchased under this plan for $10.5 million, excluding commission payments, after it was extended on November 2, 2017. In addition, during the period January 1, 2018 to March 5, 2018, the Company repurchased an additional 527,825 shares for $33.3 million, and $25.8 million was available under the plan to repurchase shares.

Purchases under the repurchase program may be made from time-to-time through a combination of open market repurchases (including Rule 10b5-1 plans), privately negotiated transactions, and accelerated share repurchase transactions, at the discretion of our officers, and as permitted by securities laws, covenants under existing bank agreements, and other legal requirements.

Off-balance sheet arrangements

As of December 31, 2017 and 2016, we did not have any relationships with unconsolidated entities or financial partnerships, such as entities referred to as structured finance or special purpose entities, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes.

New Accounting Pronouncements

The new accounting pronouncements that impact our business are included in Note 2, Significant Accounting Policies and Recent Accounting Pronouncements, to our consolidated financial statements and are incorporated herein by reference.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

Foreign currency risk

As of December 31, 2017, we conducted business in 10 countries outside the U.S. As such, our cash flows and earnings are subject to fluctuations from changes in foreign currency exchange rates. We do not currently hedge against the possible impact of currency fluctuations. For 2017, we generated $288.5 million of our net operating revenues from operations outside the U.S.

A 10% reduction in the foreign currency exchange rate from British Pounds to U.S. dollars would have a $18.8 million negative impact on consolidated revenue, and a negligible impact on net income. A 10% reduction in other foreign currency exchange rates would not have a significant impact on our financial results.

We assess the significance of foreign currency risk on a periodic basis and may implement strategies to manage such risk as we deem appropriate.

Item 8. Financial Statements and Supplementary Data.

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Management's Report on Internal Control Over Financial Reporting

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting for the registrant, as such term is defined in Rule 13a-15(f) of the Exchange Act. We designed our internal control over financial reporting to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. Our internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting can provide only reasonable assurance with respect to financial statement preparation and presentation. The design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate. The Company conducts periodic evaluations of its internal controls to enhance, where necessary, its procedures and controls.

The Company, under the supervision and with the participation of its management, including its principal executive officer and principal financial officer, conducted an evaluation of the effectiveness of the Company's internal control over financial reporting as of December 31, 2017, based on the criteria set forth in the Internal Control–Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on such evaluation, the Company concluded that its internal control over financial reporting was effective as of December 31, 2017.

KPMG LLP, an independent registered public accounting firm that audited the Company's consolidated financial statements included in this Annual Report on Form 10-K, has issued an audit report on the effectiveness of the Company's internal control over financial reporting which is presented in Part II, Item 8 of this Annual Report on Form 10-K.

Report of Independent Registered Public Accounting Firm

To the stockholders and board of directors
The Providence Service Corporation:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of The Providence Service Corporation and subsidiaries (the "Company") as of December 31, 2017 and 2016, the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2017, and the related notes and financial statement schedule II (collectively, the "consolidated financial statements"). In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2017, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated March 9, 2018 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

We did not audit the financial statements of Mercury Parent, LLC, (a 46.6 percent owned investee company) as of and for the year ended December 31, 2017. The Company's investment in Mercury Parent, LLC at December 31, 2017 was $169.7 million, and its equity in net gain of Mercury Parent, LLC was $13.4 million for the year ended December 31, 2017. The financial statements of Mercury Parent, LLC were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Mercury Parent, LLC, is based solely on the report of the other auditors.

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits and the report of the other auditors provide a reasonable basis for our opinion.

/s/ KPMG LLP

We have served as the Company's auditor since 2008.

Stamford, Connecticut
March 9, 2018

Report of Independent Registered Public Accounting Firm

To the stockholders and board of directors
The Providence Service Corporation:

Opinion on Internal Control Over Financial Reporting

We have audited The Providence Service Corporation and subsidiaries' (the "Company") internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the consolidated balance sheets of the Company as of December 31, 2017 and 2016, the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2017, and the related notes and financial statement schedule II (collectively, the "consolidated financial statements"), and our report dated March 9, 2018 expressed an unqualified opinion on those consolidated financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ KPMG LLP

Stamford, Connecticut
March 9, 2018

The Providence Service Corporation
Consolidated Balance Sheets
(in thousands except share and per share data)

	December 31,	
	2017	2016
Assets		
Current assets:		
Cash and cash equivalents	$ 95,310	$ 72,262
Accounts receivable, net of allowance of $5,762 in 2017 and $5,901 in 2016	158,926	162,115
Other receivables	5,759	12,639
Prepaid expenses and other	35,243	37,895
Restricted cash	1,091	3,192
Total current assets	296,329	288,103
Property and equipment, net	50,377	46,220
Goodwill	121,668	119,624
Intangible assets, net	43,939	49,124
Equity investments	169,912	161,363
Other assets	12,028	8,397
Restricted cash, less current portion	5,205	10,938
Deferred tax asset	4,632	1,510
Total assets	$ 704,090	$ 685,279
Liabilities, r edeemable convertible pr eferr ed stock and stockholders' equity		
Current liabilities:		
Current portion of long-term obligations	$ 2,400	$ 1,721
Accounts payable	15,404	22,177
Accrued expenses	103,838	102,381
Accrued transportation costs	83,588	72,356
Deferred revenue	17,381	20,522
Reinsurance and related liability reserves	4,319	8,639
Total current liabilities	226,930	227,796
Long-term obligations, less current portion	584	1,890
Other long-term liabilities	21,386	22,380
Deferred tax liabilities	41,627	57,973
Total liabilities	290,527	310,039
Commitments and contingencies (Note 18)		
Redeemable convertible pr eferr ed stock		
Convertible preferred stock, net: Authorized 10,000,000 shares; $0.001 par value; 803,200 and 803,398 issued and outstanding; 5.5%/8.5% dividend rate	77,546	77,565
Stockholders' equity		
Common stock: Authorized 40,000,000 shares; $0.001 par value; 17,473,598 and 17,315,661 issued and outstanding (including treasury shares)	17	17
Additional paid-in capital	313,955	302,010
Retained earnings	204,818	156,718
Accumulated other comprehensive loss, net of tax	(25,805)	(33,449)
Treasury shares, at cost, 4,126,132 and 3,478,676 shares	(154,803)	(125,201)
Total Providence stockholders' equity	338,182	300,095
Noncontrolling interest	(2,165)	(2,420)
Total stockholders' equity	336,017	297,675

Total liabilities, redeemable convertible preferred stock and stockholders' equity	$ 704,090	$ 685,279

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Consolidated Statements of Income
(in thousands except share and per share data)

	Year ended December 31,		
	2017	2016	2015
Service revenue, net	$ 1,623,882	$ 1,578,245	$ 1,478,010
Operating expenses:			
Service expense	1,489,044	1,452,110	1,381,154
General and administrative expense	72,336	69,911	70,986
Asset impairment charge	—	21,003	—
Depreciation and amortization	26,469	26,604	23,998
Total operating expenses	1,587,849	1,569,628	1,476,138
Operating income	36,033	8,617	1,872
Other expenses:			
Interest expense, net	1,278	1,583	1,853
Other income	(5,363)	—	—
Equity in net (gain) loss of investees	(12,054)	10,287	10,970
Gain on sale of equity investment	(12,377)	—	—
Loss (gain) on foreign currency transactions	345	(1,375)	(857)
Income (loss) from continuing operations before income taxes	64,204	(1,878)	(10,094)
Provision for income taxes	4,401	17,036	14,583
Income (loss) from continuing operations, net of tax	59,803	(18,914)	(24,677)
Discontinued operations, net of tax	(5,983)	108,760	107,871
Net income	53,820	89,846	83,194
Net (gain) loss attributable to noncontrolling interests	(451)	2,082	502
Net income attributable to Providence	$ 53,369	$ 91,928	$ 83,696
Net income available to common stockholders (Note 14)	$ 41,865	$ 74,374	$ 67,999
Basic earnings (loss) per common share:			
Continuing operations	$ 3.52	$ (1.45)	$ (1.83)
Discontinued operations	(0.44)	6.52	6.09
Basic earnings per common share	$ 3.08	$ 5.07	$ 4.26
Diluted earnings (loss) per common share:			
Continuing operations	$ 3.50	$ (1.45)	$ (1.83)
Discontinued operations	(0.44)	6.52	6.09
Diluted earnings per common share	$ 3.06	$ 5.07	$ 4.26
Weighted-average number of common shares outstanding:			
Basic	13,602,140	14,666,896	15,960,905
Diluted	13,673,314	14,666,896	15,960,905

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Consolidated Statements of Comprehensive Income
(in thousands)

	Year ended December 31,		
	2017	2016	2015
Net income	$ 53,820	$ 89,846	$ 83,194
Net loss (income) attributable to noncontrolling interest	(451)	2,082	502
Net income attributable to Providence	53,369	91,928	83,696
Other comprehensive income (loss):			
Foreign currency translation adjustments, net of tax	7,117	(16,618)	(8,075)
Reclassification of translation loss realized upon sale of equity investment	527	—	—
Other comprehensive income (loss)	7,644	(16,618)	(8,075)
Comprehensive income	61,464	73,228	75,119
Comprehensive loss (income) attributable to noncontrolling interest	(255)	1,968	508
Comprehensive income attributable to Providence	$ 61,209	$ 75,196	$ 75,627

See accompanying notes to the consolidated financial statements

The Pr ovidence Service Corporation
Consolidated Statements of Stockholders' Equity
(in thousands except share data)

	Common Stock		Additional Paid-In	Retained Earnings (Accumulated	Accumulated Other Comprehensive Loss, Net of	Treasury Stock		Non-Controlling	
	Shares	Amount	Capital	Deficit)	Tax	Shares	Amount	Interest	Total
Balance at December 31, 2014	16,870,285	$ 17	$ 261,155	$ (13,366)	$ (8,756)	1,014,108	$ (17,686)	$ 50	$221,414
Stock-based compensation	—	—	26,622	—	—	—	—	—	26,622
Exercise of employee stock options, including net tax benefit of $2,706	247,333	—	7,899	—	—	5,718	(299)	—	7,600
Restricted stock issued	65,447	—	—	—	—	15,961	(759)	—	(759)
Stock repurchase	—	—	—	—	—	816,468	(34,111)	—	(34,111)
Shares surrendered by employees to pay employee taxes related to shares released from escrow	—	—	—	—	—	43,743	(1,968)	—	(1,968)
Conversion of convertible preferred stock to common stock	3,715	—	150	—	—	—	—	—	150
Beneficial conversion feature related to preferred stock	—	—	1,071	—	—	—	—	—	1,071
Convertible preferred stock dividends	—	—	(2,814)	(1,121)	—	—	—	—	(3,935)
Accretion of convertible preferred stock discount	—	—	(1,071)	—	—	—	—	—	(1,071)
Foreign currency translation adjustments, net of tax	—	—	—	—	(8,075)	—	—	—	(8,075)
Noncontrolling interests	—	—	—	—	—	—	—	(502)	(502)
Net income attributable to Providence	—	—	—	83,696	—	—	—	—	83,696
Balance at December 31, 2015	17,186,780	17	293,012	69,209	(16,831)	1,895,998	(54,823)	(452)	290,132
Stock-based compensation	—	—	5,154	—	—	—	—	—	5,154
Exercise of employee stock options, including net tax benefit of $276	105,788	—	3,832	—	—	—	—	—	3,832
Restricted stock issued	22,793	—	—	—	—	2,736	(130)	—	(130)
Stock repurchase	—	—	—	—	—	1,579,942	(70,248)	—	(70,248)
Conversion of convertible preferred stock to common stock	300	—	12	—	—	—	—	—	12
Convertible preferred stock dividends	—	—	—	(4,419)	—	—	—	—	(4,419)
Foreign currency translation adjustments, net of tax	—	—	—	—	(16,618)	—	—	114	(16,504)
Noncontrolling interests	—	—	—	—	—	—	—	(2,082)	(2,082)
Net income attributable to Providence	—	—	—	91,928	—	—	—	—	91,928
Balance at December 31, 2016	17,315,661	17	302,010	156,718	(33,449)	3,478,676	(125,201)	(2,420)	297,675
Stock-based compensation	—	—	7,619	—	—	—	—	—	7,619
Exercise of employee stock options	91,400	—	2,423	—	—	5,665	(238)	—	2,185
Restricted stock issued	36,623	—	—	—	—	19,556	(878)	—	(878)
Performance restricted stock issued	3,773	—	(96)	—	—	—	—	—	(96)
Shares issued for bonus settlement and director stipends	25,646	—	1,107	—	—	—	—	—	1,107
Stock repurchase	—	—	—	—	—	622,235	(28,486)	—	(28,486)
Conversion of convertible preferred stock to common stock	495	—	20	(1)	—	—	—	—	19
Convertible preferred stock dividends	—	—	—	(4,418)	—	—	—	—	(4,418)
Foreign currency translation adjustments, net of tax	—	—	—	—	7,117	—	—	(196)	6,921
Reclassification of translation loss realized upon sale of equity investments	—	—	—	—	527	—	—	—	527
Noncontrolling interests	—	—	—	—	—	—	—	451	451

Other	—	—	22	—	—	—	—	—	22
Net income attributable to Providence	—	—	—	53,369	—	—	—	—	53,369
Cumulative effect adjustment from change in accounting principle	—	—	850	(850)	—	—	—	—	—
Balance at December 31, 2017	17,473,598	$ 17	$ 313,955	$ 204,818	$ (25,805)	4,126,132	$ (154,803)	$ (2,165)	$ 336,017

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Consolidated Statements of Cash Flows
(in thousands)

	Year ended December 31,		
	2017	2016	2015
Operating activities			
Net income	$ 53,820	$ 89,846	$ 83,194
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation	18,542	21,699	20,234
Amortization	7,927	26,026	38,067
Provision for doubtful accounts	1,372	3,759	2,539
Stock-based compensation	7,543	5,136	26,622
Deferred income taxes	(22,996)	(14,130)	(10)
Amortization of deferred financing costs and debt discount	682	1,754	2,041
Write-off of deferred financing charges	—	2,302	—
Gains on remeasurement of contingent consideration	—	—	(2,469)
Asset impairment charge	—	21,003	1,593
Equity in net (gain) loss of investee	(12,054)	10,287	10,970
Gain on sale of equity investment	(12,377)	—	—
Gain on sale of business	—	(167,895)	(123,129)
Deferred income taxes and income taxes payable on gain on sale of business	—	58,492	22,797
Other non-cash charges (credits)	296	(1,323)	(419)
Changes in operating assets and liabilities, net of effects of acquisitions:			
Accounts receivable	5,715	(19,332)	(86,627)
Prepaid expenses and other	15,457	(4,058)	14,654
Reinsurance liability reserve	(5,731)	(4,110)	(611)
Accounts payable and accrued expenses	(9,064)	33,365	(21,900)
Income taxes payable on gain from sale of business	—	(30,153)	—
Accrued transportation costs	11,232	8,654	9,045
Deferred revenue	(4,691)	(4,019)	19,043
Other long-term liabilities	(629)	4,462	463
Net cash provided by operating activities	55,044	41,765	16,097
Investing activities			
Purchase of property and equipment	(19,923)	(41,216)	(35,072)
Proceeds from sale of property	—	1,039	—
Proceeds from sale of equity investment	15,593	—	—
Acquisitions, net of cash acquired	—	—	(3,433)
Sale of business, net of cash sold	—	371,580	199,943
Purchase of equity investment	—	(13,663)	(16,072)
Purchase of cost method investments	(3,000)	—	—
Restricted cash for reinsured claims losses	7,834	5,926	(2,058)
Other investing activities	310	239	(18)
Net cash provided by investing activities	814	323,905	143,290
Financing activities			
Proceeds from issuance of preferred stock, net of issuance costs	—	—	80,667
Preferred stock dividends	(4,418)	(4,419)	(3,928)
Repurchase of common stock, for treasury	(29,364)	(70,378)	(36,838)
Proceeds from common stock issued pursuant to stock option exercise	1,921	4,108	4,894

Proceeds from long-term debt	—	52,500	34,000
Repayment of long-term debt	—	(357,450)	(305,125)
Payment of contingent consideration	—	—	(7,496)
Other financing activities	(1,927)	(1,182)	(286)
Net cash used in financing activities	(33,788)	(376,821)	(234,112)
Effect of exchange rate changes on cash	978	(1,357)	(911)
Net change in cash	23,048	(12,508)	(75,636)
Cash at beginning of period	72,262	84,770	160,406
Cash at end of period	$ 95,310	$ 72,262	$ 84,770

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Supplemental Cash Flow Information
(in thousands)

Supplemental cash flow information	Year ended December 31, 2017	2016	2015
Cash included in current assets of discontinued operations held for sale	$ —	$ —	$ 5,014
Cash paid for interest	$ 987	$ 9,768	$ 16,699
Cash paid for income taxes	$ 18,128	$ 55,827	$ 21,555
Proceeds receivable from option exercise	$ 562	$ —	$ —
Purchases of equipment in accounts payable and accrued liabilities	$ 1,362	$ 983	$ 930
Accrued unfunded future equity investment capital contributions	$ —	$ —	$ 4,654
Note receivable issued for sale of property	$ —	$ 3,130	$ —
Purchase of equipment through capital lease obligation	$ 1,474	$ 4,547	$ —
Acquisitions:			
Purchase price	$ —	$ —	$ —
Less:			
Working capital adjustments to purchase price	—	—	(3,433)
Acquisitions, net of cash acquired	$ —	$ —	$ 3,433

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Notes to Consolidated Financial Statements
December 31, 2017
(in thousands except share and per share data)

1. Organization and Basis of Presentation

Description of Business

The Providence Service Corporation ("we", the "Company" or "Providence") owns subsidiaries and investments primarily engaged in the provision of healthcare services in the United States and workforce development services internationally. The subsidiaries and other investments in which the Company holds interests comprise the following segments:

- Non-Emergency Transportation Services ("NET Services") – Nationwide manager of non-emergency medical transportation ("NET") programs for state governments and managed care organizations.
- Workforce Development Services ("WD Services") – Global provider of employment preparation and placement services, legal offender rehabilitation services, youth community service programs and certain health related services to eligible participants of government sponsored programs.
- Matrix Investment – Minority interest in CCHN Group Holdings, Inc. and its subsidiaries ("Matrix"), a nationwide provider of in-home care optimization and management solutions, including comprehensive health assessments ("CHAs"), to members of managed care organizations, accounted for as an equity method investment. On February 16, 2018, Matrix acquired HealthFair, expanding its service offerings to include mobile health assessments, advanced diagnostic testing, and additional care optimization services.

In addition to its segments' operations, the Corporate and Other segment includes the Company's activities at its corporate office that include executive, accounting, finance, internal audit, tax, legal, public reporting, certain strategic and corporate development functions and the results of the Company's captive insurance company.

Discontinued Operations

During the periods presented, the Company completed the following transactions, which resulted in the presentation of the operations as Discontinued Operations. On November 1, 2015, the Company completed the sale of its Human Services segment. In addition to the results through the sale date, the Company has recorded additional expenses related to legal proceedings as described in Note 18, Commitment and Contingencies, related to an indemnified legal matter. On October 19, 2016, affiliates of Frazier Healthcare Partners purchased a 53.2% equity interest in Matrix with Providence retaining a 46.8% equity interest (the "Matrix Transaction"). Prior to the closing of the Matrix Transaction, the financial results of Matrix were included in the Company's Health Assessment Services ("HA Services") segment.

Basis of Presentation

The Company follows accounting standards set by the Financial Accounting Standards Board ("FASB"). The FASB establishes accounting principles generally accepted in the United States ("GAAP"). Rules and interpretive releases of the Securities and Exchange Commission ("SEC") under authority of federal securities laws are also sources of authoritative GAAP for SEC registrants. References to GAAP issued by the FASB in these footnotes are to the FASB Accounting Standards Codification ("ASC"), which serves as a single source of authoritative non-SEC accounting and reporting standards to be applied by non-governmental entities. All amounts are presented in U.S. dollars, unless otherwise noted.

The Company holds investments that are accounted for using the equity method. The Company does not control the decision-making process or business management practices of these affiliates. While the Company has access to certain information and performs certain procedures to review the reasonableness of information, the Company relies on management of these affiliates to provide accurate financial information prepared in accordance with GAAP. The Company receives audit reports relating to such financial information from the significant affiliates' independent auditors on an annual basis. The Company is not aware of any errors in or possible misstatements of the financial information provided by its equity affiliates that would have a material effect on the Company's consolidated financial statements.

Reclassifications

The Company has reclassified certain amounts relating to its prior period results to conform to its current period presentation. See Note 2, Significant Accounting Policies and Recent Accounting Pronouncements, for additional information on other reclassifications.

2. Significant Accounting Policies and Recent Accounting Pronouncements

Principles of Consolidation

The accompanying consolidated financial statements include The Providence Service Corporation, its wholly-owned subsidiaries, and entities it controls, or in which it has a variable interest and is the primary beneficiary of expected cash profits or losses. The Company records its investments in entities that it does not control, but over which it has the ability to exercise significant influence, using the equity method. The Company has eliminated significant intercompany transactions and accounts.

Accounting Estimates

The Company uses estimates and assumptions in the preparation of the consolidated financial statements in accordance with GAAP. Those estimates and assumptions affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the Company's consolidated financial statements. These estimates and assumptions also affect the reported amount of net income or loss during any period. The Company's actual financial results could differ significantly from these estimates. The significant estimates underlying the Company's consolidated financial statements include revenue recognition; allowance for doubtful accounts; accrued transportation costs; accrued restructuring; income taxes; recoverability of current and long-lived assets, including equity method investments; intangible assets and goodwill; loss contingencies; accounting for business combinations, including amounts assigned to definite and indefinite lived intangibles and contingent consideration; loss reserves for reinsurance and self-funded insurance programs; and stock-based compensation.

Cash and Cash Equivalents

Cash and cash equivalents include all cash balances and highly liquid investments with an initial maturity of three months or less. Investments in cash equivalents are carried at cost, which approximates fair value. The Company places its temporary cash investments with high credit quality financial institutions. At times, such investments may be in excess of the federally insured limits.

At December 31, 2017 and 2016, $40,127 and $21,411, respectively, of cash was held in foreign countries. Such cash is generally used to fund foreign operations, although it may be used also to repay intercompany indebtedness or similar arrangements. As of December 31, 2017, cash held in foreign countries included approximately $15,593 of proceeds from the sale of the Company's joint venture Mission Providence Pty Ltd ("Mission Providence").

Restricted Cash

At December 31, 2017 and 2016, the Company had $6,296 and $14,130, respectively, of restricted cash:

	December 31,	
	2017	2016
Collateral for letters of credit - Reinsured claims losses	$ —	$ 2,265
Escrow/Trust - Reinsured claims losses	6,296	11,865
Restricted cash for reinsured claims losses	6,296	14,130
Less current portion	1,091	3,192
Restricted cash, less current portion	$ 5,205	$ 10,938

Of the restricted cash amount at December 31, 2017 and 2016:

- $0 and $2,265, respectively, served as collateral for irrevocable standby letters of credit to secure any reinsured claims losses under the Company's reinsurance program;

- the remaining $6,296 and $11,865, respectively, is primarily related to restricted cash held in trusts for reinsurance claims losses under the Company's historical workers' compensation, general and professional liability and auto liability reinsurance programs, as well as amounts restricted for withdrawal under our self-insured medical and benefits plans.

Accounts Receivable and Allowance for Doubtful Accounts

The Company records accounts receivable amounts at the contractual amount, less an allowance for doubtful accounts. The Company maintains an allowance for doubtful accounts at an amount it estimates to be sufficient to cover the risk that an account will not be collected. The Company regularly evaluates its accounts receivable, especially receivables that are past due, and reassesses its allowance for doubtful accounts based on identified customer collection issues. In circumstances where the Company is aware of a customer's inability to meet its financial obligation, the Company records a specific allowance for doubtful accounts to reduce its net recognized receivable to an amount the Company reasonably expects to collect. The Company also provides a general allowance, based upon historical experience. Under certain contracts of NET Services, final payment is based on a reconciliation of actual utilization and cost, and the final reconciliation may require a considerable period of time. As of December 31, 2017 and 2016, accounts receivable under these reconciliation contracts totaled $42,054 and $45,287, respectively. In addition, certain government entities which WD Services serves remit payment substantially beyond the payment terms. The Company monitors these amounts due to the aging of receivables, but generally believes the balances are collectible. However, factors within those government entities could change and there can be no assurance that such changes would not result in an inability to collect the receivables.

The Company's provision for doubtful accounts expense from continuing operations for the years ended December 31, 2017, 2016 and 2015 was $1,372, $2,892 and $1,369, respectively.

Property and Equipment

Property and equipment are stated at historical cost, net of accumulated depreciation, or at fair value if the assets were initially recorded as the result of a business combination or if the asset was remeasured due to an impairment. Depreciation is calculated using the straight-line method over the estimated useful life of the asset. Maintenance and repairs are expensed as incurred. Gains and losses resulting from the disposition of an asset are reflected in operating expense.

Recoverability of Goodwill

In accordance with ASC 350, Intangibles-Goodwill and Other, the Company reviews goodwill for impairment annually, or more frequently, if events and circumstances indicate that an asset may be impaired. Such circumstances could include, but are not limited to: (1) the loss or modification of significant contracts, (2) a significant adverse change in legal factors or in business climate, (3) unanticipated competition, (4) an adverse action or assessment by a regulator, or (5) a significant decline in the Company's stock price. We perform the annual goodwill impairment test for all reporting units as of October 1.

First, we perform qualitative assessments for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If the qualitative assessment suggests that it is more likely than not that the fair value of a reporting unit is less than its carrying value amount, then we perform a quantitative assessment and compare the fair value of the reporting unit to its carrying value.

We adopted ASU No. 2017-04, Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment ("ASU 2017-04") effective April 1, 2017. ASU 2017-04 removes the requirement to compare the implied fair value of goodwill with its carrying amount as part of step two of the goodwill impairment test. Instead, if we deem it necessary to perform the quantitative goodwill impairment test in an annual or interim period, we recognize an impairment charge equal to the excess, if any, of a reporting unit's carrying amount over its fair value, not to exceed the total amount of goodwill allocated to the reporting unit.

The Company estimates the fair value of the Company's reporting units using either an income approach, a market valuation approach, a transaction valuation approach or a blended approach. The income approach produces an estimated fair value of a reporting unit based on the present value of the cash flows the Company expects the reporting unit to generate in the future. Estimates included in the discounted cash flow model include the discount rate, which the Company determines based on adjusting an industry-wide weighted-average cost of capital for size, geography, and company specific risk factors, long-term rates of growth and profitability of the Company's business, working capital effects and planned capital expenditures. The market approach produces an estimated fair value of a reporting unit based on a comparison of the reporting unit to comparable publicly traded entities in similar lines of business. The transaction valuation approach produces an estimated fair value of a reporting unit

based on a comparison of the reporting unit to publicly available transactional data involving both publicly traded and private entities in similar lines of business. The Company's significant estimates in both the market and transaction approach include the selected similar companies with comparable business factors such as size, growth, profitability, risk and return on investment and the multiples the Company applies to revenue and earnings before interest, taxes, depreciation and amortization ("EBITDA") to estimate the fair value of the reporting unit.

As discussed in Note 6, Goodwill and Intangibles, the Company determined that goodwill was impaired for the WD Services segment during the year ended December 31, 2016, and the Company recorded an asset impairment charge related to its goodwill of $5,224. The Company did not record any impairment charges for the year ended December 31, 2017. The Company recorded $1,593 of impairment charges related to its Human Services segment during the year ended December 31, 2015, which is included in "Discontinued operations, net of tax" in the consolidated statements of income.

Recoverability of Intangible Assets Subject to Amortization and Other Long-Lived Assets

Intangible assets subject to amortization and other long-lived assets are carried at cost and are amortized or depreciated on a straight-line basis over their estimated useful lives of 5 to 15 years. In accordance with ASC 360, Property, Plant, and Equipment, the Company reviews the carrying value of long-lived assets or groups of assets to be used in operations whenever events or changes in circumstances indicate that the carrying amount of the assets may be impaired. Factors that may necessitate an impairment assessment include, among others, significant adverse changes in the extent or manner in which an asset or group of assets is used, significant adverse changes in legal factors or the business climate that could affect the value of an asset or group of assets or significant declines in the observable market value of an asset or group of assets. The presence or occurrence of those events indicates that an asset or group of assets may be impaired. In those cases, the Company assesses the recoverability of an asset or group of assets by determining whether the carrying value of the asset or group of assets exceeds the sum of the projected undiscounted cash flows expected to result from the use and eventual disposition of the assets over the remaining economic life of the asset or the primary asset in the group of assets. If such testing indicates the carrying value of the asset or group of assets is not recoverable, the Company estimates the fair value of the asset or group of assets using appropriate valuation methodologies, which would typically include an estimate of discounted cash flows. If the fair value of those assets or groups of assets is less than carrying value, the Company records an impairment loss equal to the excess of the carrying value over the estimated fair value. As discussed in Note 6, Goodwill and Intangibles, the Company determined that the WD Services segment's intangible assets and property and equipment were impaired during the year ended December 31, 2016, and the Company recorded asset impairment charges of $9,983 and $4,381 to property and equipment and customer relationship intangible assets, respectively. The Company did not record any impairment charges for the years ended December 31, 2017 and 2015.

Accrued Transportation Costs

Eligible members of our customers schedule transportation through the Company's central reservation system. NET Services generally contracts with third-party providers to provide the transportation. The cost of transportation is recorded in the month the services are rendered, based upon contractual rates and mileage estimates. Transportation providers provide invoices once the trip is completed. Any trips that have not been invoiced require an accrual, based upon the expected cost as well as an estimate for cancellations, as the Company is generally only obligated to pay the transportation provider for completed trips. These estimates are based upon the historical trend associated with each contract's population and the transportation provider network servicing the program. There may be differences between actual invoiced amounts and estimated costs, and any resulting adjustments are included in expense. Accrued transportation costs were $83,588 and $72,356 at December 31, 2017 and 2016, respectively.

Deferred Financing Costs and Debt Discounts

The Company capitalizes direct expenses incurred in connection with its credit facilities and other borrowings, and amortizes such expenses over the life of the respective credit facility or other borrowings. Fees charged by lenders on the revolving facility and all fees charged by third parties are recorded as deferred financing costs and fees charged by lenders on term loans are recorded as a debt discount. Deferred financing costs, net of amortization, totaling $388 and $1,070 as of December 31, 2017 and 2016, respectively, are included in "Prepaid expenses and other" and "Other assets", respectively, on the consolidated balance sheet as there were no borrowings outstanding under the Company's credit facility.

Revenue Recognition

The Company recognizes revenue when it is earned and realizable based on the following criteria: persuasive evidence that an arrangement exists, services have been rendered, the price is fixed or determinable and collectability is reasonably assured.

NET Services

Capitated contracts. The majority of NET Services revenue is generated under capitated contracts with customers where the Company assumes the responsibility of meeting the covered transportation requirements of a specific geographic population based on per-member per-month fees for the number of members in the customer's program. Revenue is recognized based on the population served during the period. In some capitated contracts, partial payment is received as a prepayment during the month service is provided. These partial payments may be due back to the customer, or additional payments may be due to the Company, after each reconciliation period, based on a reconciliation of actual utilization and cost compared to the prepayment made.

Fee for service contracts. Revenues earned under fee for service ("FFS") contracts are based upon contractually established billing rates. Revenues are recognized when the service is provided based upon contractual amounts.

Flat fee contracts. Revenues earned under flat fee contracts are recognized ratably over the covered service period based upon contractually established fees which do not fluctuate with any changes in the membership population who are eligible to receive the transportation services.

For most contracts, the Company arranges for transportation of members through its network of independent transportation providers, whereby it remits payment to the transportation providers. However, for certain contracts, the Company only provides administrative management services to support the customers' efforts to serve its clients, and the amount of revenue recognized is based upon the management fee earned.

WD Services

WD Services revenues are primarily generated from providing workforce development and offender rehabilitation services, both of which include employment preparation and placement, apprenticeship and training, youth community service programs and certain health related services to clients on behalf of governmental and private entities. While the specific terms vary by contract and country, the Company often receives four types of revenue streams under contracts with government entities: referral/attachment fees, job placement/job outcome fees, sustainment fees and incentive fees. Referral/attachment fees are typically upfront payments that are payable when a client is referred by the contracting government entity or that client enters the program. Job placement fees are typically payable when a client is employed. Job outcome fees are typically payable when a client attains and holds employment for a specified minimum period of time. Sustainment fees are typically payable when clients maintain a job outcome past specified employment tenure milestones. Incentive fees are generally based upon a calculation that includes a variety of factors and inputs, such as average sustainment rates and client referral rates. Incentive fees vary greatly by contract.

Referral/attachment fee revenue is recognized ratably over the period of service, based upon an estimated period of time general services will be provided (i.e. the person is placed in a job or reaches the maximum time period for the program). The estimated period of time services will be rendered is based upon historical data. Job placement, job outcome and sustainment fee revenue is recognized when certain milestones are achieved, and amounts become billable. Incentive fee revenue is generally recognized when fixed and determinable, frequently at the end of the cumulative calculation period, unless contractual terms allow for earned payments on a fixed or ratable basis.

Revenue is also earned under fixed FFS arrangements, based upon contractual rates established at the outset of the contract or the applicable contract year, although the rate may be prospectively adjusted during the contract year based upon actual volumes.

If the rate is adjusted but the Company is unable to adjust its costs accordingly, or if the volume or types of referrals are lower than estimated, our profitability may be negatively impacted. Volume levels are typically not guaranteed under contracts.

Deferred Revenue

At times we may receive funding for certain services in advance of services being rendered. These amounts are reflected in the consolidated balance sheets as "Deferred revenue" until the services are rendered.

Stock-Based Compensation

The Company follows the fair value recognition provisions of ASC Topic 718 – Compensation – Stock Compensation ("ASC 718"), which requires companies to measure and recognize compensation expense for all share based payments at fair value.

- The Company calculates the fair value of stock options using the Black-Scholes option-pricing formula. The fair value of non-vested restricted stock grants is determined based on the closing market price of the Company's Common Stock on the date of grant. Stock-based compensation expense charged against income for stock options and stock grants is based on the grant-date fair value. Forfeitures are recorded as they occur. The expense for stock-based compensation awards is amortized on a straight-line basis over the requisite service period, which is typically the vesting period.

- The Company records restricted stock units ("RSUs") that may be settled by the holder in cash, rather than shares, as a liability and remeasures these liabilities at fair value at the end of each reporting period. Upon settlement of these awards, the total compensation expense recorded over the vesting period of the awards will equal the settlement amount, which is based on the Company's stock price on the settlement date.

- Performance-based RSUs vest upon achievement of certain company specific performance conditions. On the date of grant, the Company determines the fair value of the performance-based award using the fair value of the Company's Common Stock at that time and it assesses whether it is probable that the performance targets will be achieved. If assessed as probable, the Company records compensation expense for these awards over the requisite service period. At each reporting period, the Company reassesses the probability of achieving the performance targets and the performance period required to meet those targets. The estimation of whether the performance targets will be achieved and of the performance period required to achieve the targets requires judgment, and to the extent actual results or updated estimates differ from the Company's current estimates, the cumulative effect on current and prior periods of those changes will be recorded in the period estimates are revised, or the change in estimate will be applied prospectively depending on whether the change affects the estimate of total compensation cost to be recognized or merely affects the period over which compensation cost is to be recognized. The ultimate number of shares issued and the related compensation expense recognized will be based on a comparison of the final performance metrics to the specified targets.

- The Company calculates the fair value of market-based stock awards, including the Company's 2015 Holding Company LTI Program (the "HoldCo LTIP") awards, using the Monte-Carlo simulation valuation model. Forfeitures are recorded as they occur. Compensation expense for market-based awards is recognized over the requisite service period regardless of whether the market conditions are expected to be achieved.

Income Taxes

Deferred income taxes are determined by the liability method in accordance with ASC Topic 740 - Income Taxes. Under this method, deferred tax assets and liabilities are determined based on differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes and are measured using the enacted tax rates and laws that are expected to be in effect when the differences are expected to reverse. The Company considers many factors when assessing the likelihood of future realization of deferred tax assets, including recent earnings experience by jurisdiction, expectations of future taxable income, and the carryforward periods available for tax reporting purposes, as well as other relevant factors. The Company establishes a valuation allowance to reduce deferred tax assets to the amount that is more likely than not to be realized. Due to inherent complexities arising from the nature of the Company's businesses, future changes in income tax law or variances between the Company's actual and anticipated operating results, the Company makes certain judgments and estimates. Therefore, actual income taxes could materially vary from these estimates.

The Company has recorded a valuation allowance which includes amounts for net operating losses and tax credit carryforwards, as more fully described in Note 17, Income Taxes, for which the Company has concluded that it is more likely than not that these net operating loss and tax credit carryforwards will not be realized in the ordinary course of operations.

The Company recognizes interest and penalties related to income taxes as a component of income tax expense.

The Company accounts for uncertain tax positions based on a two-step process of evaluating recognition and measurement criteria. The first step assesses whether the tax position is more likely than not to be sustained upon examination by the tax authority, including resolution of any appeals or litigation, based on the technical merits of the position. If the tax position meets the more likely than not criteria, the portion of the tax benefit greater than 50% likely to be realized upon settlement with the tax authority is recognized in the consolidated financial statements.

On December 22, 2017, the U.S. bill commonly referred to as the Tax Cuts and Jobs Act ("Tax Reform Act") was enacted as more fully described in Note 17, Income Taxes.

Foreign Currency Translation

Local currencies generally are considered the functional currencies outside the U.S. Assets and liabilities for operations in local-currency environments are translated at month-end exchange rates of the period reported. Income and expense items are translated at the average exchange rate for each applicable month. Cumulative translation adjustments are recorded as a component of accumulated other comprehensive loss, net of tax, in stockholders' equity within the consolidated balance sheets.

Loss Reserves for Certain Reinsurance and Self-Funded Insurance Programs

The Company historically reinsured a substantial portion of its automobile, general and professional liability and workers' compensation costs under reinsurance programs primarily through the Company's wholly-owned subsidiary, Social Services Providers Captive Insurance Company ("SPCIC"), a licensed captive insurance company domiciled in the State of Arizona. As of May 16, 2017, SPCIC did not renew the expiring reinsurance policies. SPCIC will continue to resolve claims under the historical policy years.

The Company utilizes a report prepared by an independent actuary to estimate the gross expected losses related to historical automobile, general and professional and workers' compensation liability reinsurance policies, including the estimated losses in excess of SPCIC's insurance limits, which would be reimbursed to SPCIC to the extent such losses were incurred. As of December 31, 2017 and 2016, the Company had reserves of $6,699 and $11,240, respectively, for the automobile, general and professional liability and workers' compensation reinsurance policies, net of expected receivables for losses in excess of SPCIC's historical insurance limits. The gross reserve as of December 31, 2017 and 2016 of $12,448 and $16,505, respectively, is classified as "Reinsurance liability reserves" and "Other long-term liabilities" in the consolidated balance sheets. The estimated amount to be reimbursed to SPCIC as of December 31, 2017 and 2016 was $5,749 and $5,265, respectively, and is classified as "Other receivables" and "Other assets" in the consolidated balance sheets.

The Company also maintains a self-funded health insurance program with a stop-loss umbrella policy with a third-party insurer to limit the maximum potential liability for individual claims generally to $275 per person, subject to an aggregating stop-loss limit of $400. In addition, the program has a total stop-loss limit for total claims, in order to limit the Company's exposure to catastrophic claims. With respect to this program, the Company considers historical and projected medical utilization data when estimating its health insurance program liability and related expense. As of December 31, 2017 and 2016, the Company had $2,229 and $3,022, respectively, in reserve for its self-funded health insurance programs. The reserves are classified as "Reinsurance and related liability reserves" in the consolidated balance sheets.

The Company utilizes analysis prepared by third-party administrators and independent actuaries based on historical claims information with respect to the general and professional liability coverage, workers' compensation coverage, automobile liability, automobile physical damage, and health insurance coverage to determine the amount of required reserves.

The Company regularly analyzes its reserves for incurred but not reported claims, and for reported but not paid claims related to its reinsurance and self-funded insurance programs. The Company believes its reserves are adequate. However, significant judgment is involved in assessing these reserves, such as assessing historical paid claims, average lag times between the claims' incurred date, reported dates and paid dates, and the frequency and severity of claims. There may be differences between actual settlement amounts and recorded reserves and any resulting adjustments are included in expense once a probable amount is known.

Restructuring, Redundancy and Related Reorganization Costs

The Company has engaged in employee headcount optimization actions within the WD Services segment which require management to estimate the timing and amount of severance and other employee separation costs for workforce reduction. The Company accrues for severance and other employee separation costs under these actions when it is probable that benefits will be paid and the amount is reasonably estimable. The amounts used in determining severance accruals are based on an estimate of the salaries and related benefit costs payable under existing plans, and are included in accrued expenses to the extent they have not been paid.

Noncontrolling Interests

Noncontrolling interests represent the noncontrolling holders' percentage share of income or losses from a subsidiary in which the Company holds a majority, but less than 100%, ownership interest and the results of which are consolidated and included in the Company's consolidated financial statements. The Company has a 90% ownership in The Reducing Reoffending Partnership Limited, which commenced operations in 2015.

Discontinued Operations

In determining whether a group of assets disposed (or to be disposed) of should be presented as a discontinued operation, the Company makes a determination of whether the criteria for held-for-sale classification is met and whether the disposition represents a strategic shift that has (or will have) a major effect on the entity's operations and financial results. If these determinations can be made affirmatively, the results of operations of the group of assets being disposed of (as well as any gain or loss on the disposal transaction) are aggregated for separate presentation apart from continuing operating results of the Company in the consolidated financial statements. See Note 20, Discontinued Operations, for a summary of discontinued operations.

Earnings Per Share

The Company computes basic earnings per share by taking net income attributable to the Company available to common stockholders divided by the weighted average number of common shares outstanding during the period, including restricted stock and stock held in escrow if such shares are participating securities. Diluted earnings per share includes the potential dilution that may occur from stock-based awards and other stock-based commitments using the treasury stock or the as-if converted methods, as applicable. For additional information on how the Company computes earnings per share, see Note 14, Earnings Per Share.

Fair Value of Financial Instruments

The Company discloses the fair value of its financial instruments based on the fair value hierarchy using the following three categories:

Level 1 – Quoted prices in active markets for identical assets or liabilities that are accessible at the measurement date.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The Company may be required to pay additional consideration in relation to certain acquisitions based on the achievement of certain earnings targets. Acquisition-related contingent consideration is initially measured and recorded at fair value as an element of consideration paid in connection with an acquisition with subsequent adjustments recognized in "General and administrative expense" in the consolidated statements of income. The Company determines the fair value of acquisition-related contingent consideration, and any subsequent changes in fair value using a discounted probability-weighted approach. This approach takes into consideration Level 3 unobservable inputs including probability assessments of expected future cash flows over the period in which the obligation is expected to be settled and applies a discount factor that captures the uncertainties associated with the obligation. Changes in these unobservable inputs could significantly impact the fair value of the obligation recorded in the accompanying consolidated balance sheets and operating expenses in the consolidated statements of income.

The carrying amounts of cash and cash equivalents, restricted cash, accounts receivable and accounts payable approximate their fair value because of the relatively short-term maturity of these instruments.

Recent Accounting Pronouncements

The Company adopted the following accounting pronouncements during the year ended December 31, 2017:

In November 2015, the FASB issued Accounting Standards Update ("ASU") No. 2015-17, Income Taxes (Topic 740): Balance Sheet Classification of Deferred Taxes ("ASU 2015-17"), which changes how deferred taxes are classified on organizations' balance sheets. The ASU eliminates the current requirement for organizations to present deferred tax liabilities and assets as current and noncurrent in a classified balance sheet. Instead, organizations will be required to classify all deferred tax assets and liabilities as noncurrent. The amendments apply to all organizations that present a classified balance sheet. For public companies, the amendments are effective for financial statements issued for annual periods beginning after December 16, 2016, and interim periods within those annual periods. The Company adopted ASU 2015-17 retrospectively on January 1, 2017, which resulted in the reclassification of the December 31, 2016 deferred tax assets-current balance of $6,825 and non-current deferred tax assets of $2,493 to long-term deferred tax liabilities in the amount of $9,318.

In March 2016, the FASB issued ASU No. 2016-07, Investments - Equity Method and Joint Ventures (Topic 323): Simplifying the Transition to the Equity Method of Accounting ("ASU 2016-07"). ASU 2016-07 eliminates the requirement that when an investment qualifies for use of the equity method as a result of an increase in the level of ownership interest or degree of influence, an investor must adjust the investment, results of operations, and retained earnings retroactively on a step-by-step basis as if the equity method had been in effect during all previous periods that the investment had been held. ASU 2016-07 instead specifies that the investor should add the cost of acquiring the additional interest in the investee to the current basis of the investor's previously held interest and apply the equity method of accounting as of the date the investment became qualified for equity method accounting. ASU 2016-07 is effective for all entities for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2016 and should be applied prospectively. The Company adopted ASU 2016-07 on January 1, 2017. The adoption of ASU 2016-07 had no impact on the Company's financial statements or disclosures.

In March 2016, the FASB issued ASU No. 2016-09, Compensation - Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting ("ASU 2016-09"). ASU 2016-09 is intended to improve the accounting for employee share-based payments and affect all organizations that issue share-based payment awards to their employees. Several aspects of the accounting for share-based payment award transactions are simplified, including income tax consequences, classification of awards as either equity or liabilities and classification in the statement of cash flows. For public companies, the amendments are effective for annual periods beginning after December 15, 2016, and interim periods within those annual periods. The Company adopted ASU 2016-09 on January 1, 2017, and elected to recognize forfeitures as they occur. As a result, the Company recorded a cumulative effect adjustment of $850 to retained earnings as of January 1, 2017. Upon adoption, all excess tax benefits and tax deficiencies related to employee share-based payments are recognized through income tax expense prospectively.

The Company excluded the related tax benefits when applying the treasury stock method for computing diluted shares outstanding on a prospective basis resulting in a decrease in diluted weighted average shares outstanding of 4,642 shares for the year ended December 31, 2017.

The adoption of ASU 2016-09 subjects our tax rate to quarterly volatility from the effects of stock award exercises and vesting activities, including the adverse impact on our income tax provision for awards which result in a tax deduction less than the amount recorded for financial reporting purposes based upon the fair value of the award at the grant date. For the year ended December 31, 2017, the Company recorded excess tax deficiencies, net, of $3,604 as an increase to the provision for income taxes. This deficiency primarily related to the Company's Holdco LTIP. As further explained in Note 12, Stock-Based Compensation and Similar Arrangements, no shares were distributed under the Company's HoldCo LTIP as the volume weighted average of Providence's stock price over the 90-day trading period ended on December 31, 2017 did not exceed $56.79. As this market condition was not satisfied, a related tax deficiency was recognized during the year ended December 31, 2017 of $3,590.

The Company elected to apply the change in classification of cash flows resulting from excess tax benefits or deficiencies on a retrospective basis. This resulted in an increase in cash flows provided by operating activities of $282, offset by an increase of $282 in cash flows used in financing activities in the consolidated statement of cash flows for the year ended December 31, 2016, and an increase in cash flows provided by operating activities of $2,857, offset by an increase of $2,857 in cash flows used in financing activities in the consolidated statement of cash flows for the year ended December 31, 2015. Additionally, ASU 2016-09 requires that employee taxes paid when an employer withholds shares for tax-withholding purposes be reported as financing activities in the consolidated statements of cash flows, which is how the Company has historically classified these amounts.

In January 2017, the FASB issued ASU No. 2017-01, Business Combinations (Topic 805): Clarifying the Definition of a Business ("ASU 2017-01"). ASU 2017-01 clarifies the definition of a business with the objective of adding guidance to assist entities with evaluating whether transactions should be accounted for as acquisitions (or disposals) of assets or businesses. The definition of a business affects many areas of accounting including acquisitions, disposals, goodwill, and consolidation. ASU 2017-01 is effective for annual periods beginning after December 15, 2017, including interim periods within those periods. The Company adopted ASU 2017-01 on April 1, 2017. The adoption of ASU 2017-01 had no impact on the Company's financial statements or disclosures.

In January 2017, the FASB issued ASU No. 2017-03, Accounting Changes and Error Corrections (Topic 250) and Investments - Equity Method and Joint Ventures (Topic 323) ("ASU 2017-03"). ASU 2017-03 expands required qualitative disclosures when registrants cannot reasonably estimate the impact that adoption of an ASU will have on the financial statements. Such qualitative disclosures would include a comparison of the registrant's new accounting policies, if determined, to current accounting policies, a description of the status of the registrant's process to implement the new standard and a description of the significant implementation matters yet to be addressed by the registrant. The Company implemented ASU 2016-15 in its consolidated financial statements for the year ended December 31, 2017 resulting in enhanced qualitative disclosures regarding future adoption of new ASUs.

In January 2017, the FASB issued ASU No. 2017-04, Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment ("ASU 2017-04"). ASU 2017-04 removes the requirement to compare the implied fair value of goodwill with its carrying amount as part of step two of the goodwill impairment test. As a result, under ASU 2017-04, an entity should perform its annual, or interim, goodwill impairment test by comparing the fair value of a reporting unit with its carrying amount and should recognize an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value; however, the impairment loss recognized should not exceed the total amount of goodwill allocated to that reporting unit. This guidance is effective prospectively for fiscal years beginning after December 15, 2019. Early adoption is permitted for interim or annual goodwill impairment tests performed after January 1, 2017. The Company adopted ASU 2017-04 on April 1, 2017. The adoption of ASU 2017-04 had no impact on the Company's financial statements or disclosures.

Recent accounting pronouncements that were not yet adopted by the Company through December 31, 2017 are as follows:

In May 2014, the FASB issued ASU No. 2014-09, Revenue from Contracts with Customers (Topic 606) ("ASU 2014-09"). ASU 2014-09 introduced FASB Accounting Standards Codification Topic 606 ("ASC 606"), which will replace most currently applicable existing revenue recognition guidance and is intended to improve and converge with international standards the financial reporting requirements for revenue from contracts with customers. The core principle of ASC 606 is that an entity should recognize revenue for the transfer of goods or services equal to the amount that it expects to be entitled to receive for those goods or services. ASC 606 also requires additional disclosures about the nature, timing and uncertainty of revenue and cash flows arising from customer contracts, including significant judgments and changes in judgments. ASU 2014-09 allows for adoption either on a full retrospective basis to each prior reporting period presented or on a modified retrospective basis with the cumulative effect of initially applying the new guidance recognized at the date of initial application, which is effective for the Company on January 1, 2018.

The Company has substantially completed its adoption plan, under which it performed conceptual and detailed contract reviews to determine the impact of ASC 606 on its financial statements, internal controls and operational processes. The guidance in ASC 606 on the following topics was critical to the Company's analysis:

- the effect of specified clauses on the term of many of the Company's contracts with customers;
- the nature of the promises in many of the Company's contracts with customers to perform integrated services over a period of time;
- whether and how much variable consideration to include when determining the transaction prices for its contracts with customers;
- whether any of the Company's customer contracts require performance over a series of distinct service periods and the impact on determining and allocating the transaction price; and
- the manner in which the Company will measure its progress towards fully satisfying its performance obligations, including a determination of whether the Company may be able to use certain practical expedients.

The impact of adoption on revenue for each segment is as follows:

NET Services – For non-emergency transportation solutions, the Company will primarily use the right-to-invoice practical expedient to account for revenue when the Company has a right to consideration from a customer in an amount that corresponds directly with the value of the entity's performance completed to date. This is consistent with the Company's current revenue recognition policy. The only impact identified for NET Services is the presentation of one contract on a net basis which is currently accounted for on a gross basis, as the Company does not control the service, as defined under the new standard.

WD Services – WD Services has a number of contracts which include variable consideration, whereby it earns revenues if certain contractually defined outcomes occur in the future. When the related performance obligations are satisfied over time, the Company will recognize revenue in the proportion that the outcome has been earned based on services provided. The amount of revenue is based upon the Company's estimate of the final amount of outcome fees to be earned. The Company will evaluate probability using either the expected value method or the most likely amount method, as appropriate. At each reporting period, the Company will update its estimate of outcome fees, based upon actual results as well as refined estimates of future results, and will record an adjustment to revenue, based upon services performed to date. Under the new standard, the Company may recognize revenues for outcome fees earlier under the new standard, as revenue is currently recognized upon the final resolution of the contingency, i.e. the outcome is able to be invoiced. However, under certain contracts the Company receives up-front fees, which may be recognized over a longer period under the new standard as compared to current guidance. As of adoption, such impacts are not material to the consolidated financial statements.

The new standard will require the Company to recognize contract assets and liabilities on its balance sheet as appropriate. Additionally, the Company will be required to make additional disclosures about the nature of its contracts and the related performance obligations.

The Company is in its final stages of quantifying the financial impacts of the new guidance based on the contracts that exist at the date of adoption, as well as evaluating presentation of our revenues and required enhancements to disclosures. We have implemented both process and information systems changes to identify and assess contracts that are impacted by the new revenue recognition criteria and accumulate data to satisfy new disclosure requirements. As discussed above, we expect the new standard will have an immaterial impact on our consolidated financial statements, other than increased disclosures, upon adoption. Changes to revenue recognition as a result of applying the new standard will largely arise from outcome fees as described above, as well as the timing of revenue recognition for up-front fees. The Company will use the modified retrospective adoption method, and plans to adopt the standard on January 1, 2018.

In February 2016, the FASB issued ASU No. 2016-02, Leases (Topic 842) ("ASU 2016-02"). ASU 2016-02 introduced FASB Accounting Standards Codification Topic 842 ("ASC 842"), which will replace ASC 840, Leases. Under ASC 842, lessees will be required to recognize the following for all leases (with the exception of short-term leases) at the commencement date: a lease liability, which is a lessee's obligation to make lease payments arising from a lease, measured on a discounted basis; and a right-of-use asset, which is an asset that represents the lessee's right to use, or control the use of, a specified asset for the lease term.

ASU 2016-02 is effective for publicly held entities for fiscal years beginning after December 15, 2018, including interim periods within those fiscal years. Early application is permitted. Lessees must apply a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. The modified retrospective approach does not require transition accounting for leases that expired before the earliest comparative period presented. Lessees may not apply a full retrospective transition approach. The Company has not entered into significant lease agreements in which it is the lessor; however, the Company does have lease agreements in which it is the lessee. The Company is assessing the impact of applying ASC 842 to its lease agreements. It is in the process of developing an adoption plan, assembling a cross-functional project team and assessing the impacts of applying ASC 842 to the Company's financial statements, information systems and internal controls. The assessment of applying ASU 2016-02 is ongoing and, therefore, the Company has not yet determined whether the impacts will be material to the Company's consolidated financial statements.

In June 2016, the FASB issued ASU No. 2016-13, Financial Instruments – Credit Losses (Topic 326) ("ASU 2016-13"). The amendments in ASU 2016-13 will supersede or clarify much of the existing guidance for reporting credit losses for assets held at amortized cost basis and available for sale debt securities. The amendments in ASU 2016-13 affect loans, debt securities, trade receivables, net investments in leases, off balance sheet credit exposures, reinsurance receivables, and any other financial assets not excluded from the scope that have the contractual right to receive cash. ASU 2016-13 is effective for financial statements issued for fiscal years beginning after December 15, 2019, with early adoption permitted for fiscal years beginning after December 15, 2018. The Company has not evaluated the impact of ASU 2016-13 on its consolidated financial statements.

In August 2016, the FASB issued ASU No. 2016-15, Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments ("ASU 2016-15"). ASU 2016-15 provides guidance for eight targeted changes with respect to how cash receipts and cash payments are classified in the statements of cash flows, with the objective of reducing diversity in practice. ASU 2016-15 is effective for financial statements issued for fiscal years beginning after December 15, 2017, with early adoption permitted. The Company will adopt ASU 2016-15 on January 1, 2018. The adoption is not expected to have a significant impact on the Company's consolidated financial statements.

In November 2016, the FASB issued ASU No. 2016-18, Statement of Cash Flows (Topic 230): Restricted Cash ("ASU 2016-18"). ASU 2016-18 requires that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. ASU 2016-18 is effective for public entities for fiscal years beginning after December 15, 2017, and interim periods within those fiscal years. Early adoption is permitted, including adoption in an interim period; however, any adjustments must be reflected as of the beginning of the fiscal year that includes that interim period. ASU 2016-18 must be adopted retrospectively. The Company will adopt ASU 2016-15 on January 1, 2018. The adoption will impact the Company's consolidated statements of cash flow as the Company has restricted cash totaling $6,296 at December 31, 2017. Additionally, the Company will be required to make additional disclosures detailing the balance sheet line items that are included in the sum of cash, cash equivalents and restricted cash in the consolidated statements of cash flow.

In May 2017, the FASB issued ASU No. 2017-09, Compensation–Stock Compensation (Topic 718): Scope of Modification Accounting ("ASU 2017-09"). ASU 2017-09 provides guidance about which changes to the terms of a share-based payment award

should be accounted for as a modification. A change to an award should be accounted for as a modification unless the fair value of the modified award is the same as the original award, the vesting conditions do not change, and the classification as an equity or liability instrument does not change. This guidance is effective for fiscal years beginning after December 15, 2017. Early adoption is permitted. The Company will adopt ASU 2016-15 on January 1, 2018. The adoption of ASU 2017-09 is not expected to have a material impact on the Company's consolidated financial statements.

3. Equity Investment

Matrix

Prior to the closing of the Matrix Transaction on October 19, 2016, the financial results of Matrix were included in the Company's HA Services segment. Subsequent to the closing of the Matrix Transaction, the Company owned a 46.8% noncontrolling interest in Matrix. As of December 31, 2017, the Company owned a 46.6% noncontrolling interest in Matrix. Pursuant to a Shareholder's Agreement, affiliates of Frazier Healthcare Partners hold rights necessary to control the fundamental operations of Matrix. The Company accounts for this investment in Matrix under the equity method of accounting and the Company's share of Matrix's income or losses are recorded as "Equity in net (gain) loss of investees" in the accompanying consolidated statements of income.

The carrying amount of the assets included in the Company's consolidated balance sheet and the maximum loss exposure related to the Company's interest in Matrix as of December 31, 2017 and 2016 totaled $169,699 and $157,202, respectively.

Summary financial information for Matrix on a standalone basis is as follows:

	December 31,	
	2017	2016
Current assets	$ 37,563	$ 28,589
Long-term assets	597,613	614,841
Current liabilities	27,718	25,791
Long-term liabilities	240,513	281,348

	Twelve months ended December 31, 2017	October 19, 2016 through December 31, 2016
Revenue	$ 227,872	$ 41,635
Operating income (loss)	11,870	(4,079)
Net income (loss)	26,665	(4,200)

Included in Matrix's standalone net income of $26,665 for the year ended December 31, 2017 is depreciation and amortization of $33,512, transaction related expenses of $3,537, which includes $2,679 of transaction incentive compensation, equity compensation of $2,639, management fees paid to Matrix's shareholders of $2,331, merger and acquisition due diligence related costs of $685, interest expense of $14,818 and an income tax benefit of $29,613. The income tax benefit primarily related to the re-measurement of deferred tax liabilities arising from a lower U.S. corporate tax rate as a result of the Tax Reform Act. Included in Matrix's standalone net loss of $4,200 for the year ended December 31, 2016 is depreciation and amortization of $6,356, transaction related expenses of $6,367, which includes $4,033 of transaction incentive compensation, equity compensation of $407, management fees paid to Matrix's shareholders of $396, interest expense of $2,949 and an income tax benefit of $2,828.

See Note 20, Discontinued Operations, for Matrix's January 1, 2016 through October 19, 2016 results of operations, as well as the results of operations for the year ended December 31, 2015.

Mission Providence

The Company entered into a joint venture agreement in November 2014 with Mission Australia ACN ("Mission Australia") to form Mission Providence. Mission Providence delivers employment preparation and placement services in Australia. The

Company had a 60% ownership interest in Mission Providence, and had rights to 75% of Mission Providence's distributions of cash or profit surplus twice per calendar year. The Company accounted for this investment under the equity method of accounting and the Company's share of Mission Providence's income or losses was recorded as "Equity in net (gain) loss of investees" in the accompanying consolidated statements of income. Cash contributions made to Mission Providence in exchange for its equity interests are included in the consolidated statements of cash flows as "Purchase of equity investments".

On September 29, 2017, the Company and Mission Australia completed the sale of 100% of the stock of Mission Providence pursuant to a share sale agreement. Upon the sale of Mission Providence, the Company received AUD 20,184, or $15,823 of proceeds, for its equity interest, net of transaction fees. Subsequently, a working capital adjustment was finalized in December 2017 resulting in the return of $229 of the proceeds. The related gain on sale of Mission Providence totaling $12,377 is recorded as "Gain on sale of equity investment" in the accompanying consolidated statements of income. The carrying amount of the assets included in the Company's consolidated balance sheet related to the Company's interest in Mission Providence was $4,021 at December 31, 2016.

Summary financial information for Mission Providence on a standalone basis is as follows:

	December 31, 2016
Current assets	$ 4,640
Long-term assets	10,473
Current liabilities	12,844
Long-term liabilities	1,655

	Nine months ended September 30, 2017	Twelve months ended December 31, 2016
Revenue	$ 30,125	$ 36,546
Operating loss	(1,765)	(9,664)
Net loss	(1,934)	(8,843)

4. Prepaid Expenses and Other

Prepaid expenses and other were comprised of the following:

	December 31,	
	2017	2016
Prepaid income taxes	$ 1,106	$ 1,467
Escrow funds	10,000	10,000
Prepaid insurance	2,121	3,153
Prepaid taxes and licenses	906	3,570
Note receivable	3,224	3,130
Prepaid rent	2,268	2,013
Deposits held for leased premises and bonds	2,849	2,609
Other	12,769	11,953
Total prepaid expenses and other	$ 35,243	$ 37,895

Escrow funds represent amounts related to indemnification claims from the sale of the Human Services segment, which was completed on November 1, 2015. The Company has accrued $15,000 as a contingent liability for the settlement of potential indemnification claims, which is included in "Accrued expenses" in the consolidated balance sheet as of December 31, 2017. The escrow funds will be used to satisfy a portion of this settlement. See Note 18, Commitments and Contingencies, for further information.

5. Property and Equipment

Property and equipment consisted of the following:

	Estimated Useful Life (years)	December 31, 2017	December 31, 2016
Computer and telecom equipment	3 — 5	$ 35,915	$ 31,854
Software	3 — 5	32,989	26,883
Leasehold improvements	Shorter of 7 years or lease term	17,890	16,720
Furniture and fixtures	5 — 10	6,416	8,070
Automobiles	5	3,797	3,597
Construction and development in progress	N/A	13,384	5,831
		110,391	92,955
Less accumulated depreciation		60,014	46,735
Total property and equipment, net		$ 50,377	$ 46,220

Depreciation expense from continuing operations was $18,542, $18,038 and $14,488 for the years ended December 31, 2017, 2016 and 2015, respectively.

The Company sold the building and land that included holding company office space in Arizona effective December 31, 2016 resulting in an asset impairment charge of $1,415 for the year ended December 31, 2016. The Company recorded an asset impairment charge of $9,983 for the year ended December 31, 2016 related to its WD Services segment based on its review of the carrying value of long-lived assets. The impairment charges are reflected in “Asset impairment charge” in the consolidated statement of income for the year ended December 31, 2016. See Note 6, Goodwill and Intangibles, for further discussion of the impairment charges incurred related to the WD Services segment during 2016. Construction in progress as of December 31, 2017 is primarily comprised of NET Services, which has incurred substantial software development costs for its LCAD NextGen technology system. Such amounts are expected to be placed into service during 2018.

6. Goodwill and Intangibles

Impairment

The Company did not record any impairment charges for the year ended December 31, 2017. During the fourth quarter of 2016, the Company reviewed WD Services for impairment, primarily due to lower than expected volumes and unfavorable service mix shifts under a large contract in the United Kingdom (“UK”) impacting future projections; additional clarity into the anticipated size and structure of the Work and Health Programme in the UK; the absence of additional details regarding the restructuring of the offender rehabilitation contract in the UK; and a change in senior management at WD Services during the fourth quarter. As a result, the Company performed a quantitative test comparing the fair value of the asset groupings comprising WD Services with the carrying amounts and recorded an asset impairment charge of $4,381 to definite-lived customer relationship intangible assets, which is recorded in “Asset impairment charge” on the Company’s consolidated statement of operations. In addition, the Company reviewed the carrying value of goodwill of WD Services, noting the carrying value exceeded the fair value. Therefore, the Company performed the second step of the impairment test, in which the fair value of the reporting unit is allocated to all of the assets and liabilities, on a fair value basis, with any excess representing the implied value of goodwill of the reporting unit. The fair value was determined using an income approach, which estimates the present value of future cash flows based on management’s forecast of revenue growth rates and operating margins, working capital requirements and capital expenditures. Based on this analysis, the carrying value of goodwill of the WD Services reporting unit exceeded the implied fair value and the Company recorded an asset impairment charge of $5,224, which is included in “Asset impairment charge” on the Company’s consolidated statement of operations. The Company reviewed the carrying value of other long-lived assets and goodwill, and noted no indicators of impairment for NET Services or the Matrix Investment during the year ended December 31, 2016. The Company recorded $1,593 of impairment charges related to its Human Services segment during the year ended December 31, 2015, which is included in “Discontinued operations, net of tax” in the consolidated statements of income.

Goodwill

Changes in goodwill were as follows:

	NET Services	WD Services	Consolidated Total
Balances at December 31, 2015			
Goodwill	$ 191,215	$ 40,784	$ 231,999
Accumulated impairment losses	(96,000)	(6,041)	(102,041)
	95,215	34,743	129,958
Asset impairment charge	—	(5,224)	(5,224)
Foreign currency translation adjustment	—	(5,110)	(5,110)
Balances at December 31, 2016			
Goodwill	191,215	35,674	226,889
Accumulated impairment losses	(96,000)	(11,265)	(107,265)
	95,215	24,409	119,624
Foreign currency translation adjustment	—	2,044	2,044
Balances at December 31, 2017			
Goodwill	191,215	37,718	228,933
Accumulated impairment losses	(96,000)	(11,265)	(107,265)
	$ 95,215	$ 26,453	$ 121,668

The total amount of goodwill that was deductible for income tax purposes related to acquisitions as of December 31, 2017 and 2016 was $4,222.

Intangible Assets

Intangible assets are comprised of acquired customer relationships, trademarks and trade names, and developed technology. Intangible assets consisted of the following:

		December 31,			
		2017		2016	
	Estimated Useful Life (Yrs)	Gross Carrying Amount	Accumulated Amortization	Gross Carrying Amount	Accumulated Amortization
Customer relationships	15	$ 48,128	$ (33,136)	$ 48,020	$ (29,941)
Customer relationships	10	30,583	(11,871)	27,915	(8,147)
Trademarks and Trade Names	10	14,525	(5,205)	13,282	(3,431)
Developed technology	5	3,228	(2,313)	2,951	(1,525)
Total		$ 96,464	$ (52,525)	$ 92,168	$ (43,044)

The gross carrying amount as of December 31, 2017 and 2016 includes the asset impairment charge of $4,381 to definite-lived customer relationship intangible assets of WD Services recorded during the year ended December 31, 2016. The weighted-average amortization period at December 31, 2017 for intangibles was 12.3 years. No significant residual value is estimated for these intangible assets. Amortization expense from continuing operations was $7,927, $8,566 and $9,510 for the years ended December 31, 2017, 2016 and 2015, respectively.

The total amortization expense is estimated to be as follows for the next five years and thereafter as of December 31, 2017 based upon the applicable foreign exchange rates as of December 31, 2017:

Year	Amount
2018	$ 8,126
2019	7,749
2020	7,473
2021	7,387
2022	7,025
Thereafter	6,179
Total	$ 43,939

7. Accrued Expenses

Accrued expenses consisted of the following:

	December 31,	
	2017	2016
Accrued compensation and related	$ 33,653	$ 23,050
NET Services accrued contract payments	17,487	32,836
Accrued settlement	15,000	6,000
Income taxes payable	3,723	372
Other	33,975	40,123
Total accrued expenses	$ 103,838	$ 102,381

8. Restructuring, Redundancy and Related Reorganization Costs

WD Services has two active redundancy programs at December 31, 2017. During the year ended December 31, 2017, WD Services had four redundancy programs. Of these four redundancy plans, two were approved in 2015 and have been completed; a plan related to the termination of employees delivering services under an offender rehabilitation program ("Offender Rehabilitation Program") and a plan related to the termination of employees delivering services under the Company's employability and skills training programs and certain other employees in the United Kingdom ("UK Restructuring Program"). In addition, a redundancy plan related to the termination of employees as part of a value enhancement project ("Ingeus Futures' Program") to better align costs with revenue for certain contracts in the UK and to improve overall operating performance was approved in 2016 and a further redundancy program to align costs with revenue for offender rehabilitation services ("Delivery First Program") was approved in the fourth quarter of 2017. The Company recorded severance and related charges of $2,577 and $8,511 during the years ended December 31, 2017 and 2016, respectively, relating to the termination benefits for employee groups and specifically identified employees impacted by these plans. The severance charges incurred are recorded as "Service expense" in the accompanying consolidated statements of income.

The initial estimates of severance and related charges for the plans were based upon the employee groups impacted, average salary and benefits, and redundancy benefits pursuant to the existing policies. Additional charges above the initial estimates were incurred for the redundancy plans related to the actualization of termination benefits for specifically identified employees impacted under these plans, as well as an increase in the number of individuals impacted by these plans. The final identification of the employees impacted by each program is subject to customary consultation procedures. In addition, additional phases of value enhancement projects may be undertaken in the future, if costs and revenue are not aligned.

Summary of Severance and Related Charges

	January 1, 2017	Costs Incurred	Cash Payments	Foreign Exchange Rate Adjustments	December 31, 2017
Ingeus Futures' Program	$ 2,486	$ 1,223	$ (3,386)	$ 159	$ 482
Offender Rehabilitation Program	1,380	(40)	(1,357)	17	—
UK Restructuring Program	50	(53)	—	3	—
Delivery First Program	—	1,447	(184)	24	1,287
Total	$ 3,916	$ 2,577	$ (4,927)	$ 203	$ 1,769

	January 1, 2016	Costs Incurred	Cash Payments	Foreign Exchange Rate Adjustments	December 31, 2016
Ingeus Futures' Program	$ —	$ 2,515	$ —	$ (29)	$ 2,486
Offender Rehabilitation Program	6,538	4,865	(8,924)	(1,099)	1,380
UK Restructuring Program	2,059	1,131	(3,031)	(109)	50
Total	$ 8,597	$ 8,511	$ (11,955)	$ (1,237)	$ 3,916

The total of accrued severance and related costs of $1,769 and $3,916 are reflected in “Accrued expenses” in the consolidated balance sheets at December 31, 2017 and 2016, respectively. The amount accrued as of December 31, 2017 for the Ingeus Futures’ Program and Delivery First Program is expected to be settled principally during 2018.

9. Long-Term Obligations

The Company’s long-term obligations were as follows:

	December 31, 2017	December 31, 2016
$200,000 revolving loan, LIBOR plus 2.25% - 3.25% with interest payable at least once every three months through August 2018	$ —	$ —
Capital lease obligations	2,984	3,611
	2,984	3,611
Less current portion of capital lease obligations	2,400	1,721
Total long-term obligations, less current portion	$ 584	$ 1,890

Annual maturities of capital lease obligations as of December 31, 2017 are as follows:

Year	Amount
2018	$ 2,400
2019	504
2020	80
Total	$ 2,984

Credit Facility

The Company is a party to the amended and restated credit and guaranty agreement, dated as of August 2, 2013 (as amended, the "Credit Agreement"), with Bank of America, N.A., as administrative agent, swing line lender and letter of credit issuer, and the other lenders party thereto. The Credit Agreement provides the Company with a $200,000 revolving credit facility (the "Credit Facility"), including a sub-facility of $25,000 for letters of credit. As of December 31, 2017, the Company had no borrowings and seven letters of credit in the amount of $11,074 outstanding under the revolving credit facility. At December 31, 2017, the Company's available credit under the revolving credit facility was $188,926. Under the Credit Agreement, the Company has an option to request an increase in the amount of the revolving credit facility from time to time (on substantially the same terms as apply to the existing facilities) in an aggregate amount of up to $75,000 with either additional commitments from lenders under the Credit Agreement at such time or new commitments from financial institutions acceptable to the administrative agent in its reasonable discretion, so long as no default or event of default exists at the time of any such increase. The Company may not be able to access additional funds under this increase option as no lender is obligated to participate in any such increase under the Credit Facility. The Credit Facility matures on August 2, 2018.

Interest on the outstanding principal amount of loans accrues, at the Company's election, at a per annum rate equal to LIBOR, plus an applicable margin, or the base rate as defined in the agreement plus an applicable margin. The applicable margin ranges from 2.25% to 3.25% in the case of LIBOR loans and 1.25% to 2.25% in the case of the base rate loans, in each case, based on the Company's consolidated leverage ratio as defined in the Credit Agreement. Interest on the loans is payable quarterly in arrears. In addition, the Company is obligated to pay a quarterly commitment fee based on a percentage of the unused portion of each lender's commitment under the Credit Facility and quarterly letter of credit fees based on a percentage of the maximum amount available to be drawn under each outstanding letter of credit. The commitment fee and letter of credit fee range from 0.25% to 0.50% and 2.25% to 3.25%, respectively, in each case, based on the Company's consolidated leverage ratio.

The Company's obligations under the Credit Facility are guaranteed by all of the Company's present and future domestic subsidiaries, excluding certain domestic subsidiaries which include the Company's insurance captive. The Company's obligations under, and each guarantor's obligations under its guaranty of, the Credit Facility are secured by a first priority lien on substantially all of the Company's respective assets, including a pledge of 100% of the issued and outstanding stock of the Company's domestic subsidiaries, excluding the Company's insurance captive, and 65% of the issued and outstanding stock of the Company's first tier foreign subsidiaries.

The Credit Agreement contains customary affirmative and negative covenants and events of default. The negative covenants include restrictions on the Company's ability to, among other things, incur additional indebtedness, create liens, make investments, give guarantees, pay dividends, sell assets, and merge and consolidate. The Company is subject to financial covenants, including consolidated net leverage and consolidated interest coverage covenants.

Capital Leases

NET Services has seven capital leases for information technology hardware and software with termination dates ranging from January 2018 through October 2020. The terms of the leases are between 12 and 36 months, with interest recorded at an incremental borrowing rate of 3.28%. At December 31, 2017, $6,045 represents equipment under capital leases and $1,642 represents accumulated depreciation recognized on this leased equipment.

10. Convertible Preferred Stock, Net

The Company completed a rights offering on February 5, 2015 (the "Rights Offering") providing all of the Company's existing common stock holders the non-transferrable right to purchase their pro rata share of $65,500 of convertible preferred stock at a price equal to $100.00 per share ("Preferred Stock"). The Preferred Stock is convertible into shares of Providence's Company's common stock, $0.001 par value per share ("Common Stock") at a conversion price equal to $39.88 per share, which was the closing price of the Company's Common Stock on the NASDAQ Global Select Market on October 22, 2014.

Stockholders exercised subscription rights to purchase 130,884 shares of the Company's Preferred Stock. Pursuant to the terms and conditions of the Standby Purchase Agreement (the "Standby Purchase Agreement") between Coliseum Capital Partners, L.P., Coliseum Capital Partners II, L.P., Coliseum Capital Co-Invest, L.P. and Blackwell Partners, LLC (collectively, the "Standby Purchasers") and the Company, the remaining 524,116 shares of the Company's Preferred Stock were purchased by the Standby Purchasers at the $100.00 per share subscription price. The Company received $65,500 in aggregate gross proceeds from the consummation of the Rights Offering and Standby Purchase Agreement. Additionally, on March 12, 2015, the Standby Purchasers exercised their right to purchase an additional 150,000 shares of the Company's Preferred Stock, at a purchase price of $105.00

per share or a total purchase price of $15,750, of the same series and having the same conversion price as the Preferred Stock sold in the Rights Offering.

The Company may pay a noncumulative cash dividend on each share of Preferred Stock, if and when declared by a committee of its Board of Directors ("Board"), at the rate of five and one-half percent (5.5%) per annum on the liquidation preference then in effect. On or before the third business day immediately preceding each fiscal quarter, the Company must determine its intention whether or not to pay a cash dividend with respect to that ensuing quarter and will give notice of its intention to each holder of Preferred Stock as soon as practicable thereafter.

In the event the Company does not declare and pay a cash dividend, the Company will declare a payment in kind ("PIK") dividend by increasing the liquidation preference of the convertible Preferred Stock to an amount equal to the liquidation preference in effect at the start of the applicable dividend period, plus an amount equal to the liquidation preference then in effect multiplied by eight and one-half percent (8.5%) per annum, computed on the basis of a 365-day year and the actual number of days elapsed from the start of the applicable dividend period to the applicable date of determination. All holders of the Company's Preferred Stock are able to convert their Preferred Stock into shares of Common Stock at a rate of approximately 2.51 shares of Common Stock for each share of Preferred Stock. As of December 31, 2017, 1,800 shares of Preferred Stock have been converted to 4,510 shares of Common Stock.

Cash dividends are payable quarterly in arrears on January 1, April 1, July 1 and October 1 of each year, and commenced on April 1, 2015, and, if declared, begin to accrue on the first day of the applicable dividend period. PIK dividends, if applicable, accrue cumulatively on the same schedule as set forth above for cash dividends and are also compounded at the applicable annual rate on each applicable subsequent dividend date. Cash dividends on redeemable convertible preferred stock totaling $4,418, or $5.50 per share, $4,419, or $5.50 per share, and $3,928, or $4.88 per share, were distributed to convertible preferred stockholders for the years ended December 31, 2017, 2016 and 2015, respectively.

The Preferred Stock is accounted for outside of stockholders' equity as it may be redeemed upon certain change in control events that are not solely in the control of the Company. Dividends are recorded in stockholders' equity and consist of the 5.5%/8.5% dividend. At the time of issuance of the Preferred Stock, the Company recorded a discount on Preferred Stock related to beneficial conversion features that arose due to the closing price of the Company's Common Stock being higher than the conversion price of the Preferred Stock on the commitment date. The amortization of this discount was recorded in stockholders' equity. The discount was fully amortized as of June 30, 2015.

The following table summarizes the Preferred Stock activity for the years ended December 31, 2017 and 2016:

	Dollar Value	Share Count
Balance at December 31, 2015	$ 77,576	803,518
Conversion to common stock	(12)	(120)
Allocation of issuance costs	1	—
Balance at December 31, 2016	$ 77,565	803,398
Conversion to common stock	(20)	(198)
Allocation of issuance costs	1	—
Balance at December 31, 2017	$ 77,546	803,200

As of December 31, 2017 and 2016, the outstanding shares of Preferred Stock were convertible into 2,014,042 and 2,014,538 shares of Common Stock, respectively.

11. Stockholders' Equity

At December 31, 2017 and 2016 there were 17,473,598 and 17,315,661 shares of the Company's Common Stock issued, respectively, including 4,126,132 and 3,478,676 treasury shares at December 31, 2017 and 2016, respectively.

Subject to the rights specifically granted to holders of any then outstanding shares of the Company's Preferred Stock, the Company's common stockholders are entitled to vote together as a class on all matters submitted to a vote of the Company's common stockholders, and are entitled to any dividends that may be declared by the Board. The Company's common stockholders do not have cumulative voting rights. Upon the Company's dissolution, liquidation or winding up, holders of the Company's Common Stock are entitled to share ratably in the Company's net assets after payment or provision for all liabilities and any

preferential liquidation rights of the Company's Preferred Stock then outstanding. The Company's common stockholders do not have preemptive rights to purchase shares of the Company's stock. The issued and outstanding shares of the Company's Common Stock are not subject to any redemption provisions and are not convertible into any other shares of the Company's capital stock. The rights, preferences and privileges of holders of the Company's Common Stock will be subject to those of the holders of any shares of the Company's Preferred Stock the Company may issue in the future.

The following table reflects the total number of shares of the Company's Common Stock reserved for future issuance as of December 31, 2017:

Shares of common stock reserved for:	
Exercise of stock options and restricted stock awards	681,608
Conversion of preferred stock to common stock	2,014,042
Issuance of Performance Restricted Stock Units	18,122
Total shares of common stock reserved for future issuance	2,713,772

Share Repurchases

On October 14, 2015, the Company entered into an agreement to repurchase 707,318 of its Common Stock held by former stockholders of Matrix for an aggregate purchase price of $29,000 (or $41.00 per share). The Company funded this purchase through a combination of borrowing on its Credit Facility and cash on hand. The purchase of these shares was completed on October 30, 2015.

On November 4, 2015, the Board authorized the Company to engage in a repurchase program to repurchase up to $70,000 in aggregate value of the Company's Common Stock during the twelve-month period following November 4, 2015. This plan terminated on November 3, 2016. A total of 1,360,249 shares were purchased through this plan for $62,981, excluding commission payments.

On October 26, 2016, the Board authorized a new repurchase program, under which the Company may repurchase up to $100,000 in aggregate value of the Company's Common Stock during the twelve-month period following October 26, 2016. Through October 26, 2017, a total of 770,808 shares were purchased through this plan for $30,360, excluding commission payments.

On November 2, 2017, the Board approved the extension of the Company's October 26, 2016 stock repurchase program, authorizing the Company to engage in a repurchase program to repurchase up to $69,640 (the amount remaining from the $100,000 repurchase amount authorized in 2016) in aggregate value of our Common Stock through December 31, 2018. As of December 31, 2017, 180,270 shares were purchased under this plan after it was extended on November 2, 2017 for $10,503, excluding commission payments.

During the years ended December 31, 2017, 2016 and 2015, the Company withheld 19,556, 2,736 and 15,961 shares, respectively, from employees to cover the settlement of income tax and related benefit withholding obligations arising from vesting of restricted stock awards. In addition, during the years ended December 31, 2017 and 2015, the Company withheld 5,665 and 5,718 shares, respectively, from employees to cover the settlement of income tax and related benefit withholding obligations and the exercise price upon the exercise of stock options. During the year ended December 31, 2015, the Company withheld 43,743 shares to cover the settlement of income tax and related benefit withholding obligations arising from shares held by employees that were released from escrow related to the Matrix acquisition, which shares are treated as treasury stock.

12. Stock-Based Compensation and Similar Arrangements

The Company provides stock-based compensation to employees, non-employee directors, consultants and advisors under the Company's 2006 Long-Term Incentive Plan ("2006 Plan"). The 2006 Plan allows the flexibility to grant or award stock options, stock appreciation rights, restricted stock, unrestricted stock, stock units including restricted stock units and performance awards to eligible persons.

The following table summarizes the activity under the 2006 Plan as of December 31, 2017:

	Number of shares of the Company's Common Stock authorized for issuance	Number of shares of the Company's Common Stock remaining for future grants	Number of shares of the Company's Common Stock subject to	
			Stock Options	Stock Grants
2006 Plan	5,400,000	1,938,666	606,695	111,157

The following table reflects the amount of stock-based compensation, for share settled awards issued to employees and non-employee directors, recorded in each financial statement line item for the years ended December 31, 2017, 2016 and 2015:

	Year Ended December 31,		
	2017	2016	2015
Service expense	$ 491	$ 830	$ 21,480
General and administrative expense	7,052	4,324	5,027
Equity in net (gain) loss of investees	76	18	—
Discontinued operations, net of tax	—	(18)	115
Total stock-based compensation	$ 7,619	$ 5,154	$ 26,622

Stock-based compensation included in service expense is related to the following segments:

	Year Ended December 31,		
	2017	2016	2015
NET Services	$ 434	$ 841	$ 724
WD Services (a)	57	(11)	20,756
Total stock-based compensation in service expense	$ 491	$ 830	$ 21,480

(a) WD Services includes $16,078 for the year ended December 31, 2015 related to the acceleration of awards pursuant to the separation agreements for two executives.

The amounts above exclude tax benefits of $2,885, $2,072 and $2,322 for the years ended December 31, 2017, 2016 and 2015, respectively.

Stock Options

During the year ended December 31, 2016, the Company did not grant any stock options. The fair value of each stock option awarded to employees is estimated on the date of grant using the Black-Scholes option-pricing formula based on the following assumptions for the years ended December 31, 2017 and 2015:

	Year Ended December 31,					
	2017			2015		
Expected dividend yield	0.0%			0.0%		
Expected stock price volatility	19.45%	—	42.95%	33.8%	—	46.14%
Risk-free interest rate	0.95%	—	2.23%	0.4%	—	1.35%
Expected life of options (years)	0.03	—	6.50	0.03	—	4.00

The risk-free interest rate was based on the U.S. Treasury security rate in effect as of the date of grant which corresponds to the expected life of the award. The expected stock price volatility was based on the Company's historical data. The expected

lives of options were based on the Company's historical data, a simplified method for plain vanilla options, or the Company's best estimate where appropriate.

During the fourth quarter of 2017, James Lindstrom resigned from the Company as Chief Executive Officer ("CEO") and board member of the Company. As a result of Mr. Lindstrom's resignation as CEO, a separation agreement was entered into between the Company and Mr. Lindstrom. As a result of this separation agreement, Mr. Lindstrom was granted 125,000 stock options with an exercise price of $61.33 per share that were immediately vested. The options are exercisable through December 31, 2018.

During the year ended December 31, 2017, the Company issued 91,400 shares of its Common Stock in connection with the exercise of employee stock options under the Company's 2006 Plan.

The following table summarizes the stock option activity for the year ended December 31, 2017:

	Year ended December 31, 2017			
	Number of Shares Under Option	Weighted-average Exercise Price	Weighted-average Remaining Contractual Term	Aggregate Intrinsic Value
Balance at beginning of period	355,598	$ 33.48		
Granted	371,775	57.08		
Exercised	(115,825)	29.77		
Forfeited/Cancelled	(854)	46.44		
Expired	(3,999)	24.59		
Outstanding at end of period	606,695	$ 48.70	2.62	$ 6,705
Vested or expected to vest at end of period	606,695	$ 48.70	2.62	$ 6,705
Exercisable at end of period	357,984	$ 44.65	2.10	$ 5,508

The weighted-average grant-date fair value for options granted, total intrinsic value and cash received by the Company related to options exercised during the years ended December 31, 2017, 2016 and 2015 were as follows:

	Year ended December 31,		
	2017	2016	2015
Weighted-average grant date fair value per share	$ 9.05	$ —	$ 8.77
Options exercised:			
Total intrinsic value	$ 2,010	$ 979	$ 6,659
Cash received	$ 1,921	$ 4,108	$ 4,894

Stock Option Modifications

During the fourth quarter of 2017, as a result of the separation agreement between the Company and Mr. Lindstrom, Mr. Lindstrom's outstanding stock options from his grants of 11,319 on August 6, 2015 and 9,798 on March 15, 2017 were modified to accelerate the vesting date of both awards to November 15, 2017 and allow exercise of the stock options until December 31, 2018. As a result of the modification to the terms of the original stock options granted to Mr. Lindstrom, the Company recognized an accelerated expense of $83 on the award for the year ended December 31, 2017.

During the second quarter of 2015, Warren Rustand terminated his role as CEO and board member of the Company, but remained employed as a Senior Advisor through the end of 2015. As a result of Mr. Rustand's termination as CEO, a separation agreement was entered into between the Company and Mr. Rustand. As a result of this separation agreement, Mr. Rustand's outstanding stock options from his grant of 200,000 stock options on September 11, 2014 were modified to accelerate the vesting date for the second tranche of options from June 30, 2015 to June 5, 2015, and the exercise period for all vested options of 133,332 was lengthened. In addition, the third tranche of options, consisting of 66,668 options, was cancelled. As a result of the modifications

to the terms of the original stock options granted to Mr. Rustand, the Company recognized additional stock-based compensation expense of $737 for the year ended December 31, 2015.

Restricted Stock Awards

During the year ended December 31, 2017, the Company granted 33,420 shares of restricted stock ("RSAs") to non-employee directors of its Board, executive officers and certain key employees. The awards primarily vest in three equal installments on the first, second and third anniversaries of the date of grant.

During the year ended December 31, 2017, the Company issued 36,623 shares of its Common Stock to non-employee directors, executive officers and key employees upon the vesting of certain RSAs granted in 2016, 2015 and 2014 under the Company's 2006 Plan. As of December 31, 2017 and 2016, 10,134 shares were vested but not released due to an additional holding period required by the grant agreement.

The following table summarizes the activity of the shares and weighted-average grant date fair value of the Company's unvested restricted Common Stock during the year ended December 31, 2017:

	Shares	Weighted-average grant date fair value
Non-vested at beginning of period	72,198	$ 44.44
Granted	33,420	$ 43.91
Vested	(36,623)	$ 43.42
Forfeited or cancelled	(4,216)	$ 47.17
Non-vested at end of period	64,779	$ 44.82

As of December 31, 2017, there was $4,331 of unrecognized compensation cost related to unvested share settled stock options and RSAs granted under the 2006 Plan. The cost is expected to be recognized over a weighted-average period of 1.2 years. The total fair value of stock options and RSAs vested was $3,550, $1,383 and $3,709 for the years ended December 31, 2017, 2016 and 2015, respectively.

Other Restricted Stock Award Grants

During the year ended December 31, 2014, the Board approved the grant of 596,915 RSAs to two individuals in connection with the Ingeus acquisition. The grants were made outside of the 2006 Plan, as they were related to the acquisition. However, since the term of the awards provided for vesting based on continued employment, the awards were accounted for as stock-based compensation. The shares necessary to settle these awards were placed in an escrow account in 2014, and were releasable from escrow in accordance with the vesting of the awards. Per the original terms of the agreements, the awards vested upon continued employment of the grantees, in four equal installments on the anniversary date of the grant. However, on October 15, 2015, the Company entered into agreements whereby the executives' employment was terminated by mutual agreement and vesting was no longer based upon continued employment. The Company recognized $16,078 in stock-based compensation expense at the time of the modification, which otherwise would have been recognized over the remainder of the vesting period. Additionally, the Company recognized accelerated deferred compensation expense of $4,714 related to these agreements during the year ended December 31, 2015. As of December 31, 2017, 149,228 underlying shares to settle the awards are held in the escrow account and will be released in 2018, although all expense was recognized as of December 31, 2015.

Restricted Stock Units

During the year ended December 31, 2016, the Company granted 5,930 restricted stock units to a key employee, related to the terms of a separation agreement, that vested on January 3, 2017. The units were settled through a cash payment of $304 during the year ended December 31, 2017. The award was liability classified, and the expense recorded was based upon the Company's closing stock price at the end of each reporting period and the completed requisite service period.

Performance Restricted Stock Units

The Company had 18,122 performance restricted stock units ("PRSUs") outstanding at December 31, 2017. These awards vest upon the Company or its segments meeting certain performance criteria over a set performance period as determined, and subject to adjustment, by the Company's Compensation Committee of the Board. 13,262 of the outstanding PRSUs at December 31, 2017 have a performance criteria tied to the Company's return on equity ("ROE"), with performance periods ending on December 31, 2017. The grantees will earn 33% of PRSUs granted if the ROE is 12% but less than 15%, and 100% of the PRSUs granted if the ROE is 15% or more. If ROE is less than 12%, no PRSUs will be earned. The Company has determined, subsequent to December 31, 2017, that none of these PRSUs, with a performance period ended December 31, 2017, will vest. 4,860 of the outstanding PRSUs at December 31, 2017 have a performance criteria tied to NET Services' EBITDA and the Company's EBITDA performance with performance periods ending on December 31, 2017. The Company expects all of these PRSUs, with a performance period ended December 31, 2017, to vest. Compensation expense (benefit) related to these awards totaled $19, ($270) and $613 for the years ended December 31, 2017, 2016 and 2015, respectively.

Cash Settled Awards

During the years ended December 31, 2017, 2016 and 2015, respectively, the Company issued 3,097, 3,360 and 4,000 stock equivalent units ("SEUs"), which settle in cash upon vesting, to Coliseum Capital Partners, L.P., in lieu of a grant to Christopher Shackelton, Chairman of the Board, for his service on the Board, which vest one-third upon each anniversary of the vesting date. The fair value of the SEUs is based on the closing stock price on the last day of the period and the completed requisite service period. The Company recorded $235, $287 and $588 of expense for SEUs during the years ended December 31, 2017, 2016 and 2015, respectively.

During the year ended December 31, 2014, the Company issued 200,000 stock option equivalent units ("SOEUs"), with an exercise price of $43.81 per share, which settle in cash, to Coliseum Capital Partners, L.P in lieu of a grant to Christopher Shackelton, for other services rendered. All 200,000 SOEUs were outstanding and exercisable at December 31, 2017. This award vested one-third upon grant, one-third on June 30, 2015 and one-third on June 30, 2016. No additional SOEUs were granted during the years ended December 31, 2017, 2016 and 2015. The Company recorded $2,146 and $1,888 of expense for SOEUs during the years ended December 31, 2017 and 2015, respectively, and a benefit of $1,517 during the year ended December 31, 2016. The expenses and benefit are included in "General and administrative expense" in the consolidated statements of income. The fair value of the SOEUs was estimated as of December 31, 2017, 2016 and 2015 using the Black-Scholes option-pricing formula and amortized over the option's graded vesting periods with the following assumptions:

	Year ended December 31,								
	2017			2016			2015		
Expected dividend yield	0.0%			0.0%			0.0%		
Expected stock price volatility	23.36%	—	32.09%	35.71%	—	41.82%	43.75%	—	45.3%
Risk-free interest rate	1.75%	—	1.95%	1.11%	—	1.64%	1.2%	—	1.70%
Expected life of options (in years)	0.75	—	2.75	1.0	—	3.00	2.75	—	4.75

As of December 31, 2017 and 2016, the Company had a short-term liability of $3,938 and $1,764, respectively, in "Accrued expenses" in the consolidated balance sheet related to unexercised vested and unvested cash settled share-based payment awards. The cash settled share-based compensation benefit in total excluded tax expense of $492 for the year ended December 31, 2016. The cash settled share-based compensation expense in total excluded a tax benefit of $908 and $990 for the years ended December 31, 2017 and 2015. The unrecognized compensation cost for SEUs is expected to be recognized over a weighted average period of 0.8 years; however, the total expense for both SEUs and SOEUs will continue to be adjusted until the awards are settled.

Holdco Long-Term Incentive Plan

On August 6, 2015 (the "Award Date"), the Compensation Committee of the Board adopted the HoldCo LTIP under the 2006 Plan. The Holdco LTIP was designed to provide long-term performance based awards to certain executive officers of Providence. Under the program, executives would receive shares of Providence Common Stock based on the shareholder value created in excess of an 8.0% compounded annual return between the Award Date and December 31, 2017 (the "Extraordinary Shareholder Value"). The Award Date value was calculated on the basis of the Providence stock price equal to the volume weighted average of the common share price over the 90-day trading period ending on the Award Date. The Extraordinary Shareholder Value was calculated on the basis of the Providence stock price equal to the volume weighted average of the common share price

over the 90-day trading period ending on December 31, 2017. A pool for use in the allocation of awards was created equal to 8.0% of the Extraordinary Shareholder Value.

Participants in the HoldCo LTIP would receive a percentage allocation of any such pool and, following determination of the size of the pool, would be entitled to a number of shares equal to their pro rata portion of the pool divided by the volume weighted average of the Company's per share price over the 90-day trading period ending on December 31, 2017. Of the shares allocated, 60% would be issued to the participant on or shortly following determination of the pool, 25% would vest and be issued on the one-year anniversary of such determination date, subject to continued employment, and the remaining 15% would be issued on the second anniversary of the determination date, subject to continued employment.

It was determined that no shares would be distributed under the Holdco LTIP as the calculation of the pool amount was zero. $4,738, $3,319 and $1,353 of expense is included in "General and administrative expense" in the consolidated statements of income for the years ended December 31, 2017, 2016 and 2015, respectively. As of December 31, 2017, the Company accelerated all remaining unrecognized compensation expense for the Holdco LTIP as there was no further requisite service period associated with the award, resulting in an acceleration of expense of $1,053.

These awards were equity classified and the fair value of the awards was calculated using a Monte-Carlo simulation valuation model. The fair value of the awards granted in 2016 and 2015 were estimated using the following assumptions:

	Year ended December 31,					
	2016			2015		
Forward interest rate	0.24%	—	2.71%	0.04%	—	2.90%
Expected Volatility		40.0%			45.0%	
Dividend Yield		—%			—%	
Fair Value of Total Pool		$12,870			$12,590	

13. Vertical Long-Term Incentive Plan

The Company established Long-Term Incentive Plans ("Vertical LTIPs") for the Company's operating segments, or verticals, during the fourth quarter of 2015. The Vertical LTIPs are consistent in their basic terms, but each were customized for specific aspects of the associated vertical. The awards pay in cash, however up to 50% of the award may be paid in unrestricted stock if the recipient elects this option when the Vertical LTIP offer letter is received. In addition, at the discretion of the Company, the recipients may be able to elect unrestricted stock in lieu of cash compensation at a later date. The Vertical LTIPs reward participants based on certain measures of free cash flow and EBITDA results adjusted as specified in the plan document. The awards vest in three installments: 60% of the award will pay out immediately following December 31, 2017, 25% one year following the performance period (i.e. December 31, 2018) and 15% two years following the performance period (i.e. December 31, 2019). Payout is subject to the participant remaining employed by the Company.

During 2017, the Company revised the structure of the NET Services long-term incentive plan. As a result, the Company finalized the amount payable under the plan at $2,956. The total value will be paid to the awarded participants per the terms of the original agreement and thus the remaining unamortized expense relating to this plan continues to be recognized over the remaining service period. As of December 31, 2017, unamortized compensation expense is $299. For the years ended December 31, 2017, 2016, and 2015, $816, $1,513 and $328 of expense, respectively, is included in "Service expense" in the consolidated statements of income related to this plan. At December 31, 2017, the liability for long-term incentive plans of the Company's operating segments of $2,657 is reflected in "Accrued expenses" and "Other long-term liabilities" in the consolidated balance sheet. At December 31, 2016, the liability for long-term incentive plans of the Company's operating segments of $1,841 is reflected in "Other long-term liabilities" in the consolidated balance sheet.

14. Earnings Per Share

The following table details the computation of basic and diluted earnings per share:

	Year ended December 31,		
	2017	2016	2015
Numerator:			
Net income attributable to Providence	$ 53,369	$ 91,928	$ 83,696
Less dividends on convertible preferred stock	(4,419)	(4,419)	(3,935)
Less accretion of convertible preferred stock discount	—	—	(1,071)
Less income allocated to participating securities	(7,085)	(13,135)	(10,691)
Net income available to common stockholders	$ 41,865	$ 74,374	$ 67,999
Continuing operations	$ 47,848	$ (21,251)	$ (29,181)
Discontinued operations	(5,983)	95,625	97,180
	$ 41,865	$ 74,374	$ 67,999
Denominator:			
Denominator for basic earnings per share -- weighted-average shares	13,602,140	14,666,896	15,960,905
Effect of dilutive securities:			
Common stock options	66,314	—	—
Performance-based restricted stock units	4,860	—	—
Denominator for diluted earnings per share -- adjusted weighted-average shares assumed conversion	13,673,314	14,666,896	15,960,905
Basic earnings (loss) per share:			
Continuing operations	$ 3.52	$ (1.45)	$ (1.83)
Discontinued operations	(0.44)	6.52	6.09
	$ 3.08	$ 5.07	$ 4.26
Diluted earnings (loss) per share:			
Continuing operations	$ 3.50	$ (1.45)	$ (1.83)
Discontinued operations	(0.44)	6.52	6.09
	$ 3.06	$ 5.07	$ 4.26

The accretion of Preferred Stock discount in the table above related to a beneficial conversion feature of the Company's Preferred Stock that was fully amortized as of June 30, 2015. Income allocated to participating securities is calculated by allocating a portion of net income attributable to Providence, less dividends on convertible stock, to the convertible preferred stockholders on a pro-rata as converted basis; however, the convertible preferred stockholders are not allocated losses.

The following weighted-average shares were not included in the computation of diluted earnings per share as the effect of their inclusion would have been anti-dilutive:

	Year ended December 31,		
	2017	2016	2015
Stock options to purchase common stock	362,392	22,638	173,925
Convertible preferred stock	803,323	803,442	700,241

15. Operating Leases

The Company has non-cancelable contractual obligations in the form of operating leases for office space, related office equipment and other facilities. The leases expire in various years and generally provide for renewal options. In the normal course of business, it is expected that these leases will be renewed or replaced by leases on other properties.

Certain operating leases provide for increases in future minimum annual rental payments based on defined increases in the Consumer Price Index, subject to certain minimum increases. Several of these lease agreements contain provisions for periods in which rent payments are reduced. The total amount of rental payments due over the lease term is being charged to rent expense on a straight-line basis over the term of the lease. The cumulative difference between rent expense recorded and the amount paid, for continuing operations, as of December 31, 2017 and 2016 was $3,957 and $3,253, respectively, and is included in “Accrued expenses” and “Other long-term liabilities” in the consolidated balance sheets.

Future minimum payments under non-cancelable operating leases for equipment and property with initial terms of one year or more consisted of the following at December 31, 2017:

	Operating Leases
2018	$ 20,875
2019	13,376
2020	9,738
2021	8,022
2022	6,142
Thereafter	3,939
Total future minimum lease payments	$ 62,092

Rent expense for continuing operations related to operating leases was $27,511, $29,316 and $31,191, for the years ended December 31, 2017, 2016 and 2015, respectively. Also, the lease agreements generally require the Company to pay executory costs such as real estate taxes, insurance, and repairs, which are recorded to expense as incurred.

16. Retirement Plan

The Company maintains a qualified defined contribution plan under Section 401(k) of the Internal Revenue Code of 1986, as amended, for all employees of its NET Services operating segment and corporate personnel. The Company, at its discretion, may make a matching contribution to the plan. Any matching contributions vest over 5 years. Unvested matching contributions are forfeitable upon employee termination. Employee contributions are fully vested and non-forfeitable. The Company’s contributions to the plan for continuing operations were $320, $248 and $221, for the years ended December 31, 2017, 2016 and 2015, respectively.

WD Services’ employees are entitled to benefits under certain retirement plans. The WD Services’ segment has separate plans in each country it operates. The plans receive fixed contributions from WD Services’ companies and the legal or constructive obligation is limited to these contributions, although the benefits the employees ultimately receive are determined by the plan administrators, which includes government entities and third-party administrators. The Company’s contributions to these plans were $8,219, $9,139 and $10,331 for the years ended December 31, 2017, 2016 and 2015, respectively.

The Company also maintains a Deferred Compensation Rabbi Trust Plan for highly compensated employees of NET Services. This plan was put in place to compensate for the inability of highly compensated employees to take full advantage of the Company’s 401(k) plan. Additional information is included in Note 18, Commitments and Contingencies.

17. Income Taxes

The following table summarizes our U.S. and foreign income (loss) from continuing operations before income taxes:

	Year Ended December 31,		
	2017	2016	2015
US	48,719	65,559	43,598
Foreign	15,485	(67,437)	(53,692)
Total	$ 64,204	$ (1,878)	$ (10,094)

The federal, state and foreign income tax provision is summarized as follows:

	Year Ended December 31,		
	2017	2016	2015
Federal:			
Current	$ 18,792	$ 21,202	$ 15,161
Deferred	(19,767)	(6,477)	(1,606)
	(975)	14,725	13,555
State:			
Current	3,975	4,580	2,644
Deferred	723	(938)	(38)
	4,698	3,642	2,606
Foreign:			
Current	1,197	266	523
Deferred	(519)	(1,597)	(2,101)
	678	(1,331)	(1,578)
Total provision for income taxes	$ 4,401	$ 17,036	$ 14,583

A reconciliation of the provision for income taxes with amounts determined by applying the statutory U.S. federal income tax rate to income (loss) from continuing operations before income taxes is as follows:

	Year Ended December 31,		
	2017	2016	2015
Federal statutory rates	35%	35 %	35 %
Federal income tax at statutory rates	$ 22,471	$ (657)	$ (3,533)
Revaluation of net deferred tax liabilities due to U.S. tax reform	(19,397)	—	—
U.S. tax reform impact on equity income of investee	(1,646)	—	—
Change in valuation allowance	2,299	9,480	3,574
Change in uncertain tax positions	7	73	(76)
State income taxes, net of federal benefit	3,203	2,396	1,785
Difference between federal statutory and foreign tax rate	(1,648)	9,427	4,642
Stock compensation	3,400	—	(184)
Meals and entertainment	100	96	81
Amortization of deferred consideration	—	—	9,444
Transaction costs	159	—	(447)
Contingent consideration liability reversal	—	—	(854)
Nontaxable income	(1,203)	—	(965)
Tax credits	(354)	(947)	(456)
Legal expense	(805)	522	284
Depreciation	—	—	649
Equity in net loss of investee	569	624	366
Sale of joint venture	(6,021)	—	—
Asset impairment	—	2,353	—
Foreign exchange	2,925	(7,001)	—
Other	342	670	273
Provision for income taxes	$ 4,401	$ 17,036	$ 14,583
Effective income tax rate	7%	(907)%	(144)%

The Company recognized an income tax provision for the years ended December 31, 2016 and December 31, 2015 despite having losses from continuing operations before income taxes. Because of foreign net operating losses (including equity investee losses) for which the future income tax benefit currently cannot be recognized, and non-deductible expenses such as amortization of deferred consideration related to the Ingeus acquisition, the Company recognized estimated taxable income for these years upon which the income tax provision for financial reporting is calculated.

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of the Company's deferred tax assets and liabilities are as follows:

	December 31,	
	2017	2016
Deferred tax assets:		
Net operating loss carryforwards	$ 20,496	$ 17,742
Tax credit carryforwards	486	399
Accounts receivable allowance	1,134	1,341
Accrued items and reserves	14,371	18,669
Stock compensation	1,480	4,224
Deferred rent	572	915
Property and equipment depreciation	300	—
Other	173	180
	39,012	43,470
Deferred tax liabilities:		
Deferred financing costs	38	154
Prepaids	1,440	2,103
Property and equipment depreciation	—	1,238
Goodwill and intangibles amortization	5,809	9,568
Equity investment	42,113	59,244
Other	205	203
	49,605	72,510
Net deferred tax liabilities	(10,593)	(29,040)
Less valuation allowance	(26,402)	(27,423)
Net deferred tax liabilities	$ (36,995)	$ (56,463)
Net noncurrent deferred tax assets, net of valuation allowance of $26,402 and $27,423 for 2017 and 2016, respectively	4,632	1,510
Net noncurrent deferred tax liabilities, net of valuation allowance of $0 and $0 for 2017 and 2016, respectively	(41,627)	(57,973)
	$ (36,995)	$ (56,463)

At December 31, 2017, the Company had no federal or state net operating loss carryforwards. The Company had net operating loss carryforwards in the following countries which can be carried forward indefinitely:

Australia	$ 41,256
Canada	728
France	3,882
Saudi Arabia	82
UK	40,090

Realization of the Company's net operating loss carryforwards is dependent on generating sufficient taxable income. Although realization is not assured, management believes it is more likely than not that all of the deferred tax assets will be realized, to the extent they are not covered by a valuation allowance. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

The net change in the total valuation allowance for the year ended December 31, 2017 was negative $1,021, of which positive $2,299 related to current operations and negative $3,320 related to the adjustment of the beginning balance. The valuation

allowance includes $25,929 primarily for Australia, France and UK net operating loss carryforwards, and $473 for state tax credit carryforwards for which the Company has concluded that it is more likely than not that these net operating loss and tax credit carryforwards will not be realized in the ordinary course of operations. The Company will continue to assess the valuation allowance, and to the extent it is determined that the valuation allowance should be changed, an appropriate adjustment will be recorded.

U.S. Tax Reform

On December 22, 2017, the Tax Reform Act was enacted which institutes fundamental changes to the taxation of multinational corporations. The Tax Reform Act includes changes to the taxation of foreign earnings by implementing a dividend exemption system, expansion of the current anti-deferral rules, a minimum tax on low-taxed foreign earnings and new measures to deter base erosion. The Tax Reform Act also includes a permanent reduction in the corporate tax rate to 21%, repeal of the corporate alternative minimum tax, expensing of capital investment, and limitation of the deduction for interest expense. Furthermore, as part of the transition to the new tax system, a one-time transition tax is imposed on a U.S. shareholder's historical undistributed earnings and profits ("E&P") of foreign affiliates. Although the Tax Reform Act is generally effective January 1, 2018, GAAP requires recognition of the tax effects of new legislation during the reporting period that includes the enactment date, which was December 22, 2017.

As a result of the reduction in the U.S. corporate income tax rate, the Company revalued its ending net deferred tax liabilities as of December 31, 2017 and recognized a provisional tax benefit of $19,397. The Company has projected net accumulated deficits in foreign E&P; therefore, no provisional tax expense for deemed repatriation has been recognized. For any future foreign earnings, the Company will generally be free of additional U.S. tax consequences due to a dividends received deduction implemented as part of the move to a territorial tax system for foreign subsidiary earnings. The Company continues to assert indefinite reinvestment in outside basis differences. Determination of the amount of unrecognized deferred tax liability on outside basis differences is not practicable because of the complexity of laws and regulations, the varying tax treatment of alternative repatriation scenarios, and the variation due to multiple potential assumptions relating to the timing of any future repatriation.

The global intangible low taxed income ("GILTI") provisions of the Tax Reform Act require the Company to include in its U.S. income tax return foreign subsidiary earnings in excess of an allowable return on the foreign subsidiary's tangible assets. The Company may be subject to incremental U.S. tax on GILTI income beginning in 2018, and has elected to account for GILTI tax in the period in which it is incurred. Therefore, no deferred tax impacts of GILTI have been considered in the Company's consolidated financial statements for the year ended December 31, 2017.

On December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118 ("SAB 118") to address the application of GAAP in situations when a registrant does not have the necessary information available, prepared, or analyzed (including computations) in reasonable detail to complete the accounting for certain income tax effects of the Tax Reform Act. In accordance with the SAB 118 guidance, the Company has recognized the provisional tax impacts related to the benefit for the revaluation of deferred tax assets and liabilities in its consolidated financial statements for the year ended December 31, 2017. The final impact of the Tax Reform Act may differ from these provisional amounts, possibly materially, due to, among other things, issuance of additional regulatory guidance, changes in interpretations and assumptions the Company has made, and actions the Company may take as a result of the Tax Reform Act. In accordance with SAB 118, the financial reporting impact of the Tax Reform Act will be completed in the fourth quarter of 2018.

Unrecognized Tax Benefits

The Company expects no material amount of the unrecognized tax benefits to be recognized during the next twelve months. The Company recognizes interest and penalties as a component of income tax expense. During the years ended December 31, 2017, 2016 and 2015, the Company recognized approximately $65, $19 and $27, respectively, in interest and penalties. The Company had approximately $83 and $52 for the payment of penalties and interest accrued as of December 31, 2017 and 2016, respectively.

A reconciliation of the liability for unrecognized income tax benefits is as follows:

	December 31,		
	2017	2016	2015
Unrecognized tax benefits, beginning of year	$ 1,108	$ 271	$ 347
Balance upon acquisition/disposition	—	764	—
Increase (decrease) related to prior year positions	22	37	(47)
Increase related to current year tax positions	101	139	48
Statute of limitations expiration	(116)	(103)	(77)
Unrecognized tax benefits, end of year	$ 1,115	$ 1,108	$ 271

The Company is subject to taxation in the U.S. and various foreign and state jurisdictions. The statute of limitations is generally three years for the U.S., two to five years in foreign countries and between three and four years for the various states in which the Company operates. The Company is subject to the following material taxing jurisdictions: the U.S., UK, Australia, France, Saudi Arabia and Korea. The tax years that remain open for examination by the U.S. and various foreign countries and states principally include the years 2013 to 2017.

18. Commitments and Contingencies

Legal proceedings

On June 15, 2015, a putative stockholder class action derivative complaint was filed in the Court of Chancery of the State of Delaware (the "Court"), captioned Haverhill Retirement System v. Kerley et al., C.A. No. 11149-VCL (the "Haverhill Litigation"). The complaint named Richard A. Kerley, Kristi L. Meints, Warren S. Rustand, Christopher Shackelton (the "Individual Defendants") and Coliseum Capital Management, LLC ("Coliseum Capital Management") as defendants, and the Company as a nominal defendant. The complaint purported to allege that the dividend rate increase term originally in the Company's outstanding Preferred Stock was an impermissibly coercive measure that impaired the voting rights of the Company's stockholders in connection with the vote on the removal of certain voting and conversion caps previously applicable to the Preferred Stock (the "Caps"), and that the Individual Defendants breached their fiduciary duties by approving the dividend rate increase term and attempting to coerce the stockholder vote relating to the Company's Preferred Stock, and by failing to disclose all material information necessary to allow the Company's stockholders to cast an informed vote on the Caps. The complaint also purported to allege derivative claims alleging that the Individual Defendants breached their fiduciary duties to the Company by entering into the subordinated note and standby agreement with Coliseum Capital Management, and granting Coliseum Capital Management certain stock options. The complaint further alleged that Coliseum Capital Management aided and abetted the Individual Defendants in breaching their fiduciary duties. The complaint sought, among other things, an injunction prohibiting the stockholder vote relating to the dividend rate increase, corporate governance reforms, unspecified damages and other relief.

On August 31, 2015, after arms' length negotiations, the parties reached an agreement in principle and executed a Memorandum of Understanding ("MOU") providing for the settlement of claims concerning the dividend rate increase term and stockholder vote and related disclosure. The MOU stated that the Defendants had entered into the partial settlement of the litigation solely to eliminate the distraction, burden, expense, and potential delay of further litigation involving claims that have been settled. Pursuant to the partial settlement, the Company agreed to supplement the disclosures in its definitive proxy statement on Schedule 14A (the "2015 Proxy Statement"), Coliseum Capital Management and certain of its affiliates and the Company entered into an amendment to that certain Series A Preferred Stock Exchange Agreement, by and among Coliseum Capital Partners, L.P., Coliseum Capital Partners II, L.P., Coliseum Capital Co-Invest, L.P., Blackwell Partners, LLC, and The Providence Service Corporation dated as of February 11, 2015 described in the 2015 Proxy Statement, and the Board of the Company agreed to adopt a policy related to the Board's determination each quarter as to whether the Company should pay cash dividends or allow dividends to be paid in the form of PIK dividends on the Preferred Stock, as further described in the supplemental proxy disclosures. On September 2, 2015, Providence issued supplemental disclosures through a supplement to the 2015 Proxy Statement. On September 16, 2015, Providence stockholders approved the removal of the Caps. The Company provided notice of the proposed partial settlement to Providence's stockholders by December 11, 2015. At a hearing on February 9, 2016, the court denied approval of the settlement. The Court indicated that plaintiff's counsel could petition the Court for a mootness fee, and that defendants would have the opportunity to oppose any such application.

On January 12, 2016, the plaintiff filed a verified amended class action and derivative complaint (the "first amended complaint"). In addition to the defendants named in the earlier complaint, the first amended complaint named David Shackelton,

Coliseum Capital Partners, L.P., Coliseum Capital Partners II, L.P., Blackwell Partners, LLC, Coliseum Capital Co-Invest, L.P. (collectively, and together with Coliseum Capital Management, LLC, "Coliseum") and RBC Capital Markets, LLC ("RBC Capital Markets") as additional defendants. The first amended complaint purported to allege direct and derivative claims for breach of fiduciary duty against some or all of the Individual Defendants and David Shackelton (collectively, the "Amended Individual Defendants") regarding the approval of the subordinated note, the rights offering, the standby agreement with Coliseum Capital Management, and the grant to Coliseum Capital Management of certain stock options. The first amended complaint also purported to allege an additional derivative claim for unjust enrichment against Coliseum and further alleged that Coliseum and RBC Capital Markets aided and abetted the Amended Individual Defendants in breaching their fiduciary duties. The first amended complaint sought, among other things, revision or rescission of the terms of the subordinated note and Preferred Stock, corporate governance reforms, unspecified damages and other relief.

On May 6, 2016, the plaintiff filed a verified second amended class action and derivative complaint (the "second amended complaint"). In addition to the defendants named in the earlier complaint, the second amended complaint named Paul Hastings LLP ("Paul Hastings") and Bank of America, N.A. ("BofA") as additional defendants. In addition to previously asserted claims, the second amended complaint purported to assert direct and derivative claims for breach of fiduciary duties against Coliseum Capital Management, in its capacity as the controlling stockholder of the Company, in connection with the subordinated note, the Company's rights offering of Preferred Stock and the standby purchase agreement with Coliseum Capital Management (the "Financing Transactions"). The second amended complaint also alleged that Paul Hastings breached their fiduciary duties as counsel to the Company in connection with the Financing Transactions and that BofA and Paul Hastings aided and abetted certain of the Amended Individual Defendants in breaching their fiduciary duties in connection with the Financing Transactions. The second amended complaint sought, among other things, revision or rescission of the terms of the subordinated note and Preferred Stock, corporate governance reforms, disgorgement of fees paid to RBC Capital Markets, Paul Hastings and BofA for work relating to the Financing Transactions, unspecified damages and other relief.

On May 20, 2016, the Court granted a six-month stay of the proceeding (which was subsequently extended) to allow a special litigation committee, created by the Board, sufficient time to investigate, review and evaluate the facts, circumstances and claims asserted in or relating to this action and determine the Company's response thereto. On January 20, 2017, the special litigation committee advised the Court that the parties to the litigation and the special litigation committee had reached an agreement in principle to settle all of the claims in the litigation. The parties then entered into a proposed settlement agreement which was submitted to the Court for approval. On September 28, 2017, the Court approved the proposed settlement agreement among the parties that provided for a settlement amount of $10,000 less plaintiff's legal fees and expenses (the "Settlement Amount"), with 75% of the Settlement Amount to be paid to the Company and 25% of the Settlement Amount to be paid to holders of the Company's Common Stock other than certain excluded parties. In November 2017, the Company received a payment of $5,363 from the Settlement Amount, which is included in "Other income" in the consolidated statement of income for the year ended December 31, 2017.

In addition to the matter described above, in the ordinary course of business, the Company is a party to various lawsuits. Management does not expect these lawsuits to have a material impact on the liquidity, results of operations, or financial condition of Providence.

Indemnifications related to Haverhill Litigation

The Company indemnified the Standby Purchasers from and against any and all losses, claims, damages, expenses and liabilities relating to or arising out of (i) any breach of any representation, warranty, covenant or undertaking made by or on behalf of the Company in the Standby Purchase Agreement and (ii) the transactions contemplated by the Standby Purchase Agreement and the 14.0% Unsecured Subordinated Note in aggregate principal amount of $65,500, except to the extent that any such losses, claims, damages, expenses and liabilities are attributable to the gross negligence, willful misconduct or fraud of such Standby Purchaser.

The Company has also indemnified other third parties from and against any and all losses, claims, damages, expenses and liabilities arising out of or in connection with the Company's acquisition of CCHN Group Holdings, Inc. (operating under the tradename Matrix, and formerly included in our HA Services segment) in October 2014 and related financing commitments, except to the extent that any such losses, claims, damages, expenses and liabilities are found in a final, non-appealable judgment by a court of competent jurisdiction to have resulted from the gross negligence, bad faith or willful misconduct of such third parties, or a material breach of such third parties' obligations under the related agreements.

The Company recorded $318, $1,282 and $310 of such indemnified legal expenses related to the Haverhill Litigation during the years ended December 31, 2017, 2016 and 2015, respectively, which is included in "General and administrative expenses" in the consolidated statements of income. Of these amounts, $245, $757 and $310 for the years ended December 31, 2017, 2016

and 2015, respectively, were indemnified legal expenses of related parties. Other legal expenses of the Company related to the Haverhill Litigation are covered under the Company's insurance policies, subject to applicable deductibles and customary review of the expenses by the carrier. The Company recognized expense of $8, $210 and $500 for the years ended December 31, 2017, 2016 and 2015, respectively. While the carrier typically remits payment directly to the respective law firm, the Company accrues for the cost and records a corresponding receivable for the amount to be paid by the carrier. The Company has recognized an insurance receivable of $941 and $1,645 in "Other receivables" in the consolidated balance sheets at December 31, 2017 and 2016, respectively, with a corresponding liability amount recorded to "Accrued expenses".

Other Indemnifications

The Company has provided certain standard indemnifications in connection with the sale of the Human Services segment to Molina Healthcare Inc. ("Molina") effective November 1, 2015. All representations and warranties made by the Company in the Membership Interest Purchase Agreement (the "Purchase Agreement") to sell the Human Services segment ended on February 1, 2017. However, claims made prior to February 1, 2017 by the purchaser of the Human Services segment against these representations and warranties may survive until the claims are settled. In addition, certain representations, including tax representations, survive until the expiration of applicable statutes of limitation, and healthcare representations survive until the third anniversary of the closing date. The Company has received indications from the purchaser of the Human Services segment regarding potential indemnification claims. One potential indemnification claim relates to Rodriguez v. Providence Community Corrections (the "Rodriguez Litigation"), a complaint filed in the District Court for the Middle District of Tennessee, Nashville Division (the "Rodriquez Court"), against Providence Community Corrections, Inc. ("PCC"), an entity sold under the Purchase Agreement. On September 18, 2017, the plaintiffs in the Rodriguez Litigation filed an unopposed motion for preliminary approval of a proposed settlement, pursuant to which PCC would pay $14,000 to the plaintiffs and $350 to co-defendant Rutherford County, Tennessee. On October 5, 2017, the Rodriguez Court denied preliminary approval of the settlement and requested additional information. On October 18, 2017, the plaintiffs filed a second unopposed motion for approval of the proposed settlement. On January 2, 2018, the Rodriguez Court granted preliminary approval of the proposed settlement and authorized notice to class members.

On September 15, 2017, Molina and the Company entered into a memorandum of understanding; and on March 1, 2018, Molina and the Company entered into a settlement agreement, regarding a settlement of an indemnification claim by Molina with respect to the Rodriguez Litigation and other matters. As of December 31, 2017, the accrual is $15,000 with respect to an estimate of loss for potential indemnification claims. The Company expects to recover a portion of the settlement through insurance coverage, although this cannot be assured.

Litigation is inherently uncertain and the actual losses incurred in the event that the related legal proceedings were to result in unfavorable outcomes could have a material adverse effect on the Company's business and financial performance.

The Company has provided certain standard indemnifications in connection with its Matrix stock subscription transaction whereby Mercury Fortuna Buyer, LLC ("Subscriber"), Providence and Matrix entered into a stock subscription agreement (the "Subscription Agreement"), dated August 28, 2016. The representations and warranties made by the Company in the Subscription Agreement ended January 19, 2018; however, certain fundamental representations survive through the 36th month following the closing date. The covenants and agreements of the parties to be performed prior to the closing ended January 19, 2018, and all other covenants and agreements survive until the expiration of the applicable statute of limitations in the event of a breach, or for such lesser periods specified therein. The Company is not aware of any indemnification liabilities with respect to Matrix that require accrual at December 31, 2017.

Other Contingencies

On January 25, 2018, the UK Ministry of Justice (the "MOJ") released a report on reoffending statistics for certain offenders who entered probation services during the period October 2015 to March 2016. The report provides statistics for all providers of probation services, including our subsidiary RRP, which is in our WD Services segment. This information is the second data set that is utilized to determine performance payments under the various providers' transforming rehabilitation contracts with the MOJ, as the actual rates of recidivism are compared to benchmark rates established by the MOJ. Performance payments and penalties are linked to two separate measures of recidivism - the binary measure and the frequency measure. The binary measure defines the percentage of offenders within a cohort, formed quarterly, who reoffend in the following 12 months. The frequency measure defines the average number of offenses committed by reoffenders within the same 12-month measurement period. The performance for the frequency measure for most providers has been below the benchmarks established by the MOJ. As a result, RRP could be required to make payments to the MOJ and the amounts of such payments could be material. The amount of potential payments to the MOJ, if any, under RRP's contracts with the MOJ cannot be estimated at this time, as the MOJ is

reviewing the data to understand the underlying reasons for the increase in certain rates of recidivism and other factors that could impact the contractual measure.

Deferred Compensation Plan

The Company has one deferred compensation plan for management and highly compensated employees of NET Services as of December 31, 2017. The deferred compensation plan is unfunded, and benefits are paid from the general assets of the Company. The total of participant deferrals, which is reflected in "Other long-term liabilities" in the consolidated balance sheets, was $1,806 and $1,430 at December 31, 2017 and 2016, respectively.

19. Transactions with Related Parties

The Company incurred legal expenses under an indemnification agreement with the Standby Purchasers as further discussed in Note 18, Commitments and Contingencies. Preferred Stock dividends earned by the Standby Purchasers during the years ended December 31, 2017 and 2016 totaled $4,213 each year.

During the year ended December 31, 2017, the Company made a $566 loan to Mission Providence. The loan was also repaid during the year ended December 31, 2017.

20. Discontinued Operations

Effective October 19, 2016, the Company completed the Matrix Transaction. At the closing, (i) cash consideration of $180,614 was paid by the Subscriber to Matrix based upon an enterprise value of $537,500 and (ii) Matrix borrowed approximately $198,000 pursuant to a credit and guaranty agreement providing for term loans in an aggregate principal amount of $198,000 and revolving loan commitments in an aggregate principal amount not to exceed $10,000, which was not drawn at the closing. At the closing, Matrix distributed $381,163 to Providence, in full satisfaction of a promissory note and accumulated interest between Matrix and Providence. At the closing, Providence made a $5,663 capital contribution to Matrix, as described in the Subscription Agreement, as amended, based upon its pro-rata ownership of Matrix, to fund the near-term cash needs of Matrix. On the day that was fifteen days following the closing date, Providence was, to the extent payable pursuant to the terms of the Subscription Agreement, as amended, entitled to receive from Matrix, or required to pay to Matrix, subsequent working capital adjustment payments. Providence received an initial payment of $5,172 from Matrix in November 2016 which is net of the capital contribution of $5,663 described above, based upon the initial working capital calculation as described in the Subscription Agreement. Additionally, in February 2017, the Company received a $75 payment from Matrix representing the final working capital adjustment payment.

In accordance with ASC 205-20, Presentation of Financial Statements-Discontinued Operations, a component of an entity is reported in discontinued operations after meeting the criteria for held for sale classification if the disposition represents a strategic shift that has (or will have) a major effect on the entity's operations and financial results. The Company analyzed the quantitative and qualitative factors relevant to the Matrix stock subscription transaction resulting in the Company no longer owning a controlling interest in Matrix, and determined that those held for sale conditions for discontinued operations presentation were met during the third quarter of 2016. As such, the historical financial results of Matrix, the Company's historical HA Services segment, and the related income tax effects have been presented as discontinued operations for all periods presented in the accompanying consolidated financial statements through October 19, 2016.

The Company has continuing involvement with Matrix through its ownership of 46.6% of the equity interests in Matrix as of December 31, 2017, as well as through a management consulting agreement, not to exceed ten years. Prior to the Matrix Transaction, the Company owned 100% of the equity interest in Matrix. Subsequent to the Matrix Transaction, the Company accounts for its investment in Matrix under the equity method of accounting. The Company's share of Matrix's losses subsequent to the Matrix Transaction, which totaled $13,445 and $1,789, is recorded as "Equity in net (gain) loss of investees" in its consolidated statement of income for the years ended December 31, 2017 and 2016, respectively. Matrix's pretax loss for the year ended December 31, 2017 totaled $2,948 and includes $3,537 of transaction related expenses. Matrix's pretax loss for the period of October 19, 2016 through December 31, 2016 totaled $7,027 and includes $6,367 of transaction related expenses. There have been no cash inflows or outflows from or to Matrix subsequent to the closing of the Matrix Transaction, other than the working capital adjustments discussed above and management fees associated with its ongoing relationship with Matrix, of which $1,103 was received during the year ended December 31, 2017. $247 and $185 are included in "Other receivables" in the consolidated balance sheets at December 31, 2017 and 2016, respectively, related to management fees receivable.

On September 3, 2015, the Company entered into a Purchase Agreement, pursuant to which the Company agreed to sell all of the membership interests in Providence Human Services, LLC and Providence Community Services, LLC, comprising the

Company's Human Services segment, in exchange for cash proceeds of approximately $200,000 prior to adjustments for estimated working capital, certain seller transaction costs, debt assumed by the buyer, and a $20,099 cash payment received for the Providence Human Services cash and cash equivalents on hand at closing. The net proceeds were $230,703, although $10,000 is held in an indemnity escrow and recorded within "Prepaid expenses and other" in the consolidated balance sheet at December 31, 2017. Proceeds include a customary working capital adjustment of $13,246. During the years ended December 31, 2017 and 2016, the Company recorded additional expenses related to the Human Services segment, principally related to legal proceedings as described in Note 18, Commitment and Contingences, related to an indemnified legal matter.

Results of Operations

The following table summarizes the results of operations classified as discontinued operations, net of tax, for the years ended December 31, 2017, 2016 and 2015. The HA Services segment column in the table below for the year ended December 31, 2016 reflects the financial results for HA Services from January 1, 2016 through October 19, 2016.

	Year ended December 31, 2017		
	Human Services Segment	HA Services Segment	Total Discontinued Operations
Operating expenses:			
General and administrative expense	$ 9,674	$ —	$ 9,674
Total operating expenses	9,674	—	9,674
Loss from discontinued operations before income taxes	(9,674)	—	(9,674)
Income tax benefit	3,691	—	3,691
Discontinued operations, net of tax	$ (5,983)	$ —	$ (5,983)

	Year ended December 31, 2016		
	Human Services Segment	HA Services Segment	Total Discontinued Operations
Service revenue, net	$ —	$ 166,090	$ 166,090
Operating expenses:			
Service expense	—	120,906	120,906
General and administrative expense	7,966	2,148	10,114
Depreciation and amortization	—	21,121	21,121
Total operating expenses	7,966	144,175	152,141
Operating income (loss)	(7,966)	21,915	13,949
Other expenses:			
Write-off of deferred financing fees	—	2,302	2,302
Interest expense, net	—	9,929	9,929
Income (loss) from discontinued operations before gain on disposition and income taxes	(7,966)	9,684	1,718
Gain on disposition	—	167,895	167,895
(Provision) benefit for income taxes	2,401	(63,254)	(60,853)
Discontinued operations, net of tax	$ (5,565)	$ 114,325	$ 108,760

	Year ended December 31, 2015		
	Human Services Segment	HA Services Segment	Total Discontinued Operations
Service revenue, net	$ 291,510	$ 217,436	$ 508,946
Operating expenses:			
Service expense	264,293	163,211	427,504
General and administrative expense	14,975	2,630	17,605
Asset impairment charge	1,593	—	1,593
Depreciation and amortization	4,831	29,472	34,303
Total operating expenses	285,692	195,313	481,005
Operating income	5,818	22,123	27,941
Other expenses:			
Interest expense, net	2,829	14,359	17,188
Income from discontinued operations before gain on disposition and income taxes	2,989	7,764	10,753
Gain on disposition	123,129	—	123,129
Provision for income taxes	(24,318)	(1,693)	(26,011)
Discontinued operations, net of tax	$ 101,800	$ 6,071	$ 107,871

Interest expense, net

The Company allocated interest expense, including amortization of deferred financing fees, to discontinued operations based on the portion of the debt that was required to be paid with the proceeds from the sale of the Human Services segment and the Matrix Transaction. The total allocated interest expense is included in “Interest expense, net” in the tables above. The total allocated interest expense for the years ended December 31, 2016 and 2015 is as follows:

	Year ended December 31,	
	2016	2015
Human Services Segment	$ —	$ 2,871
HA Services Segment	9,939	14,376
Total	$ 9,939	$ 17,247

Cash Flow Information

The following table presents depreciation, amortization, capital expenditures and significant operating noncash items of the discontinued operations for the years ended December 31, 2016 and 2015:

	For the year ended December 31, 2016		
	Human Services Segment	HA Services Segment	Total Discontinued Operations
Cash flows from discontinued operating activities:			
Depreciation	$ —	$ 3,661	$ 3,661
Amortization	—	17,460	17,460
Stock-based compensation	—	(18)	(18)
Deferred income taxes	—	52,338	52,338
Cash flows from discontinued investing activities:			
Purchase of property and equipment	$ —	$ 9,174	$ 9,174

	For the year ended December 31, 2015		
	Human Services Segment	HA Services Segment	Total Discontinued Operations
Cash flows from discontinued operating activities:			
Depreciation	$ 2,376	$ 3,370	$ 5,746
Amortization	2,455	26,102	28,557
Asset impairment charge	1,593	—	1,593
Stock-based compensation	7	108	115
Deferred income taxes	(5,680)	730	(4,950)
Cash flows from discontinued investing activities:			
Purchase of property and equipment	$ 2,224	$ 8,079	$ 10,303

21. Segments

The Providence Service Corporation owns subsidiaries and investments primarily engaged in the provision of healthcare services in the United States and workforce development services internationally. The subsidiaries and other investments in which the Company holds interests comprise the following segments:

- NET Services – Nationwide manager of non-emergency medical transportation programs for state governments and managed care organizations.
- WD Services – Global provider of employment preparation and placement services, legal offender rehabilitation services, youth community service programs and certain health related services to eligible participants of government sponsored programs.
- Matrix Investment – Minority interest in Matrix, a nationwide provider of in-home care optimization and management solutions, including CHAs, to members of managed care organizations, accounted for as an equity method investment as a result of the Matrix Transaction on October 19, 2016, which is further discussed in Note 20, Discontinued Operations

In addition to its segments' operations, the Corporate and Other segment includes the Company's activities at its corporate office that include executive, accounting, finance, internal audit, tax, legal, public reporting, certain strategic and corporate development functions, and the Company's captive insurance company.

Segment results are based on how the Company's chief operating decision maker ("CODM") manages the Company's business, makes operating decisions and evaluates operating performance. The operating results of the segments include revenue and expenses incurred by the segment, as well as an allocation of direct expenses incurred by Corporate on behalf of the segment. Indirect expenses, including unallocated corporate functions and expenses, such as executive, accounting, finance, internal audit, tax, legal, public reporting, certain strategic and corporate development functions and the results of the Company's captive insurance company as well as elimination entries recorded in consolidation are reflected in Corporate and Other.

The following table sets forth certain financial information from continuing operations attributable to the Company's business segments for the years ended December 31, 2017, 2016 and 2015.

	Year Ended December 31, 2017				
	NET Services	WD Services	Matrix Investment	Corporate and Other	Total
Service revenue, net	$ 1,318,220	$ 305,662	$ —	$ —	$ 1,623,882
Service expense	1,227,426	265,417	—	(3,799)	1,489,044
General and administrative expense	11,779	25,438	—	35,119	72,336
Depreciation and amortization	13,275	12,851	—	343	26,469
Operating income (loss)	$ 65,740	$ 1,956	$ —	$ (31,663)	$ 36,033
Equity in net (gain) loss of investees	$ —	$ 1,391	$ (13,445)	$ —	$ (12,054)
Investment in equity method investee	$ —	$ 213	$ 169,699	$ —	$ 169,912
Total assets	$ 294,127	$ 184,805	$ 169,699	$ 55,459	$ 704,090
Long-lived asset expenditures	$ 15,319	$ 4,527	$ —	$ 77	$ 19,923

	Year Ended December 31, 2016				
	NET Services	WD Services	Matrix Investment	Corporate and Other	Total
Service revenue, net	$ 1,233,720	$ 344,403	$ —	$ 122	$ 1,578,245
Service expense	1,132,857	320,147	—	(894)	1,452,110
General and administrative expense	11,406	30,300	—	28,205	69,911
Asset impairment charge	—	19,588	—	1,415	21,003
Depreciation and amortization	12,375	13,824	—	405	26,604
Operating income (loss)	$ 77,082	$ (39,456)	$ —	$ (29,009)	$ 8,617
Equity in net (gain) loss of investees	$ —	$ 8,498	$ 1,789	$ —	$ 10,287
Investment in equity method investee	$ —	$ 4,161	$ 157,202	$ —	$ 161,363
Total assets	$ 313,371	$ 160,152	$ 157,202	$ 54,554	$ 685,279
Long-lived asset expenditures	$ 10,845	$ 19,810	$ —	$ 1,387	$ 32,042

	Year Ended December 31, 2015			
	NET Services	WD Services	Corporate and Other	Total
Service revenue, net	$ 1,083,015	$ 395,059	$ (64)	$ 1,478,010
Service expense	991,659	393,803	(4,308)	1,381,154
General and administrative expense	10,704	29,846	30,436	70,986
Depreciation and amortization	9,429	13,776	793	23,998
Operating income (loss)	$ 71,223	$ (42,366)	$ (26,985)	$ 1,872
Equity in net (gain) loss of investees	$ —	$ 10,970	$ —	$ 10,970
Long-lived asset expenditures	$ 12,232	$ 11,869	$ 668	$ 24,769

Geographic Information

The following table details the Company's revenue from continuing operations and long-lived assets by geographic location.

	For the year ended December 31, 2017			
	United States	United Kingdom	Other Foreign	Consolidated Total
Service revenue, net	$ 1,335,389	$ 187,655	$ 100,838	$ 1,623,882
Long-lived assets (a)	37,700	9,354	3,323	50,377

	For the year ended December 31, 2016			
	United States	United Kingdom	Other Foreign	Consolidated Total
Service revenue, net	$ 1,250,043	$ 235,061	$ 93,141	$ 1,578,245
Long-lived assets (a)	32,007	9,823	4,390	46,220

	For the year ended December 31, 2015			
	United States	United Kingdom	Other Foreign	Consolidated Total
Service revenue, net	$ 1,099,918	$ 298,386	$ 79,706	$ 1,478,010

(a) Represents property and equipment, net.

Domestic service revenue, net, totaled 82.2%, 79.2% and 74.4% of service revenue, net for the years ended December 31, 2017, 2016 and 2015, respectively. Foreign service revenue, net, totaled 17.8%, 20.8% and 25.6% of service revenue, net for the years ended December 31, 2017, 2016 and 2015, respectively.

At December 31, 2017, $99,071 of the Company's net assets from continuing operations were located in countries outside of the U.S. At December 31, 2016, $76,579 of the Company's net assets from continuing operations were located in countries outside of the U.S.

Customer Information

11.2%, 10.2% and 11.0% of the Company's consolidated revenue was derived from one U.S. state Medicaid program for the years ended December 31, 2017, 2016 and 2015, respectively. 10.7% of the Company's consolidated revenue was derived from one UK governmental agency for the year ended December 31, 2015. In addition, substantially all of the Company's revenues are generated from domestic and foreign governmental agencies or entities that contract with governmental agencies.

22. Quarterly Results (Unaudited)

The quarterly consolidated financial statements presented below reflect HA Services and Human Services as discontinued operations for all periods presented.

	Quarter ended			
	March 31, 2017 (1)	June 30, 2017	September 30, 2017 (2)	December 31, 2017 (3)(4)(5)
Service revenue, net	$ 399,494	$ 407,983	$ 409,517	$ 406,888
Operating Income	6,788	5,999	6,309	16,937
Income from continuing operations, net of tax	1,915	3,858	14,964	39,066
Discontinued operations, net of tax	(5,866)	(117)	(16)	16
Net income (loss) attributable to Providence	(4,325)	3,915	14,853	38,926
Earnings (loss) per common share (10):				
Basic	$ (0.40)	$ 0.18	$ 0.88	$ 2.43
Diluted	$ (0.40)	$ 0.18	$ 0.88	$ 2.41

	Quarter ended			
	March 31, 2016	June 30, 2016	September 30, 2016 (6)	December 31, 2016 (7)(8)(9)
Service revenue, net	$ 382,036	$ 398,119	$ 412,271	$ 385,819
Operating Income (loss)	8,304	6,712	9,793	(16,192)
Income (loss) from continuing operations, net of tax	1,376	1,624	3,743	(25,657)
Discontinued operations, net of tax	753	2,370	(2,791)	108,428
Net income attributable to Providence	2,235	4,623	650	84,420
Earnings (loss) per common share (10):				
Basic	$ 0.07	$ 0.21	$ (0.05)	$ 4.92
Diluted	$ 0.07	$ 0.21	$ (0.05)	$ 4.92

(1) The Company recorded expenses, net of tax, of $5,866 in Discontinued operations, net of tax, in the quarter ending March 31, 2017 related to the Company's former Human Services segment, which are principally related to an ongoing legal matter.

(2) The Company recorded a gain on sale of equity investment of $12,606, net of tax, related to the sale of its equity interest in Mission Providence during the quarter ended September 30, 2017. During the quarter ended December 31, 2017, the Company recorded a reduction to the gain on sale of $229, related to the finalization of the working capital adjustment per the sale agreement.

(3) Operating income for the quarter ended December 31, 2017 increased as compared to the prior quarters in 2017 as a result of a decrease in service expense as a percentage of revenue for NET Services and WD Services. This was primarily a result of lower operating costs of both segments as well as certain NET Services contractual adjustments recorded in the fourth quarter of 2017.

(4) The quarter ended December 31, 2017 includes the receipt of the Haverhill Litigation settlement of $5,363.

(5) The quarter ended December 31, 2017 includes a net tax benefit of $16,017 related to the enactment of the Tax Reform Act during the fourth quarter of 2017, due to the re-measurement of deferred tax liabilities by Providence as a result of the reduction in the U.S. corporate tax rate. Providence realized a tax benefit of $19,397, partially offset by $3,379 of increased tax expense resulting from additional equity in net gain of Matrix, due to Matrix' re-

measurement of its deferred tax liabilities. The equity in net gain from Matrix for the quarter ended December 31, 2017 includes a tax benefit of $13,610 related to Matrix's re-measurement of deferred tax liabilities as a result of the Tax Reform Act.

(6) The Company recorded expenses, net of tax, of $5,035 in Discontinued operations, net of tax, in the quarter ended September 30, 2016 related to the Company's former Human Services segment, which are principally related to an ongoing legal matter.

(7) Service revenue, net for the quarter ending December 31, 2016 decreased from the quarter ended September 30, 2016 primarily due to decreased revenue associated with the WD Services' National Citizen Service summer youth programs, which are seasonal in nature. Additionally, the quarter ended September 30, 2016 included revenue of $5,367 under the WD Services' offender rehabilitation program related to the finalization of a contractual adjustment for the contract years ended March 31, 2015 and 2016.

(8) The Company recorded an asset impairment charge of $1,415 related to the building and land utilized by the holding company, which was sold effective December 30, 2016. Also, the Company recorded asset impairment charges in its WD Services segment of $9,983, $4,381 and $5,224 to its property and equipment, intangible assets and goodwill, respectively.

(9) The quarter ended December 31, 2016 includes gain on loss of controlling interest in Matrix, net of tax, of $109,403.

(10) Earnings per share is computed independently for each of the quarters presented. Therefore, the sum of quarterly earnings per share may not equal the total computed for the year.

23. Subsequent Events

On February 16, 2018, Matrix acquired HealthFair, a leading provider of mobile health assessment and advanced diagnostic testing services for a purchase price of $160,000 plus an earnout payment contingent upon HealthFair's 2018 financial performance. Additionally, Matrix entered into a financing transaction consisting of a $330,000 first lien term loan and a $20,000 revolving line of credit, of which none was drawn, and issued an aggregate of approximately 24,200,000 shares of its common units related to a seller roll-over contribution. As a result of the rollover of certain equity interests in HealthFair, Providence's equity ownership is 43.6% as of February 16, 2018.

On November 2, 2017, the Company's Board approved the extension of the Company's existing stock repurchase program, authorizing the Company to engage in a repurchase program to repurchase up to $69,640 (the amount remaining from the $100,000 repurchase amount authorized in 2016) in aggregate value of our Common Stock through December 31, 2018. During the period January 1, 2018 to March 5, 2018, the Company repurchased 527,825 shares for $33,330, and $25,807 was available under the plan to repurchase shares.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

The Company, under the supervision and with the participation of its management (including its principal executive officer and principal financial officer), evaluated the effectiveness of the design and operation of the Company's disclosure controls and procedures, as defined in Rule 13a-15(e) of the Exchange Act as of the end of the period covered by this Annual Report on Form 10-K (December 31, 2017). Based upon this evaluation, the Company's principal executive and financial officers have concluded that such disclosure controls and procedures were effective to provide reasonable assurance that (i) information required to be disclosed by the Company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and (ii) information required to be disclosed by the Company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the Company's management, including its principal executive and financial officers, or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure.

Management's Report on Internal Control Over Financial Reporting

Management's report on internal control over financial reporting is presented in Part II, Item 8, of this Annual Report and is hereby incorporated by reference.

Report of Independent Registered Public Accounting Firm

The attestation report of the registered public accounting firm on the Company's internal control over financial reporting is presented in Part II, Item 8, of this Annual Report and is hereby incorporated by reference.

Changes in Internal Control Over Financial Reporting

The principal executive and financial officers also conducted an evaluation of whether any changes in the Company's internal control over financial reporting occurred during the quarter ended December 31, 2017 that have materially affected or which are reasonably likely to materially affect such control. Such officers have concluded that no such changes have occurred.

Item 9B. Other Information.

Effective March 12, 2018, Matthew Umscheid, our current Senior Vice President, Strategic Services, is being transferred to employment in such role at our LogistiCare business, pursuant to an offer letter dated March 6, 2018. In connection with this transfer, Mr. Umscheid is resigning as an officer of the Company. Under the terms of his offer letter with LogistiCare, Mr. Umscheid's annual base salary will remain at $350,000, his target annual bonus for 2018 will remain at 75% of his base salary, and there is no term of employment. In his new role, Mr. Umscheid will also be eligible to participate in other compensation and benefit programs made available to LogistiCare's senior executives, including a long-term incentive plan.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2018 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2018, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

Code of Ethics

We have adopted a code of ethics that applies to our senior management, including our chief executive officer, chief financial officer, controller and persons performing similar functions, as well as our directors, officers and employees. This code of ethics is part of our broader Compliance and Ethics Plan and Code of Conduct, which is available free of charge in the Investor Relations section of our website at www.prscholdings.com. We intend to disclose any amendment to, or waiver from, a provision of the code of ethics that applies to our principal executive officer, principal financial officer or principal accounting officer on our website. The information contained on our website is not part of, and is not incorporated in, this Annual Report on Form 10-K or any other report we file with or furnish to the SEC.

Item 11. Executive Compensation.

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2018 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2018, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2018 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2018, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2018 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2018, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

Item 14. Principal Accounting Fees and Services.

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2018 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2018, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a)(1) Financial Statements

The following consolidated financial statements including footnotes are included in Item 8.

- Consolidated Balance Sheets at December 31, 2017 and 2016;
- Consolidated Statements of Income for the years ended December 31, 2017, 2016 and 2015;
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2017, 2016 and 2015;
- Consolidated Statements of Stockholders' Equity for the years ended December 31, 2017, 2016 and 2015; and
- Consolidated Statements of Cash Flows for the years ended December 31, 2017, 2016 and 2015.

(2) Financial Statement Schedules

Schedule II Valuation and Qualifying Accounts

	Balance at beginning of period	Additions: Charged to costs and expenses	Additions: Charged to other accounts	Deductions	Balance at end of period
Year Ended December 31, 2017:					
Allowance for doubtful accounts	$ 5,901	$ 815	$ (466) (1)	$ 488 (2)	$ 5,762
Year Ended December 31, 2016:					
Allowance for doubtful accounts	$ 4,380	$ 3,298	$ 1,058 (1)	$ 2,835 (2)	$ 5,901
Year Ended December 31, 2015:					
Allowance for doubtful accounts	$ 3,198	$ 1,928	$ 1,152 (1)	$ 1,898 (2)	$ 4,380

Notes:

Schedule above has been recast from prior year to exclude activity related to discontinued operations.

(1) Amounts primarily include the allowance for contractual adjustments related to our non-emergency transportation services operating segment that are recorded as adjustments to non-emergency transportation services revenue. Amount additionally includes impact from change in foreign currency rates.

(2) Write-offs, net of recoveries.

All other schedules are omitted because they are not applicable or the required information is shown in our financial statements or the related notes thereto.

(3) Exhibits

Exhibit Number	Description
2.1	Share Sale Agreement, dated as of March 31, 2014, by and among The Providence Service Corporation, Pinnacle Australia Holdco Pty Ltd, Thérèse Virginia Rein, Gregory Kenneth Ashmead and GK Ashmead Holdings Pty Limited (as trustee of the GK Ashmead Nominees Trust) (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on April 1, 2014).
2.2	Australian Share Sale Agreement Side Deed, dated as of March 31, 2014, by and among The Providence Service Corporation, Pinnacle Australia Holdco Pty Ltd, Thérèse Virginia Rein, Gregory Kenneth Ashmead, GK Ashmead Holdings Pty Limited (as trustee of the GK Ashmead Nominees Trust) and Deloitte LLP (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on April 1, 2014).
2.3	Membership Interest Purchase Agreement, dated September 3, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp. and Molina Healthcare, Inc. (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on September 8, 2015).
2.4	Amendment to Membership Interest Purchase Agreement, dated October 30, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp. and Molina Pathways, LLC, as assignee of Molina Healthcare, Inc. (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on November 5, 2015).
2.5	Stock Subscription Agreement, dated as of August 28, 2016, by and among The Providence Service Corporation, CCHN Group Holdings, Inc. and Mercury Fortuna Buyer, LLC (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 31, 2016).
2.6	Amendment No. 1, dated as of October 19, 2016, to the Stock Subscription Agreement, dated August 28, 2016, by and among The Providence Service Corporation, CCHN Group Holdings, Inc. and Mercury Fortuna Buyer, LLC (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on October 25, 2016).
3.1	Second Amended and Restated Certificate of Incorporation of The Providence Service Corporation, including Certificate of Designation of Series A Junior Participating Preferred Stock, as filed with the Secretary of State of Delaware on December 9, 2011 (Incorporated by reference from an exhibit to the registrant's annual report on Form 10-K for the year ended December 31, 2011 filed with the SEC on March 15, 2012).
3.2	Certificate of Amendment of the Certificate of Incorporation of The Providence Service Corporation, dated as of May 6, 2015 (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on May 7, 2015).
3.3	Amended and Restated Bylaws of The Providence Service Corporation, effective March 10, 2010 (Incorporated by reference from an exhibit to the registrant's annual report on Form 10-K for the year ended December 31, 2009 filed with the SEC on March 12, 2010).
4.1	Certificate of Designations of Series A Convertible Preferred Stock of The Providence Service Corporation, dated as of February 6, 2015 (Incorporated by reference from an exhibit to Amendment No. 1 to the registrant's annual report on Form 10-K/A for the year ended December 31, 2014 filed with the SEC on April 30, 2015).
10.1	Amended and Restated Credit and Guaranty Agreement, dated as of August 2, 2013 (the "Credit Agreement"), by and among The Providence Service Corporation and certain of its subsidiaries party thereto, Bank of America, N.A., SunTrust Bank, BMO Harris Bank, Merrill Lynch, Pierce, Fenner & Smith Incorporated and

	SunTrust Robinson Humphrey, Inc. and the lenders party thereto (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 5, 2013).
10.2	Amended and Restated Pledge Agreement, dated as of August 2, 2013, by and among The Providence Service Corporation, certain of its subsidiaries party thereto, and Bank of America, N.A., as administrative agent (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 5, 2013).
10.3	Amended and Restated Security Agreement, dated as of August 2, 2013, by and among The Providence Service Corporation, certain of its subsidiaries party thereto, and Bank of America, N.A., as administrative agent (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 5, 2013).

10.4	First Amendment to Amended and Restated Credit and Guaranty Agreement and Consent, dated as of May 28, 2014, by and among The Providence Service Corporation, the Guarantors named therein, the New Subsidiaries named therein, the Lenders and New Lender named therein and Bank of America, N.A., as administrative agent (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on June 3, 2014).
10.5	Second Amendment to the Amended and Restated Credit and Guaranty Agreement and Consent, dated as of October 23, 2014, by and among The Providence Service Corporation, certain of its subsidiaries party thereto, Bank of America, N.A., SunTrust Bank, Royal Bank of Canada, BMO Harris Bank, N.A., HSBC Bank USA, National Association, the other Lenders party thereto, Merrill Lynch, Pierce, Fenner & Smith Incorporated, SunTrust Robinson Humphrey, Inc., and RBC Capital Markets (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on October 24, 2014).
10.6	Third Amendment and Consent to the Amended and Restated Credit and Guaranty Agreement, dated as of September 3, 2015, by and among The Providence Service Corporation, certain of its subsidiaries party thereto, Bank of America, N.A., Sun Trust Bank, Royal Bank of Canada, BMO Harris Bank, N.A., HSBC Bank USA, National Association, the other lenders party thereto, Merrill Lynch Pierce, Fenner & Smith Incorporated, Sun Trust Robinson Humphrey, Inc. and RBC Capital Markets (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on September 8, 2015).
10.7	Fourth Amendment and Consent to the Amended and Restated Credit and Guaranty Agreement, dated as of August 28, 2016, by and among The Providence Service Corporation, the guarantors party thereto, the lenders party thereto and Bank of America, N.A., as Administrative Agent (Incorporated by reference to an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 31, 2016).
10.8+	Employment Agreement, dated January 14, 2015, by and between The Providence Service Corporation and James Lindstrom (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on January 21, 2015).
10.9+	Employment Agreement, dated August 6, 2015, by and between The Providence Service Corporation and James Lindstrom (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 11, 2015).
10.10+	Separation Agreement and General Release, dated November 15, 2017, between The Providence Service Corporation and James Lindstrom (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on November 15, 2017).
10.11+	Employment Agreement, dated as of September 28, 2015, by and between The Providence Service Corporation and David Shackelton (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on November 20, 2015).
10.12+	Amended & Restated Employment Agreement, dated January 9, 2018, by and between The Providence Service Corporation and David Shackelton (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on January 16, 2018).
10.13+	Employment Agreement, dated April 4, 2016, between The Providence Service Corporation and Sophia Tawil (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended March 31, 2016 filed with the SEC on May 6, 2016).
10.14+	Amended & Restated Employment Agreement, dated January 9, 2018, by and between The Providence Service Corporation and Sophia Tawil (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on January 16, 2018).

10.15+	Employment Agreement, dated November 15, 2017, between The Providence Service Corporation and R. Carter Pate (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on November 15, 2017).
10.16+	Letter agreement, dated January 10, 2018, by and between The Providence Service Corporation and William Severance (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on January 16, 2018).
10.17+	The Providence Service Corporation 2006 Long-Term Incentive Plan, as amended and restated, effective June 30, 2015 (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended September 30, 2015 filed with the SEC on November 9, 2015).
10.18+	The Providence Service Corporation 2006 Long-Term Incentive Plan, as amended and restated effective July 27, 2016 (Incorporated by reference from an appendix to the registrant's definitive proxy statement on Schedule 14A filed with the SEC on June 14, 2016).
10.19+	Form of Restricted Stock Agreements (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended March 31, 2011 filed with the SEC on May 6, 2011).

10.20+	Form of Stock Option Agreements (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended March 31, 2011 filed with the SEC on May 6, 2011).
10.21+	Form of Special Incentive Stock Option Award Agreement (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 11, 2015).
10.22+	Form of Matching Incentive Stock Option Award Agreement (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 11, 2015).
10.23+	2015 Holding Company LTI Program (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 11, 2015).
10.24+	2015 Holding Company LTI Program, as amended and effective on November 4, 2016 (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended September 30, 2016 filed with the SEC on November 9, 2016).
10.25	Amended and Restated Limited Liability Company Agreement of Mercury Parent, LLC, by and between Prometheus Holdco, LLC and Mercury Fortuna Buyer, LLC, dated as of October 19, 2016 (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on October 25, 2016).
10.26*	Second Amended and Restated Limited Liability Company Agreement of Mercury Parent, LLC, by and between Prometheus Holdco, LLC and Mercury Fortuna Buyer, LLC, dated February 16, 2018.
10.27+	Form of Matching Stock Option Agreement (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended March 31, 2017 filed with the SEC on May 10, 2017).
10.28+*	Form of Stock Option Agreement.
10.29+*	Letter agreement, dated September 21, 2015, between The Providence Service Corporation and Matthew Umscheid.
12.1*	Statement re Computation of Ratios of Earnings to Fixed Charges.
21.1*	Subsidiaries of the Registrant.
23.1*	Consent of KPMG LLP.
23.2*	Consent of Deloitte & Touche LLP (Mercury Parent, LLC financial statements).
23.3*	Consent of KPMG LLP (Mercury Parent, LLC financial statements).
31.1*	Certification pursuant to Securities Exchange Act Rules 13a-14 and 15d-14 of the Chief Executive Officer.
31.2*	Certification pursuant to Securities Exchange Act Rules 13a-14 and 15d-14 of the Chief Financial Officer.
32.1*	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, of the Chief Executive Officer.
32.2*	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, of the Chief Financial Officer.

99.1*	Financial Statements of Mercury Parent, LLC.
101. INS*	XBRL Instance Document
101.SCH*	XBRL Schema Document
101.CAL*	XBRL Calculation Linkbase Document
101.LAB*	XBRL Label Linkbase Document
101.PRE*	XBRL Presentation Linkbase Document
101.DEF*	XBRL Definition Linkbase Document

+ Management contract or compensatory plan or arrangement.

* Filed herewith.

Item 16. Form 10-K Summary.

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

THE PROVIDENCE SERVICE CORPORATION

By: /s/ R. Carter Pate
R. Carter Pate
Interim Chief Executive Officer

Dated: March 9, 2018

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/S/ R. CARTER PATE R. Carter Pate	Interim Chief Executive Officer (Principal Executive Officer)	March 9, 2018
/S/ DAVID C. SHACKELTON David C. Shackelton	Chief Financial Officer (Principal Financial Officer)	March 9, 2018
/S/ WILLIAM SEVERANCE William Severance	Chief Accounting Officer (Principal Accounting Officer)	March 9, 2018
/S/ CHRISTOPHER S. SHACKELTON Christopher S. Shackelton	Chairman of the Board	March 9, 2018
/S/ TODD J. CARTER Todd J. Carter	Director	March 9, 2018
/S/ DAVID A. COULTER David A. Coulter	Director	March 9, 2018
/S/ RICHARD A. KERLEY Richard A. Kerley	Director	March 9, 2018
/S/ KRISTI L. MEINTS Kristi L. Meints	Director	March 9, 2018
/S/ LESLIE V. NORWALK Leslie V. Norwalk	Director	March 9, 2018
/S/ FRANK J. WRIGHT Frank J. Wright	Director	March 9, 2018

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2018

OR

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

For the transition period from to
Commission file number 001-34221

The Providence Service Corporation
(Exact name of registrant as specified in its charter)

Delaware	**86-0845127**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
700 Canal Street, Third Floor, Stamford, CT	**06902**
(Address of principal executive offices)	**(Zip code)**

Registrant's telephone number, including area code: (203) 307-2800

Securities registered pursuant to Section 12(b) of the Act:

Title of each Class	**Name of each exchange on which registered**
Common Stock, $0.001 par value per share	**The NASDAQ Global Select Market**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☒ No

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☒ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 7(a)(2)(B) of the Securities Act. ☐

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

The aggregate market value of the voting and non-voting common equity of the registrant held by non-affiliates based on the closing price for such common equity as reported on The NASDAQ Global Select Market on the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2018) was $904.9 million.

As of February 22, 2019, there were outstanding 12,833,846 shares (excluding treasury shares of 4,973,552) of the registrant's Common Stock, $0.001 par value per share.

DOCUMENTS INCORPORATED BY REFERENCE

All or a portion of Items 10 through 14 in Part III of this Annual Report on Form 10-K are incorporated by reference to our definitive proxy statement on Schedule 14A for our 2019 stockholder meeting; provided that if such proxy statement is not filed on or before April 30, 2019, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

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PART IV

Part I

In this Annual Report on Form 10-K, the words the "Company", the "registrant", "we", "our", "us", "Providence" and similar terms refer to The Providence Service Corporation and, except as otherwise specified herein, to our subsidiaries. When such terms are used in reference to the Company's common stock, $0.001 par value per share (the "Common Stock"), and the Series A Convertible Preferred Stock, $0.001 par value per share (the "Preferred Stock"), they refer specifically to The Providence Service Corporation.

DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains certain statements that may be deemed "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), including statements related to the Company's strategies or expectations about revenues, liabilities, results of operations, cash flows, ability to fund operations, profitability, ability to meet financial covenants, contracts or market opportunities. The Company may also make forward-looking statements in other reports filed with the Securities and Exchange Commission (the "SEC"), in materials delivered to stockholders and in press releases. In addition, the Company's representatives may from time to time make oral forward-looking statements. In certain cases, you may identify forward looking-statements by words such as "may", "will", "should", "could", "expect", "plan", "project", "intend", "anticipate", "believe", "seek", "estimate", "predict", "potential", "target", "forecast", "likely", the negative of such terms or comparable terminology. In addition, statements that are not historical statements of fact should also be considered forward-looking statements. These forward-looking statements are based on the Company's current expectations, assumptions, estimates and projections about its business and industry, and involve risks, uncertainties and other factors that may cause actual events to be materially different from those expressed or implied by such forward-looking statements. These risks and uncertainties include, but are not limited to, the risks described under Item 1A in Part I of this Annual Report on Form 10-K.

You are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date the statement was made. The Company is under no obligation to (and expressly disclaims any such obligation to) update any of the information in any forward-looking statement if such forward-looking statement later turns out to be inaccurate, whether as a result of new information, future events or otherwise.

Item 1. *Business.*

Overview

The Providence Service Corporation ("we", the "Company" or "Providence") owns subsidiaries and investments primarily engaged in the provision of healthcare services in the United States. The Company's NET Services segment, which primarily operates under the brands LogistiCare and Circulation, is the largest manager of non-emergency medical transportation ("NET") programs for state governments and managed care organizations ("MCOs") in the United States. On September 21, 2018, we completed the acquisition of Circulation, Inc. ("Circulation"), which offers a full suite of logistics solutions to manage NET programs across all areas of healthcare, powered by its HIPAA-compliant digital platform. Circulation's technology expands LogistiCare's capabilities to manage transportation benefits, integrating all transportation capabilities and emphasizing member convenience and satisfaction.

The Company's Matrix Investment segment consists of a minority investment in CCHN Group Holdings, Inc. and its subsidiaries ("Matrix"), a nationwide provider of home and mobile-based healthcare services for health plans in the United States, including comprehensive health assessments ("CHAs"), quality gap closure visits, "level of service" needs assessments, and post-acute and chronic care management, providing such services through a network of community-based clinicians, and a fleet of mobile health clinics with advanced diagnostics capabilities. On October 19, 2016, affiliates of Frazier Healthcare Partners purchased a controlling equity interest in Matrix, with the Company retaining a non-controlling equity interest (the "Matrix Transaction"). Matrix's financial results prior to October 19, 2016 are presented as a discontinued operation.

The Company's Corporate and Other segment includes the Company's executive, accounting, finance, internal audit, tax, legal, public reporting, and corporate development functions, as well as the results of the Company's captive insurance company. On April 11, 2018, the Company announced an organizational consolidation plan to integrate substantially all activities and functions performed at the corporate holding company level into LogistiCare (the "Organizational Consolidation"). LogistiCare will retain its name and continue to be headquartered in Atlanta, GA, and the Company will continue to be named The Providence Service Corporation and be listed on The NASDAQ Global Select Market ("NASDAQ") under the ticker symbol "PRSC". The Organizational Consolidation process involves transferring all job responsibilities previously performed by employees of the

holding company to LogistiCare and closing the current corporate offices in Stamford, Connecticut and Tucson, Arizona. The Organizational Consolidation is expected to be complete by the end of the second quarter of 2019.

On December 21, 2018, we completed the sale of substantially all of the operating subsidiaries of our Workforce Development Services ("WD Services") segment to Advanced Personnel Management Global Pty Ltd of Australia ("APM") and APM UK Holdings Limited, an affiliate of APM, except for the segment's employment services operations in Saudi Arabia (the "WD Services Sale"). Our contractual counterparties in Saudi Arabia, including an entity owned by the Saudi Arabian government, assumed these operations beginning January 1, 2019.

On June 11, 2018, the Company entered into a Share Purchase Agreement to sell Ingeus France, which was part of our WD Services segment, for a de minimis amount. The sale was effective on July 17, 2018, after court approval. The financial results of WD Services prior to December 21, 2018 are presented as discontinued operations.

The Company is a Delaware corporation formed in 1996 and headquartered in Stamford, Connecticut.

Business Strategies

The Company's mission is to provide effective and quality NET services and logistics and to create shareholder value by pursuing and implementing six key strategies.

Centers of Excellence Operations Alignment

In January 2019, we reorganized the operational structure of our NET Services segment in order to centralize and reduce the layers in core functions that form the most significant elements of our cost base and drive performance for our clients and the members and patients they serve. Our operational structure now includes six Centers of Excellence ("COEs"): Transportation Network, Call Center Operations, Client Services, Technology, Growth and Process Improvement. We implemented this operational strategy to enhance the visibility, flexibility and control we have over our operations. The Transportation Network COE is focused on increases to capacity and improvements to quality and improvements designed to reduce cost and enhance the member experience. Within our Call Center Operations, activities such as contact center workflow standardization, cross skilling, and intensive operations management are aimed at improving employee productivity. We believe the new model for Client Services will bring a closer focus on local operations as well as holistic approaches to our customers and client retention. Our Technology COE will be coordinated and focused on the support of operations and the systematic roll out of the Circulation technology platform. Growth will continue to focus our sales, marketing and business development teams on the generation and delivery of new business. Finally, our Process Improvement COE will continue to support all of our other COE's in the pursuit of effective and efficient operations. We believe this new structure makes our scale more nimble and provides us with a competitive advantage.

Technology Transformation

On September 21, 2018, we completed the acquisition of Circulation to revolutionize our technology development capability, add to our executive team, extend our business model, and open new market opportunities. We believe that this technology allows us to reduce transportation as a barrier to care and that through the deployment of our new technology we are able to extend the size of the market that we can serve. In order to achieve our target synergies and enhance our operations, we plan to roll out Circulation's technology as our core workflow platform over the next 36 months. We have 21 operations centers that we expect to convert to the Circulation platform. Our plan is to convert several call centers in 2019, beginning in the second quarter, with a target to convert all sites by the end of 2021. Technology roll outs include a substantial amount of change management and will require careful risk mitigation policies to ensure smooth transitions. Our change management process is a core strength deeply embedded in our organization and will support a major change in the way we operate today, driving significant efficiencies and enhancing the member experience benefits to our clients.

Client and Member Satisfaction

Transportation related to care is one of the most impactful experiences contributing to our clients' members' and patients' satisfaction during their care encounter. At the core of our operational and technology strategies is a focus on driving client and member satisfaction. Our COEs' operational structure allows us to develop locally tailored network solutions with a higher level of visibility. Greater access to real time information, enabled through our technology, provides us the ability to shorten cycle times to identify and resolve client and member issues. We expect our clients to begin to realize benefits in the near term from our new organizational model and roll out of the Circulation technology platform.

Organic Growth

Across the healthcare market, we see an increasing understanding of the benefit of removing transportation as a barrier to care and a way to improve other determinants of health, such as access to food, shelter, socialization, and pharmacy. We believe that our scale, deep experience, operational strategy, and technology migration uniquely position us to address customer needs related to transportation of vulnerable populations. We approach sales, marketing and business development in a manner that is focused on driving market share in our core Medicaid market including states and MCOs, Medicare Advantage ("MA") plans, health systems and providers. Simultaneously, we target business development efforts with partners to enter new transportation markets, including the movement of home health providers, pharmacy delivery and beneficiaries of workers compensation. We expect there will be network effects as we serve more and more healthcare constituencies within a geography.

Inorganic Growth

We closely follow our core NET market and expansion markets mentioned above for tuck-in acquisition opportunities. We believe our experience, relationships in the industry, scale and executive team gives us the strongest position to be a consolidation platform in healthcare transportation. Our acquisition strategy may include an evaluation of new entrants, which may not be able to otherwise compete without the benefits of scale and experience, and closely-held businesses that may seek a new capital structure or sale to achieve liquidity for founders. With our balance sheet, strong team and track record, we believe we are a natural consolidator.

Smart Capital Allocation

The WD Services sale was a significant milestone in our strategy to focus our capital allocation priorities on the opportunities available to our NET Services segment. The NET Services segment has historically generated positive cash flows and our strong balance sheet provides us with optionality with respect to capital allocation and how we can best drive shareholder value. Our immediate focus in 2019 is to invest in our operations, including the roll-out of the Circulation technology to enhance client and member experience and drive operational efficiency. We will also continue to assess the opportunities for capital deployment in order to create value for shareholders, which may include dividends, share repurchases and/or acquisitions.

NET Services

Services offered. NET Services provides non-emergency transportation solutions to clients, including health systems, in 40 states and the District of Columbia. As of December 31, 2018, approximately 24.5 million individuals were eligible to receive our transportation services, and during 2018, NET Services managed approximately 52.6 million trips. NET Services accounts for all of our consolidated revenue from continuing operations going forward.

NET Services primarily contracts with state Medicaid programs and MCOs, including MA plans, (collectively "NET customers") for the coordination of their members' ("NET end-users") non-emergency transportation needs. NET end-users are typically Medicaid or Medicare eligible members, whose limited mobility or financial resources hinders their ability to access necessary healthcare and social services. We believe our transportation services enable access to care that not only improves the quality of life and health of the populations we serve, but also enables many of the individuals we serve to pursue independent living in their homes rather than in more expensive institutional care settings. In addition, studies have shown that missed medical appointments lessens patient compliance with clinical guidelines and leads to complications and expensive medical services. Through provider access to medical transportation, NET Services can save state Medicaid programs and MCOs significant amounts of money when used as part of a care management strategy for individuals with chronic illness. We believe we are uniquely positioned to partner with NET customers to provide these savings while improving the lives of the populations we serve.

NET Services program delivery is dependent upon a highly-integrated technology platform and business process as well as the management of a multifaceted network of subcontracted transportation providers. Our technology platform is purpose-built for the unique needs of our industry and is highly scalable, capable of supporting substantial growth in our clients' current and future membership base. In addition, our technology platform efficiently provides a broad interconnectivity among NET end-users, NET customers, and our network of transportation providers. We believe this technological capability and our industry experience uniquely position us as a future focal point in the evolving healthcare industry to introduce valuable population insights. In 2016 and 2017, we introduced service offerings and new technological features for NET end-users to improve service levels, lower costs and build the foundation for additional data analytics capabilities. In 2018, we acquired Circulation to provide additional technological improvements through their digital transportation platform. Circulation's technology allows for on-demand ride scheduling, eligibility assessment, benefits management, ride assignment and dispatch, real time ride tracking, network management and analytics.

To fulfill the transportation needs of NET end-users, we apply our proprietary technology platform to an extensive network of approximately 4,500 transportation resources. This includes our in-network roster of fully contracted transportation providers who operate sedans, wheelchair equipped vehicles, multi-passenger vans and ambulances. Our system also utilizes partnerships with on-demand transportation network companies, mass transit entities, mileage reimbursement programs, taxis and county-based emergency medical service providers. To promote safety, quality, and compliance, our in-network transportation providers undergo an in-depth credentialing and education process.

Our transportation management services also include fraud, waste, and abuse prevention and utilization review programs designed to monitor that our transportation services are provided in compliance with Medicaid and Medicare program rules and remediate issues that are identified. Compliance controls include ongoing monitoring, auditing and remediation efforts, such as validating NET end-user eligibility for the requested date of service and employing a series of gatekeeping questions to verify that the treatment type is covered and the appropriate mode of transportation is assigned. We also conduct post-trip confirmations of attendance directly with the healthcare providers for certain repetitive trips and we employ field monitors to inspect transportation provider vehicles and observe some transports in real time. Our claims validation process generally limits payment to trips that are properly documented, have been authorized in advance, and are billed at the pre-trip estimated amount. Our claims process is increasingly digital, which provides more protection to member protected health information and reduces the impact on the environment. Transportation providers are able to submit their bills and supporting documentation through a secured web portal directly to LogistiCare.

Revenue and customers. In 2018, contracts with state Medicaid agencies and MCOs represented 52.9% and 47.1%, respectively, of NET Services' revenue. NET Services derived 12.6%, 13.8% and 13.1% of its revenue from a single state Medicaid agency for the years ended December 31, 2018, 2017 and 2016, respectively. The next four largest NET Services customers in the aggregate comprised 21.4%, 22.3% and 22.6% of NET Services' revenue for the years ended December 31, 2018, 2017 and 2016, respectively.

Contracts with state Medicaid agencies are typically for three to five years with multiple renewal options. Contracts with MCOs continue until terminated by either party upon reasonable notice (as determined in accordance with the contract), and allow for regular price adjustments based upon utilization and transportation cost. As of December 31, 2018, 13.2% of NET Services revenue was generated under state Medicaid contracts that are subject to renewal within the next 12 months. In 2018, NET Services renewed contracts representing 32.4% of its revenue in such year.

79.2% of NET Services' revenue in 2018 was generated under capitated contracts where we assume the responsibility of meeting the covered healthcare related transportation requirements of a specific population based on per-member per-month fees for the number of members in the customer's program. Revenue is recognized based on the population served during the period. Under certain capitated contracts, known as reconciliation contracts, partial payment is received as a prepayment during the month service is provided. These partial payments may be due back to the customer, or additional payments may be due to the Company, after each reconciliation period, based on a reconciliation of actual utilization and cost compared to the prepayment made. 20.8% of NET Services' revenue was generated under other types of fee arrangements, including administrative services only, fee for service and cost plus (collectively "FFS") and flat fee contracts, under which fees are generated based upon billing rates for specific services or defined membership populations.

Seasonality. While revenue is generally fixed, primarily as a result of the capitated nature of the majority of our contracts, service expense varies based on the utilization of our services. The quarterly operating income and cash flows of NET Services normally fluctuate as a result of seasonal variations in the business, principally due to lower transportation demand during the winter season and higher demand during the summer season.

Competition. We compete with a variety of national organizations that provide similar healthcare and social services related transportation, such as Medical Transportation Management, Southeastrans, Veyo, and Access2Care, as well as local and regional providers. Most local competitors seek to win contracts for specific counties or small geographic territories whereas we and other larger competitors seek to win contracts for an entire state or large regional area. We compete based upon a number of factors, including our nationwide network, technical expertise, experience, service capability, service quality, and price.

Matrix Investment

Our Matrix Investment is comprised of our interest in Matrix. Since the completion of the Matrix Transaction, the Company has had a non-controlling equity interest in Matrix. The Company and an affiliate of Frazier Healthcare Partners (the "Frazier Subscriber"), which holds the controlling equity interest in Matrix, are party to the Second Amended and Restated Limited Liability Company Agreement (the "Operating Agreement") of Mercury Parent, LLC, the company through which the parties hold their equity interests in Matrix. The Operating Agreement sets forth certain terms and conditions regarding the ownership by the Company

and Frazier Subscriber of interests in Mercury Parent and their indirect ownership of common stock of Matrix, and provides for, among other things, certain liquidity and governance rights and other obligations and rights, in each case, on the terms and conditions contained therein.

At December 31, 2018, the Company owned a 43.6% non-controlling interest in Matrix. Prior to the closing of the Matrix Transaction, the financial results of Matrix were included in our Health Assessment Services ("HA Services") segment. The Company's proportionate share of Matrix's net assets and financial results for the period following the closing of the Matrix Transaction are presented using the equity method. The assets, liabilities and financial results of Matrix for the period prior to the closing of the Matrix Transaction are presented within discontinued operations. For additional information regarding the Matrix Transaction, see Note 23, *Discontinued Operations,* to our consolidated financial statements.

Services offered. Matrix offers in-home care optimization services for members, including CHAs, through a national network of community-based clinicians and a fleet of mobile health clinics with advanced diagnostics capabilities. As of December 31, 2018, Matrix utilized a national network of approximately 3,500 clinical providers, including 1,800 nurse practitioners ("NPs"), located across 48 states, to provide its services primarily to members of Medicare Advantage ("MA") health plans.

Matrix expanded its provider network and service offerings through two acquisitions in 2017 and 2018. In December 2017, Matrix grew its clinical provider network through its acquisition of LP Health Services, a provider of quality and wellness visits on behalf of Medicaid/Duals managed care plans across the U.S., for a purchase price of $3.6 million. In February 2018, Matrix completed its acquisition of HealthFair, a leading operator of mobile clinics which offer preventative health assessment and advanced diagnostic testing services, including laboratory, ultrasound, EKG and mammography testing, for a purchase price of $155 million. Although to date the results of HealthFair have been below our expectations, we still believe the combination of the two organizations provides health plan members with more convenient access to important care management and preventative health services.

Matrix primarily generates revenue from CHAs, which obtain a health plan member's information related to health status, social, environmental and medical risks and help the MA plans improve the accuracy of such information. Matrix also operates a care management offering which provides additional data analytics and chronic care management services.

Matrix's services are dependent upon its technology platform which integrates the clinical provider network, operations infrastructure, call centers and clients. Matrix's platform is designed for the unique needs of its industry, is highly scalable and can support substantial growth. We believe Matrix's network and platform position Matrix as a future focal point in the evolving healthcare industry in the introduction of both additional population insights and care management services. With data provided by its health plan clients, Matrix utilizes analytics to determine which members it can most effectively lower costs and improve outcomes through face-to-face engagements with clinicians. Each program is customized and is served by a comprehensive team of case managers, nurse practitioners, registered nurses, and trained call center colleagues.

Revenue, customers and clients. As of December 31, 2018, Matrix's customers included 65 health plans, including for-profit multi-state health plans and non-profit health plans that operate in only one state or several counties within one state. For the year ended December 31, 2018, Matrix's top five customers accounted for 66.3% of its revenue, as its largest customer accounted for 31.5% of its revenue and its second largest customer accounted for 21.2% of its revenue. Matrix enters into annual or multi-annual contracts with its customers under which it is paid on a per assessment basis. However, volumes are not guaranteed under contracts and customers may choose to utilize other third party providers or in-source capabilities. A significant customer has indicated it intends to in-source certain services, which may result in a decrease in volume for Matrix.

Seasonality. Matrix attempts to perform CHAs evenly throughout the year to efficiently utilize NP capacity, although the timing of performance is driven by client demand.

Competition. We believe that Matrix and Signify Health are the largest independent providers of CHAs to the health plan market. There are many smaller competitors, such as EMSI Healthcare Services, MedXM, which was acquired by Quest Diagnostics on February 1, 2018, and Inovalon. In addition, some health plans in-source CHA services. Matrix's chronic care management competitors include Landmark Healthcare, PopHealthCare and Optum.

Employees

As of December 31, 2018, we had approximately 4,000 employees. None of our employees are members of a union. We believe we have good relationships with our employees.

Regulatory Environment

Overview

Our NET Services and Matrix Investment segments (the "Healthcare Segments") are subject to numerous U.S. federal, state and local laws, regulations and agency guidance (collectively, "Laws"). These Laws significantly affect the way in which these segments operate various aspects of their businesses. Our Healthcare Segments must also comply with state and local licensing requirements, state and federal requirements for participation in Medicare and Medicaid, requirements for contracting with MA plans, and contractual requirements imposed upon them by the federal, state and local agencies and third-party commercial customers to which they provide services. Failure to follow the rules and requirements of these programs can significantly affect our Healthcare Segments' ability to be paid for the services they provide and be authorized to provide services on an ongoing basis.

The Medicare and Medicaid programs are governed by significant and complex Laws. Both Medicare and Medicaid are financed, at least in part, with federal funds. Therefore, any direct or indirect recipients of those funds are subject to federal fraud, waste and abuse Laws. In addition, there are federal privacy and security Laws that govern the healthcare industry. State Laws primarily pertain to the licensure of certain categories of healthcare professionals and providers and the state's interest in regulating the quality of healthcare in the state, regardless of the source of payment, but may also include state Laws pertaining to fraud, waste and abuse, privacy and security Laws, and the state's regulation of its Medicaid program. Federal and state regulatory laws that may affect our Healthcare Segments' businesses, include, but are not limited to the following:

- false and other improper claims or false statements Laws pertaining to reimbursement;
- the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its privacy, security, breach notification and enforcement and code set regulations and guidance, along with evolving state Laws protecting patient privacy and requiring notifications of unauthorized access to, or use of, patient medical information;
- civil monetary penalties Law;
- anti-kickback Laws;
- the Stark Law and other self-referral, financial inducement, fee splitting, and patient brokering Laws;
- The Centers for Medicare and Medicaid Services ("CMS") regulations pertaining to Medicare as well as CMS releases applicable to the operation of MA plans, such as reimbursement rates, risk adjustment and data collection methodologies, adjustments to quality management measurements and other relevant factors; and
- state licensure laws.

A violation of certain of these Laws could result in civil and criminal damages and penalties, the refund of monies paid by government or private payors, our Healthcare Segments' exclusion from participation in federal healthcare payor programs, or the loss of our segments' license to conduct business within a particular state's boundaries.

Federal Law

Federal healthcare Laws apply in any case in which our Healthcare Segments are providing an item or service that is reimbursable or provide information to such segments' customers that results in reimbursement by a federal healthcare payor program to such segments or to them. The principal federal Laws that affect our Healthcare Segments' businesses include those that prohibit the filing of false or improper claims or other data with federal healthcare payor programs and those that prohibit unlawful inducements for the referral of business reimbursable under federal healthcare payor programs.

False and Other Improper Claims

Under the federal False Claims Act (31 U.S.C. §§ 3729-3733) and similar state Laws, the government may impose civil liability on our Healthcare Segments if they knowingly submit a false claim to the government or cause another to submit a false claim to the government, or knowingly make a false record or statement intended to get a false claim paid by the government. The False Claims Act defines a claim as a demand for money or property made directly to the government or to a contractor, grantee, or other recipient if the money is to be spent on the government's behalf or if the government will reimburse the contractor or grantee. Liability can be incurred for submitting (or causing another to submit) false claims with actual knowledge or for submitting false claims with reckless disregard or deliberate ignorance. Liability can also be incurred for knowingly making or using a false record or statement to receive payment from the federal government or for knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government. Consequently, a provider need not take an affirmative action to conceal or avoid an obligation to the government, but the mere retention of an overpayment from the government could lead to potential liability under the False Claims Act.

Many states also have similar false claims statutes. In addition, healthcare fraud is a priority of the U.S. Department of Justice ("DOJ"), the Department of Health and Human Services ("DHHS"), its program integrity contractors and its Office of Inspector General, the Federal Bureau of Investigation and state Attorneys General. These agencies have devoted a significant amount of resources to investigating healthcare fraud.

If our Healthcare Segments are ever found to have violated the False Claims Act, they could be required to make significant payments to the government (including damages and penalties in addition to the return of reimbursements previously collected) and could be excluded from participating in federal healthcare programs or providing services to entities which contract with those programs. Although our Healthcare Segments monitor their billing practices for compliance with applicable laws, such laws are very complex, and they might not be able to detect all errors or interpret such laws in a manner consistent with a court or an agency's interpretation. While the criminal statutes generally are reserved for instances evidencing fraudulent intent, the civil and administrative penalty statutes are being applied by the federal government in an increasingly broad range of circumstances. Examples of the types of activities giving rise to liability for filing false claims include billing for services not rendered, misrepresenting services rendered (i.e., miscoding), applications for duplicate reimbursement and providing false information that results in reimbursement or impacts reimbursement amounts. Additionally, the federal government takes the position that a pattern of claiming reimbursement for unnecessary services violates these statutes if the claimant should have known that the services were unnecessary. The federal government also takes the position that claiming reimbursement for services that are substandard is a violation of these statutes if the claimant should have known that the care was substandard. Criminal penalties also are available even in the case of claims filed with private insurers if the federal government shows that the claims constitute mail fraud or wire fraud or violate any of the federal criminal healthcare fraud statutes.

State Medicaid agencies and state Attorneys General also have authority to seek criminal or civil sanctions for fraud and abuse violations. In addition, private insurers may bring actions under state false claim laws. In certain circumstances, federal and state laws authorize private whistleblowers to bring false claim or "qui tam" suits on behalf of the government against providers and reward the whistleblower with a portion of any final recovery. In addition, the federal government has engaged a number of private audit organizations to assist it in tracking and recovering claims for healthcare services that may have been improperly submitted.

Governmental investigations and whistleblower "qui tam" suits against healthcare companies have increased significantly in recent years, and have resulted in substantial penalties and fines and exclusions of persons and entities from participating in government healthcare programs. For more information on the risks related to a failure to comply with applicable government coding and billing rules, see "Risk Factors—Regulatory Risks—Our Healthcare Segments could be subject to actions for false claims or recoupment of funds pursuant to certain audits if they do not comply with government coding and billing rules, which could have a material adverse impact on our segments' operating results."

Health Information Practices

Under HIPAA, DHHS issued rules to define and implement standards for the electronic transactions and code sets for the submission of transactions such as claims, and privacy and security of individually identifiable health information in whatever manner it is maintained.

The Final Rule on Enforcement of the HIPAA Administrative Simplification provisions, including the transaction standards, the security standards and the privacy rule, published by DHHS addresses, among other issues, DHHS's policies for determining violations and calculating civil monetary penalties, how DHHS will address the statutory limitations on the imposition of civil monetary penalties, and various procedural issues. The rule extends enforcement provisions currently applicable to the healthcare privacy regulations to other HIPAA standards, including security, transactions and the appropriate use of service code sets.

The Health Information Technology for Economic and Clinical Health Act ("HITECH"), enacted as part of the American Recovery and Reinvestment Act of 2009, extends certain of HIPAA's obligations to parties providing services to healthcare entities covered by HIPAA known as "business associates," imposes new notice of privacy breach reporting obligations, extends enforcement powers to state Attorneys General and amends the HIPAA privacy and security laws to strengthen the civil and criminal enforcement of HIPAA. HITECH establishes four categories of violations that reflect increasing levels of culpability, four corresponding tiers of penalty amounts that significantly increase the minimum penalty amount for each violation, and a maximum penalty amount of $1.5 million for all violations of an identical provision. With the additional HIPAA enforcement power under HITECH, the Office for Civil Rights of the DHHS and states are increasing their investigations and enforcement of HIPAA compliance. Our Healthcare Segments have taken steps to ensure compliance with HIPAA and we are monitoring compliance on an ongoing basis.

Additionally, the HITECH Final Rule imposes various requirements on covered entities and business associates, and expands the definition of "business associates" to cover contractors of business associates. Even when our Healthcare Segments are not operating as covered entities, they may be deemed to be "business associates" for HIPAA rule purposes of such covered entities. Our Healthcare Segments monitor their compliance obligations under HIPAA as modified by HITECH, and implement operational and systems changes, associate training and education, conduct risk assessments and allocate resources as needed. Any noncompliance with HIPAA requirements could expose such segments to the criminal and increased civil penalties provided under HITECH and require them to incur significant costs in order to seek to comply with its requirements or to remediate potential issues that may arise.

Federal and State Anti-Kickback Laws

Federal law commonly known as the "Anti-Kickback Statute" prohibits the knowing and willful offer, solicitation, payment or receipt of anything of value (direct or indirect, overt or covert, in cash or in kind) which is intended to induce: the referral of an individual for a service for which payment may be made by Medicare, Medicaid or certain other federal healthcare programs; or the ordering, purchasing, leasing, or arranging for, or recommending the purchase, lease or order of, any service or item for which payment may be made by Medicare, Medicaid or certain other federal healthcare programs.

Interpretations of the Anti-Kickback Statute have been very broad and under current Law, courts and federal regulatory authorities have stated that the Anti-Kickback Statute is violated if even one purpose (as opposed to the sole or primary purpose) of the arrangement is to induce referrals. Even bona fide investment interests in a healthcare provider may be questioned under the Anti-Kickback Statute if the government concludes that the opportunity to invest was offered as an inducement for referrals.

This act is subject to numerous statutory and regulatory "safe harbors." Compliance with the requirements of a safe harbor offers defenses against Anti-Kickback Statute allegations. Failure of an arrangement to satisfy all of the requirements of a particular safe harbor does not mean that the arrangement is unlawful. However, it may mean that such an arrangement will be subject to scrutiny by the regulatory authorities.

Many states, including some where our Healthcare Segments do business, have adopted anti-kickback laws that are similar to the federal Anti-Kickback Statute. Some of these state laws are very closely patterned on the federal Anti-Kickback Statute; others, however, are broader and reach reimbursement by private payors. If our Healthcare Segments' activities were deemed to be inconsistent with state anti-kickback or illegal remuneration laws, they could face civil and criminal penalties or be barred from such activities, any of which could harm such segments' businesses.

If our Healthcare Segments' arrangements are found to violate the Anti-Kickback Statute or applicable state laws, these segments, along with their clients would be subject to civil and criminal penalties, and these segments' arrangements would not be legally enforceable, which could materially and adversely affect their business. For more information on the risks related to failure to comply with applicable anti-bribery and anti-corruption regulations, see "Risk Factors—Regulatory Risks—Our segments' business could be subject to civil penalties and loss of business if we fail to comply with applicable bribery, corruption and other regulations governing business with governments."

Federal and State Self-Referral Prohibitions

Our Healthcare Segments may be subject to federal and state statutes banning payments for referrals of patients and referrals by physicians to healthcare providers with whom the physicians have a financial relationship. Section 1877 of the Social Security Act, also known as the "Stark Law", prohibits physicians from making a "referral" for "designated health services" for Medicare (and in many cases Medicaid) patients from entities or facilities in which such physicians directly or indirectly hold a "financial relationship".

A financial relationship can take the form of a direct or indirect ownership, investment or compensation arrangement. A referral includes the request by a physician for, or ordering of, or the certifying or recertifying the need for, any designated health services.

Certain services that our Healthcare Segments provide may be identified as "designated health services" for purposes of the Stark Law. Such segments cannot provide assurance that future regulatory changes will not result in other services they provide becoming subject to the Stark Law's ownership, investment or compensation prohibitions in the future.

Many states, including some states where our Healthcare Segments do business, have adopted similar or broader prohibitions against payments that are intended to induce referrals of clients. Moreover, many states where such segments operate

have laws similar to the Stark Law prohibiting physician self-referrals. While our Healthcare Segments believe that they are operating in compliance with the Stark Law, there can be no guarantee that violations will not occur.

Healthcare Reform

On March 23, 2010, the President of the United States signed into law comprehensive health reform through the Patient Protection and Affordable Care Act (Pub. L. 11-148) ("PPACA"). On March 30, 2010, the President signed a reconciliation budget bill that included amendments to the PPACA (Pub. L. 11-152). These laws in combination form the "ACA" referred to herein. The changes to various aspects of the healthcare system in the ACA were far-reaching and included, among many others, substantial adjustments to Medicare reimbursement, establishment of individual mandates for healthcare coverage, extension of coverage to certain populations, expansion of Medicaid, restrictions on physician-owned hospitals, and increased efficiency and oversight provisions.

Some of the provisions of the ACA took effect immediately, while others will take effect later or will be phased in over time, ranging from a few months following approval to ten years. Due to the complexity of the ACA, it is likely that additional legislation will be considered and enacted. The ACA requires the promulgation of regulations that will likely have significant effects on the healthcare industry and third-party payors. Thus, the healthcare industry and our operations may be subjected to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges.

The ACA also implemented significant changes to healthcare fraud and abuse laws that intensify the risks and consequences of enforcement actions. These included expansion of the False Claims Act by: (a) narrowing the public disclosure bar; and (b) explicitly stating that violations of the Anti-Kickback Statute trigger false claims liability. In addition, the ACA lessened the intent requirements under the Anti-Kickback Statute to provide that a person may violate the statute without knowledge or specific intent. The ACA also provided new funding and expanded powers to investigate fraud, including through expansion of the Medicare Recovery Audit Contractor ("RAC") program to Medicare Parts C and D and Medicaid and authorizing the suspension of Medicare and Medicaid payments to a provider of services pending an investigation of a credible allegation of fraud. Finally, the legislation created enhanced penalties for noncompliance, including increased criminal penalties and expansion of administrative penalties under Medicare and Medicaid. Collectively, such changes could have a material adverse impact on our Healthcare Segments' operations.

On January 20, 2017, the President of the United States issued an executive order that directed federal agencies to take steps to ensure the government's implementation of the ACA minimizes the burden on impacted parties (such as individuals and states). The underlying intent of the executive order was to take the first steps to repeal and replace the ACA. The executive order specifically instructed agencies to "waive, defer, grant exemptions from, or delay implementation of provisions" that place a "fiscal burden on any State" or that impose a "cost, fee, tax, penalty, or regulatory burden" on stakeholders including patients, providers, and insurers. The order stated that any changes should be made only to the extent "permitted by law" and should comply with the law governing administrative rule-making. The executive order did not, however, provide specifics on next steps or provisions that would be reexamined nor was it clear how the executive branch would be reconciled with Republican congressional efforts to repeal and replace the ACA or what portions of the ACA may continue in any replacement legislation. There are multiple pending legislative proposals to amend the ACA which, among other effects, could repeal all or parts of the ACA without replacing its extension of coverage to expansion populations. In addition, there are pending legislative proposals to materially restructure Medicaid and other government health care programs and there is litigation challenging, amongst other claims, the constitutionality of the ACA. Most recently, on December 14, 2018, a federal district court judge in Texas issued a widely anticipated opinion that struck down the entire ACA as unconstitutional. The judge ruled in favor of the plaintiffs by determining that the ACA's individual mandate is no longer a tax and is therefore an unconstitutional exercise of congressional authority. The judge also found that the individual mandate could not be severed from the rest of the ACA, rendering the entire ACA, not just the guaranteed issue and community rating provisions, unconstitutional. Sixteen states and the District of Columbia intervened as defendants in *Texas v. United States* to proffer a defense of the constitutionality of the ACA. The DOJ declined to defend the ACA on constitutional grounds. The intervenor defendant states have announced they will appeal the District Court's decision to the Fifth Circuit Court of Appeals. We are not able to predict the outcome of this matter nor are we able to predict the impact of a full or partial invalidation of the ACA.

In 2017, legislation was proposed in the U.S. Congress, but did not advance out of committee and was not passed, which would reduce or eliminate certain non-emergency medical transportation services provided by NET Services as a required Medicaid benefit. A similar proposal was made in 2018 by the President of the United States in a federal budget proposal. If additional privatization initiatives are not proposed or enacted, or if previously enacted privatization initiatives are challenged, repealed or invalidated, there could be a material adverse impact on our segments' operating results.

Surveys and Audits

Our Healthcare Segments' programs are subject to periodic surveys by government authorities or their contractors to ensure compliance with various requirements. Regulators conducting periodic surveys often provide reports containing statements of deficiencies for alleged failures to comply with various regulatory requirements. In most cases, if a deficiency finding is made by a reviewing agency, our segments will work with the reviewing agency to agree upon the steps to be taken to bring our program into compliance with applicable regulatory requirements. In some cases, however, an agency may take a number of adverse actions against a program, including:

- the imposition of fines or penalties or the recoupment of amounts paid;
- temporary suspension of admission of new clients to our program's service;
- in extreme circumstances, exclusion from participation in Medicaid, Medicare or other programs;
- revocation of our license; or
- contract termination.

While our Healthcare Segments believe that our programs are in compliance with Medicare, Medicaid and other program certification requirements and state licensure requirements, failure to comply with these requirements could have a material adverse impact on such segments' businesses and their ability to enter into contracts with other agencies to provide services.

Billing/claims Reviews and Audits

Agencies and other third-party commercial payors periodically conduct pre-payment or post-payment medical reviews or other audits of our Healthcare Segments' claims or other audits in conjunction with their obligations to comply with the requirements of Medicare or Medicaid. In order to conduct these reviews, payors request documentation from our Healthcare Segments and then review that documentation to determine compliance with applicable rules and regulations, including the eligibility of clients to receive benefits, the appropriateness of the care provided to those clients, and the documentation of that care. Any determination that such segments have not complied with applicable rules and regulations could result in adjustment of payments or the incurrence of fines and penalties, or in situations of significant compliance failures review or non-renewal of related contracts.

Corporate Practice of Medicine and Fee Splitting

Some states in which our Healthcare Segments operate prohibit general business entities, such as these segments, from "practicing medicine," which definition varies from state to state and can include employing physicians, as well as engaging in fee-splitting arrangements with these healthcare providers. Among other things, our Healthcare Segments currently contract with and employ NPs to perform CHAs. We believe that such segments have structured their operations appropriately; however, they could be alleged or found to be in violation of some or all of these laws. If a state determines that some portion of our Healthcare Segments' businesses violate these laws, it may seek to have such segments discontinue or restructure those portions of their operations or subject them to increased costs, penalties, fines, certain license requirements or other measures. Any determination that such segments have acted improperly in this regard may result in liability to them. In addition, agreements between the corporation and the professional may be considered void and unenforceable.

Professional Licensure and Other Requirements

Many of our Healthcare Segments' employees are subject to federal and state laws and regulations governing the ethics and practice of their professions. For example, our mid-level practitioners (e.g., NPs) are subject to state laws requiring physician supervision and state laws governing mid-level scope of practice. As physicians' use of mid-level practitioners increases, state governing boards are implementing more robust regulations governing mid-levels and their scope of practice under physician supervision. Our Healthcare Segments' ability to provide mid-level practitioner services may be restricted by the enactment of new state laws governing mid-level scope of practice and by state agency interpretations and enforcement of such existing laws. In addition, services rendered by mid-level practitioners may not be reimbursed by payors at the same rates as payors may reimburse physicians for the same services. Lastly, professionals who are eligible to participate in Medicare and Medicaid as individual providers must not have been excluded from participation in government programs at any time. Our Healthcare Segments' ability to provide services depends upon the ability of their personnel to meet individual licensure and other requirements and maintain such licensure in good standing.

Additional Information

The Company's website at www.prscholdings.com provides access to its periodic reports, certain corporate governance documents, press releases, interim shareholder reports and links to its subsidiaries' websites. The Company makes available to the public on its website its annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act, as soon as reasonably practicable after it electronically files such material with, or furnishes such material to, the SEC. Copies are also available, without charge, upon request to The Providence Service Corporation, 700 Canal Street, Third Floor, Stamford, CT 06902, (203) 307-2800, Attention: Corporate Secretary. The information contained on our website is not part of, and is not incorporated by reference in, this Annual Report on Form 10-K or any other report we file with or furnish to the SEC.

Item 1A. ***Risk Factors.***

You should consider and read carefully all of the risks and uncertainties described below, as well as other information included in this Annual Report on Form 10-K, including our consolidated financial statements and related notes. The risks described below are not the only ones facing us. The occurrence of any of the following risks or additional risks and uncertainties not presently known to us or that we currently believe to be immaterial could materially and adversely affect our business, financial condition and results of operations. This Annual Report on Form 10-K also contains forward-looking statements and estimates that involve risks and uncertainties. Our actual results could differ materially from those anticipated in any forward-looking statements as a result of specific factors, including the risks and uncertainties described below.

Risks Related to Our Business

There can be no assurance that our contracts will survive until the end of their stated terms, or that upon their expiration will be renewed or extended on satisfactory terms, if at all. Disruptions to, the early expiration of or the failure to renew our contracts could have a material adverse impact on our financial condition and results of operations.

Our NET Services contracts are subject to frequent renewal. For example, many of our state Medicaid contracts, which represented 52.9% of NET Services revenue for the year ended December 31, 2018, have terms ranging from three to five years and are typically subject to a competitive bidding process near the end of the term. NET Services also contracts with MCOs, which represented 47.1% of NET Services revenue for the year ended December 31, 2018. MCO contracts typically continue until terminated by either party upon reasonable notice (as determined in accordance with the contract). We cannot anticipate if, when or to what extent we will be successful in renewing our state Medicaid contracts or retaining our MCO contracts. As of December 31, 2018, 13.2% of NET Services revenue was generated under state Medicaid contracts that are subject to renewal within the next 12 months. Renewed contracts represented 32.4% of our NET Services revenue for the year ended December 31, 2018.

In addition, with respect to many of our state contracts, the payor may terminate the contract without cause, or for convenience, at will and without penalty to the payor, either immediately or upon the expiration of a short notice period in the event that, among other reasons, government appropriations supporting the programs serviced by the contract are reduced or eliminated.

We cannot anticipate if, when or to what extent a payor might terminate its contract with us prior to its expiration, or fail to renew or extend a contract with us. If we are unable to retain or renew our contracts, or replace lost contracts, on satisfactory terms our financial conditions and results of operations could be materially adversely affected. While we pursue new contract awards and also undertake efficiency measures, there can be no assurance that such measures will fully offset the impact of contracts that are not renewed or are canceled on our operating income and results of operations.

We obtain a significant portion of our business through responses to government requests for proposals and we may not be awarded contracts through this process in the future, or contracts we are awarded may not be profitable.

We obtain, and will continue to seek to obtain, a significant portion of our business from state government entities, which generally entails responding to a government request for proposals ("RFP"). To propose effectively, we must accurately estimate our cost structure for servicing a proposed contract, the time required to establish operations and submit the most attractive proposal with respect to both technical and price specifications. We must also assemble and submit a large volume of information within rigid and often short timetables. Our ability to respond successfully to RFPs will greatly affect our business. If we misinterpret bid requirements as to performance criteria or do not accurately estimate performance costs in a binding bid for an RFP, we will seek to correct such mistakes in the final contract. However, there can be no assurance that we will be able to modify the proposed contract and we may be required to perform under a contract that is not profitable.

If we fail to satisfy our contractual obligations, we could be liable for damages and financial penalties, which may place existing pledged performance and payment bonds at risk as well as harm our ability to keep our existing contracts or obtain new contracts and future bonds.

Our failure to comply with our contractual obligations could, in addition to providing grounds for immediate termination of the contract for cause, negatively impact our financial performance and damage our reputation, which, in turn, could have a material adverse effect on our ability to maintain current contracts or obtain new contracts. The termination of a contract for cause could, for instance, subject us to liabilities for excess costs incurred by a payor in obtaining similar services from another source. In addition, our contracts require us to indemnify payors for our failure to meet standards of care, and some of them contain liquidated damages provisions and financial penalties that we must pay if we breach these contracts, which amounts could be material. For example, the service commitment under one of our contracts could subject us to penalties if we do not utilize the

minimum level of services specified in such agreement. The total future minimum commitment was $28.7 million as of December 31, 2018. To the extent our actual use is less than the minimum commitment for a specified period, we may be subject to significant expense, without the benefit of corresponding revenue.

Our failure to meet contractual obligations could also result in substantial actual and consequential financial damages.

Any acquisition or integration that we undertake could disrupt our business, not generate anticipated results, dilute stockholder value or have a material adverse impact on our operating results.

Our growth strategy involves the evaluation of potential entry into complementary markets and service lines through acquisition, particularly with opportunities that may leverage the advantages inherent in our large-scale technology-enabled operations and networks. We have made acquisitions and anticipate that we will continue to consider and pursue strategic acquisition opportunities the success of which depends in part on our ability to integrate an acquired company into our business operations. For example, we completed the acquisition of Circulation in September 2018 and will utilize Circulation's technology platform to service our legacy or new customers, which will result in a decrease in the usage of our existing technology. As a result of the technology evaluation, we decided to terminate the development of our legacy LCAD NextGen technology ("NextGen"), resulting in an impairment charge in the fourth quarter of 2018 of $13.5 million. While preliminary implementation is on track, the work to deploy the Circulation technology platform is ongoing, and subject to the scalability of Circulation's technology platform to process similar levels of transactions as LogistiCare. In addition, the digitization of claims processing on the Circulation platform may have unintended financial impacts related to claim costs and working capital. To the extent we are unable to successfully integrate the Circulation acquisition, our results of operations may be adversely affected and anticipated synergies may not be realized. Integration of any acquired companies will place significant demands on our management, systems, internal controls and financial and physical resources. This could require us to incur significant expense for, among other things, hiring additional qualified personnel, retaining professionals to assist in developing the appropriate control systems and expanding our information technology infrastructure. The nature of our business is such that qualified management personnel can be difficult to find. Our inability to manage growth effectively could have a material adverse effect on our financial results.

There can be no assurance that the companies acquired will generate income or incur expenses at the historical or projected levels on which we based our acquisition decisions, that we will be able to maintain or renew the acquired companies' contracts, that we will be able to realize operating and economic efficiencies upon integration of acquired companies or that the acquisitions will not adversely affect our results of operations or financial condition.

We expect to continually review opportunities to acquire other businesses that would complement our current services, expand our markets or otherwise offer prospects for growth. In connection with our acquisition strategy, we could issue stock that would dilute existing stockholders' percentage ownership, or we could incur or assume substantial debt or contingent liabilities. Acquisitions involve numerous risks, including, but not limited to, the following:

- challenges and unanticipated costs assimilating the acquired operations;
- known and unknown legal or financial liabilities associated with an acquisition;
- diversion of management's attention from our core businesses;
- adverse effects on existing business relationships with customers;
- entering markets in which we have limited or no experience;
- potential loss of key employees of purchased organizations;
- incurrence of excessive leverage in financing an acquisition;
- failure to maintain and renew contracts and other revenue streams of the acquired business;
- costs associated with litigation or other claims arising in connection with the acquired company;
- unanticipated operating, accounting or management difficulties in connection with an acquisition; and
- dilution to our earnings per share.

There can be no assurance that we will be successful in overcoming problems encountered in connection with any acquisition or integration and our inability to do so could disrupt our operations and adversely affect our business. Our failure to address these risks or other problems encountered in connection with past or future acquisitions and investments could cause us to fail to realize the anticipated benefits of such acquisitions or investments, incur unanticipated liabilities and harm our business generally.

We may be unable to realize the benefits of any strategic initiatives that are adopted by the Company.

From time to time we may launch strategic initiatives to enhance shareholder value. For example, on April 11, 2018, we announced our Organizational Consolidation, which is expected to be completed in the middle of 2019. While we expect the

Organizational Consolidation to generate annual savings upon completion, implementation of the process will negatively impact earnings. There can be no assurance that the Organizational Consolidation will be completed in a timely fashion or at all, or that it will generate the expected cost savings. In addition, part of the rationale for the acquisition of Circulation was the ability to utilize its technology platform to generate substantial cost savings. Such cost savings require the deployment of technology and substantial changes to existing business processes. There can be no assurance as to whether any other strategic initiatives will be adopted, and the outcome of any current or future strategic initiatives is uncertain, including the roll out of the Circulation technology platform across our LogistiCare business.

Our investments in any joint ventures and unconsolidated entities could be adversely affected by our lack of sole decision-making authority, our reliance on our joint venture partners' financial condition, any disputes that may arise between us and our joint venture partners and our exposure to potential losses from the actions of our joint venture partners.

We currently hold a non-controlling interest in Matrix, which constitutes 28.2% of our consolidated assets. We do not have unilateral power to direct the activities that most significantly impact such business' economic performance. Our future growth may depend, in part, on future similar arrangements, any of which could be material to our financial condition and results of operations. These arrangements involve risks not present with respect to our wholly-owned subsidiaries, which may negatively impact our financial condition and results of operations or make the arrangements less successful than anticipated, including the following:

- we may be unable to take actions that we believe are appropriate but are opposed by our joint venture partners under arrangements that require us to cede or share decision-making authority over major decisions affecting the ownership or operation of the joint venture and any property owned by the joint venture, such as the sale or financing of the business or the making of additional capital contributions for the benefit of the business;
- our joint venture partners may take actions that we oppose;
- we may be unable to sell or transfer our interest in a joint venture to a third party if we fail to obtain the prior consent of our joint venture partners;
- our joint venture partners may become bankrupt or fail to fund their share of required capital contributions, which could adversely impact the joint venture or increase our financial commitment to the joint venture;
- our joint venture partners may have business interests or goals with respect to a business that conflict with our business interests and goals, including with respect to the timing, terms and strategies for investment, which could increase the likelihood of disputes regarding the ownership, management or disposition of the business;
- disagreements with our joint venture partners could result in litigation or arbitration that increases our expenses, distracts our officers and directors, and disrupts the day-to-day operations of the business, including the delay of important decisions until the dispute is resolved; and
- we may suffer losses as a result of actions taken by our joint venture partners with respect to our joint venture investments.

We derive a significant amount of our revenues from a few payors, which puts our financial condition and results of operations at risk. Any changes in the funding, financial viability or our relationships with these payors could have a material adverse impact on our financial condition and results of operations.

We generate a significant amount of our revenue from a few payors under a small number of contracts. For example, for the years ended December 31, 2018, 2017 and 2016, we generated 51.4%, 52.4% and 51.7%, respectively, of our consolidated revenue from continuing operations from ten payors. Additionally, the top five payors represented, in the aggregate, 34.0%, 36.1% and 35.6%, respectively, of revenue from continuing operations for the years ended December 31, 2018, 2017 and 2016. Additionally, a single payor related to Matrix represented 31.5%, 30.9% and 27.8% of Matrix revenue for the years ended December 31, 2018, 2017 and 2016, respectively. The loss of, reduction in amounts generated by, or changes in methods or regulations governing payments for our services under these contracts could have a material adverse impact on our revenue and results of operations. In addition, any consolidation of any of our private payors could increase the impact that any such risks would have on our revenue and results of operations.

If we fail to estimate accurately the cost of performing certain contracts, we may experience reduced or negative margins.

During 2018, 2017 and 2016, 79.2%, 77.9% and 78.3% of our NET Services revenue, respectively, was generated under capitated contracts with the remainder generated through FFS and flat fee contracts. Under most of NET Services' capitated contracts, we assume the responsibility of managing the needs of a specific geographic population by contracting out transportation services to local transportation companies on a per ride or per mile basis. We use "pricing models" to determine applicable contract rates, which take into account factors such as estimated utilization, state specific data, previous experience in the state or with similar services, the medically covered programs outlined in the contract, identified populations to be serviced, estimated volume,

estimated transportation provider rates and availability of mass transit. The amount of the fixed per-member, monthly fee is determined in the bidding process, but is predicated on actual historical transportation data for the subject geographic region as provided by the payor, actuarial work performed in-house as well as by third party actuarial firms and actuarial analysis provided by the payor. If the utilization of our services is more than we estimated, the contract may be less profitable than anticipated, or may not be profitable at all. Under our FFS contracts, we receive fees based on our interactions with government-sponsored clients. To earn a profit on these contracts, we must accurately estimate costs incurred in providing services. Our risk relating to these contracts is that our client population is not large enough to cover our fixed costs, such as rent and overhead. Our FFS contracts are not reimbursed on a cost basis and therefore, if we fail to estimate our costs accurately, we may experience reduced margins or losses on these contracts. Revenue under certain contracts may be adjusted prospectively if client volumes are below expectations. If we are unable to adjust our costs accordingly, our profitability may be negatively affected. In addition, certain contracts with state Medicaid agencies are renewable or extended at the state's option without an adjustment to pricing terms. If such renewed contracts require us to incur higher costs, including inflation or regulatory changes, than originally anticipated, our results of operations and financial condition may be adversely affected.

We may incur costs before receiving related revenues, which affect our liquidity.

When we are awarded a contract to provide services, we may incur expenses before we receive any contract payments. These expenses include leasing office space, purchasing office equipment, instituting information technology systems, development of supply chains and hiring personnel. As a result, in certain contracts where the payor does not fund program start-up costs, we may be required to make significant investments before receiving any related contract payments or payments sufficient to cover start-up costs. In addition, payments due to us from payors may be delayed due to billing cycles, which may adversely affect our liquidity. Moreover, any resulting mismatch in expenses and revenue could be exacerbated if we fail either to invoice the payor correctly or to collect our fee in a timely manner. Such amounts may exceed our available cash, and any resulting liquidity shortages may require additional financing, which may not be available on satisfactory terms, or at all. This could have a material adverse impact on our ongoing operations and our financial position.

Our business is subject to risks of litigation.

The services we provide are subject to lawsuits and claims. A substantial award payable by us could have a material adverse impact on our operations and cash flows, and could adversely affect our ability to continue to purchase appropriate liability insurance. We can be subject to claims for negligence or intentional misconduct (in addition to professional liability type claims) by an employee or a third party we engage to assist with the provision of services, including but not limited to claims arising out of accidents involving vehicle collisions, CHAs performed by Matrix, and various claims that could result from employees or contracted third parties driving to or from interactions with clients or while providing direct client services. We can be subject to employee-related claims such as wrongful discharge, discrimination or a violation of equal employment laws and permitting issues. While we attempt to insure against these types of claims, damages exceeding our insurance limits or outside our insurance coverage, such as a claim for fraud, certain wage and hour violations or punitive damages, could adversely affect our cash flow and financial condition.

We face risks related to attracting and retaining qualified employees and labor relations.

Our success depends, to a significant degree, on our ability to identify, attract, develop, motivate and retain highly qualified and experienced professionals who possess the skills and experience necessary to deliver high-quality services to our clients, with the continued contributions of our senior management being especially critical to our success. Our objective of providing the highest quality of service to our clients is a significant consideration when we evaluate the education, experience and qualifications of potential candidates for employment as direct care and administrative staff. A portion of our staff is professionals with requisite educational backgrounds and professional certifications. These employees are in great demand and are likely to remain a limited resource for the foreseeable future.

Our ability to attract and retain employees with the requisite experience and skills depends on several factors including, but not limited to, our ability to offer competitive wages, benefits and professional growth opportunities. While we have established programs to attract new employees and provide incentives to retain existing employees, particularly our senior management, we cannot assure you that we will be able to attract new employees or retain the services of our senior management or any other key employees in the future. Some of the companies with which we compete for experienced personnel may have greater financial, technical, political and marketing resources, name recognition and a larger number of clients and payors than we do, which may prove more attractive to employment candidates. The inability to attract and retain experienced personnel could have a material adverse effect on our business.

The performance of our business also depends on the talents and efforts of our highly skilled information technology professionals. For example, realization of the synergies related to our recent acquisition of Circulation relies heavily on our ability to deploy Circulation's technology platform across LogistiCare's existing operations, and competition for skilled information technology professionals can be intense. Our success depends on our ability to recruit, retain and motivate these individuals.

Effective succession planning is also important to our future success. If we fail to ensure the effective transfer of senior management knowledge and smooth transitions involving senior management, including the appointment of a permanent chief executive officer for the Company and the transition of several key management positions, resulting from the Organizational Consolidation, our ability to execute short and long-term strategic, financial and operating goals, as well as our business, financial condition and results of operations generally, could be adversely affected.

We may have difficulty successfully completing divestitures or exiting businesses.

As demonstrated most recently with the WD Services sale in 2018 and various other transactions involving WD Services, as well as the sale of a controlling interest in Matrix in 2016, we may dispose of all or a portion of our investments or exit businesses based on a variety of factors, including availability of alternative opportunities to deploy capital or otherwise maximize shareholder value as well as other strategic considerations. A divestiture or business termination could result in difficulties in the separation of operations, services, products and personnel, the diversion of management's attention, the disruption of our business and the potential loss of key employees and customers. A divestiture or business termination may be subject to the satisfaction of pre-closing conditions as well as to obtaining necessary regulatory approvals, which, if not satisfied or obtained, may prevent us from completing the disposition or business termination, whether or not the disposition or business termination has been publicly announced. A divestiture or business termination may also involve continued financial involvement in the divested assets and businesses, such as indemnities or other financial obligations, including continuing obligations to employees, in which the performance of the divested assets or businesses could impact our results of operations. Further, such divestitures may result in proceeds to us in an amount less than we expect or less than our assessment of the value of those assets. Any sale of our assets could result in a loss on divestiture. Any of the foregoing could adversely affect our financial condition and results of operations.

The indemnification provisions of acquisition and disposition agreements by which we have acquired or sold companies may result in liabilities.

We rely heavily on the representations and warranties and related indemnities provided to us by the sellers of acquired companies, including as they relate to creation, ownership and rights in intellectual property and compliance with laws and contractual requirements. However, the liability of the former owners is limited under the relevant acquisition agreements, and certain sellers may be unable to meet their indemnification responsibilities. Similarly, the purchasers of our divested operations may from time to time agree to indemnify us for operations of such businesses after the closing. We cannot be assured that any of these indemnification provisions will fully protect us, and as a result we may face unexpected liabilities that adversely affect our consolidated results of operations, financial condition and cash flows.

In addition, we have provided certain indemnifications in connection with the WD Services sale in 2018, the Matrix Transaction in 2016 and the Human Services Sale in 2015. To the extent we choose to divest other operations of our businesses in the future, we expect to provide certain indemnifications in connection with these divestitures. We may face liabilities in connection with these current or future indemnification obligations that may adversely affect our consolidated results of operations, financial condition and cash flows.

Our success depends on our ability to compete effectively in the marketplace.

We compete for clients and for contracts with a variety of organizations that offer similar services. Many organizations of varying sizes compete with us, including local not-for-profit organizations and community-based organizations, larger companies, organizations that currently provide or may begin to provide similar NET management services (including transportation network companies such as Uber and Lyft) and CHA providers. Some of these companies may have greater financial, technical, political, marketing, name recognition and other resources and a larger number of clients or payors than we do. In addition, some of these companies offer more services than we do. To remain competitive, we must provide superior services and performance on a cost-effective basis to our customers.

The market in which we operate is influenced by technological developments that affect cost-efficiency and quality of services, and the needs of our customers change and evolve regularly. Accordingly, our success depends on our ability to develop services that address these changing needs and to provide technology needed to deliver these services on a cost-effective basis. Our competitors may better utilize technology to change the way services in our industry are designed and delivered and they may be able to provide our customers with different or greater capabilities than we can provide, including better contract terms, technical

qualifications, price and availability of qualified professional personnel. In addition, new or disruptive technologies and methodologies by our competitors may make our services uncompetitive.

In conjunction with our ongoing efforts to improve cost-efficiency and the customer experience, in September 2018, we completed our acquisition of Circulation. We incurred costs associated with such acquisition and will also incur costs to implement the Circulation technology across LogistiCare's existing operations, but there is no guarantee that this will ultimately serve our business purposes or result in lower costs.

We have experienced, and expect to continue to experience, competition from new entrants into the markets in which we operate. Increased competition may result in pricing pressures, loss of or failure to gain market share or loss of or failure to gain clients or payors, any of which could have a material adverse effect on our operating results. Our business may also be adversely affected by the consolidation of competitors, which may result in increased pricing pressure or negotiating leverage with payors, or by the provision of our services by payors or clients directly, including through the acquisition of competitors.

We may be adversely affected by inadequacies in, or security breaches of, our information technology systems.

Our information technology systems are critically important to our operations and we must implement and maintain appropriate and sufficient infrastructure and systems to support growth and business processes. We provide services to individuals, including services that require us to maintain sensitive and personal client information, including information relating to their health, identification numbers and other identifying data. Therefore, our information technology systems store client information protected by numerous federal, state and foreign regulations. We also rely on our information technology systems (some of which are outsourced to third parties) to manage the data, communications and business processes for all other functions, including our marketing, sales, logistics, customer service, accounting and administrative functions. Further, our systems include interfaces to third-party stakeholders, often connected via the Internet. In addition, certain of our services or information related to our services are carried out or hosted within our customers' IT systems, and any failure or weaknesses in their IT systems may negatively impact our ability to deliver the services, for which we may not receive relief from contractual performance obligations or compensation for services provided. As a result of the data we maintain and third-party access, we are subject to increasing cybersecurity risks. The nature of our business, where services are often performed outside a secured location, adds additional risk.

If we do not allocate and effectively manage the resources necessary to build, sustain and protect an appropriate technology infrastructure, our business or financial results could be negatively impacted. Furthermore, computer hackers and data thieves are increasingly sophisticated and operate large scale and complex automated attacks and our information technology systems may be vulnerable to material security breaches (including the access to or acquisition of customer, employee or other confidential data), cyber-based attacks or other material system failures. Because the techniques used to obtain unauthorized access or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to implement adequate preventative measures sufficient to prevent a breach of our systems and protect sensitive data. Any breach of our data security could result in an unauthorized release or transfer of customer or employee information, or the loss of valuable business data or cause a disruption in our business. A failure to prevent, detect and respond in a timely manner to a major breach of our data security or to other cybersecurity threats could result in system disruption, business continuity issues or compromised data integrity. These events or any other failure to safeguard personal data could give rise to unwanted media attention, damage our reputation, damage our customer relationships and result in lost sales, fines or lawsuits. We may also be required to expend significant capital and other resources to protect against or respond to or alleviate problems caused by a security breach. If we are unable to prevent material failures, our operations may be impacted, and we may suffer other negative consequences such as reputational damage, litigation, remediation costs, a requirement not to operate our business until defects are remedied or penalties under various data privacy laws and regulations, any of which could detrimentally affect our business, financial condition and results of operations.

Failure to protect our client's privacy and confidential information could lead to legal liability, adversely affect our reputation and have a material adverse effect on our business, financial condition and results of operations.

We retain confidential information in our computer systems, including personal information about our customers, such as names, addresses, phone numbers, email addresses, identification numbers and payment account information. Malicious cyber- attacks to gain access to personal information affect many companies across various industries, including ours. Pursuant to federal and state laws, various government agencies have established rules protecting the privacy and security of personal information. In addition, most states have enacted laws, which vary significantly from jurisdiction to jurisdiction, to safeguard the privacy and security of personal information. An increasing number of states require that customers be notified if a security breach results in the inappropriate disclosure of personally identifiable customer information. Any compromise of the security of our systems that results in the disclosure of personally identifiable customer or employee information or inadvertent disclosure of any clients' personal information could damage our reputation, deter people from using our services, expose us to litigation, increase regulatory

scrutiny and require us to incur significant technical, legal and other expenses. In addition, data breaches impacting other companies, such as our vendors, may allow cybercriminals to obtain personally identifiable information about our customers. Cybercriminals may then use this information to, among other things, attempt to gain unauthorized access to our customers' accounts, which could have a material adverse effect on our reputation, business and results of operations or financial condition.

Failure to maintain or to develop further reliable, efficient and secure information technology systems would be disruptive to our operations and diminish our ability to compete and grow our business successfully.

We are highly dependent on efficient and uninterrupted performance of our information technology and business systems. These systems quote, process and service our business, and perform financial functions necessary for pricing and service delivery. These systems must also be able to undergo periodic modifications and improvements without interruptions or untimely delays in service. Additionally, our ability to integrate our systems with those of our clients is critical to our success. Our information systems rely on the commitment of significant financial and managerial resources to maintain and enhance existing systems as well as develop and create new systems to keep pace with continuing changes in information processing technology or evolving industry and regulatory requirements. However, we still rely on manual processes and procedures, including accounting, reporting and consolidation processes that may result in errors and may not scale proportionately with our business growth.

A failure or delay to achieve improvements in our information technology platforms could interrupt certain processes or degrade business operations and could place us at a competitive disadvantage. If we are unable to implement appropriate systems, procedures and controls, we may not be able to successfully offer our services and grow our business and account for transactions in an appropriate and timely manner, which could have an adverse effect on our business, financial condition and results of operations.

Our results of operations will continue to fluctuate due to seasonality.

Our operating results and operating cash flows normally fluctuate as a result of seasonal variations in our business. Due to higher demand in the summer months and lower demand in the winter months, coupled with a primarily fixed revenue stream based on a per-member, per-month payment structure, we normally experience lower operating margins in the summer and higher operating margins in the winter.

Our reported financial results could suffer if there is an impairment of long-lived assets.

We are required under generally accepted accounting principles in the United States of America ("GAAP") to review the carrying value of long-lived assets to be used in operations whenever events or changes in circumstances indicate that the carrying amount of the assets may be impaired. Factors that may necessitate an impairment assessment include, among others, significant adverse changes in the extent or manner in which an asset is used, significant adverse changes in legal factors or the business climate that could affect the value of an asset or significant declines in the observable market value of an asset. Where the presence or occurrence of those events indicates that an asset may be impaired, we assess its recoverability by determining whether the carrying value of the asset exceeds the sum of the projected undiscounted cash flows expected to result from the use and eventual disposition of the assets over the remaining economic life of the asset. If such testing indicates the carrying value of the asset is not recoverable, we estimate the fair value of the asset using appropriate valuation methodologies, which would typically include an estimate of discounted cash flows. If the fair value of those assets is less than carrying value, we record an impairment loss equal to the excess of the carrying value over the estimated fair value. The use of different estimates or assumptions in determining the fair value of our intangible assets may result in different values for those assets, which could result in an impairment or, in the period in which an impairment is recognized, could result in a materially different impairment charge. For example, we recorded an asset impairment charge of $14.2 million in 2018 related to NextGen.

In addition, goodwill may be impaired if the estimated fair value of one or more of our reporting units is less than the carrying value of the respective reporting unit. As a result of our growth, in part through acquisitions, goodwill and other intangible assets represent a significant portion of our assets. For example, goodwill generated in relation to the acquisition of Circulation was $40.0 million. We perform an analysis on our goodwill balances to test for impairment on an annual basis. Interim impairment tests may also be required in advance of our annual impairment test if events occur or circumstances change that would more likely than not reduce the fair value, including goodwill, of one or more of our reporting units below the reporting unit's carrying value. Such circumstances could include but are not limited to: (1) loss of significant contracts, (2) a significant adverse change in legal factors or in the climate of our business, (3) unanticipated competition, (4) an adverse action or assessment by a regulator or (5) a significant decline in our stock price.

As of December 31, 2018, the carrying value of goodwill, intangibles and property and equipment, net was $135.2 million, $26.1 million and $23.0 million, respectively. We continue to monitor the carrying value of these long-lived assets. If future

conditions are different from management's estimates at the time of an acquisition or market conditions change subsequently, we may incur future charges for impairment of our goodwill or intangible assets, which could have a material adverse impact on our results of operations and financial position.

Our use of a reinsurance program and insurance programs to cover certain claims for losses suffered and costs or expenses incurred could negatively impact our business.

We reinsured a substantial portion of our automobile, general liability, professional liability and workers' compensation insurance policies through May 15, 2017. Upon renewal of the policies, we made the decision to no longer reinsure these risks, although we continue to resolve claims under the historical policy years. Through February 15, 2011, one of our subsidiaries also insured certain general liability, automobile liability, and automobile physical damage coverage for independent third-party transportation providers. In the event that actual reinsured losses increase unexpectedly and substantially exceed actuarially determined estimated reinsured losses under the program, the aggregate of such losses could materially increase our liability and adversely affect our financial condition, liquidity, cash flows and results of operations.

In addition, under our current insurance policies, we are subject to deductibles, and thus retain exposure within these limits. In the event that actual losses within our deductible limits increase unexpectedly and substantially exceed our expected losses, the aggregate of such losses could materially increase our liability and adversely affect our financial condition, liquidity, cash flows and results of operations.

As the availability to us of certain traditional insurance coverage diminishes or increases in cost, we will continue to evaluate the levels and types of insurance coverage we include in our reinsurance and self-insurance programs, as well as the deductible limits within our traditional insurance programs. Any increase to these reinsurance and self-insurance programs or increases in deductible limits increases our risk exposure and therefore increases the risk of a possible material adverse effect on our financial condition, liquidity, cash flows and results of operations.

Inaccurate, misleading or negative media coverage could damage our reputation and harm our ability to maintain or procure contracts.

There is sometimes media coverage regarding services that we or our competitors provide or contracts that we or our competitors are a party to. Inaccurate, misleading or negative media coverage about us could harm our reputation and, accordingly, our ability to maintain our existing contracts or procure new contracts.

Regulatory Risks

Our Healthcare Segments conduct business in a heavily regulated healthcare industry. Compliance with existing Laws is costly, and changes in Laws or violations of Laws may result in increased costs or sanctions that could reduce our segments' revenue and profitability.

The U.S. healthcare industry is subject to extensive federal and state Laws relating to, among other things:

- professional licensure;
- conduct of operations;
- addition of facilities, equipment and services, including certificates of need;
- coding and billing related to our services; and
- payment for services.

Both federal and state government agencies have increased coordinated civil and criminal enforcement efforts related to the healthcare industry. Regulations related to the healthcare industry are extremely complex and, in many instances, the industry does not have the benefit of significant regulatory or judicial interpretation of those laws. The Patient Protection and Affordable Care Act, as well as the anticipated attempts to repeal all or portions of those laws by the President and Congress, has also introduced some degree of regulatory uncertainty as the industry does not know how the changes it introduced or changes to it will affect many aspects of the industry. Medicare and Medicaid anti-fraud and abuse laws prohibit certain business practices and relationships related to items and services reimbursable under Medicare, Medicaid and other governmental healthcare programs, including the payment or receipt of remuneration to induce or arrange for referral of patients or recommendation for the provision of items or services covered by Medicare or Medicaid or any other federal or state healthcare program. Federal and state Laws prohibit the submission of false or fraudulent claims, including claims to obtain reimbursement under Medicare and Medicaid. Our Healthcare Segments have implemented compliance policies to help assure their compliance with these regulations as they become effective; however, different interpretations or enforcement of these laws and regulations in the future could subject our practices to allegations

of impropriety or illegality or could require such segments to make changes in their facilities, equipment, personnel, services or the manner in which they conduct our business.

Changes in budgetary priorities of the government entities that fund the services our Healthcare Segments provide could result in our segments' loss of contracts or a decrease in amounts payable to them under their contracts.

Our Healthcare Segments' revenue is largely derived from contracts that are directly or indirectly paid or funded by government agencies. All of these contracts are subject to legislative appropriations and state or national budget approval, as well as changes to potential eligibility for services. The availability of funding under NET Services' contracts with state governments is dependent in part upon federal funding to states. Changes in Medicaid methodology may further reduce the availability of federal funds to states in which our Healthcare Segments provide services. The President of the United States and Congress have proposed various changes to the Medicaid program, including considering converting the Medicaid program to a block grant format or capping the federal contribution to state Medicaid programs to a fixed amount per beneficiary. CMS has invited states to submit requests for waivers to CMS that would allow states to reduce or eliminate the NET benefit for some populations. In response, several states have asked for and received temporary waivers of NET requirements for the Medicaid expansion or non-disabled adult population. In addition, in late 2018, DHHS published in the Unified Agenda its intention to revise the current regulations under which states are required to provide NET services for all Medicaid beneficiaries. The stated goal of this proposed rule is to provide states with greater flexibility as part of the administration's reform initiatives. It is possible that revised regulations could be issued in 2019 or 2020 making it optional for the states to provide NET services to certain populations. Such changes, individually or in the aggregate, could have a material adverse effect on our Healthcare Segments operations.

Among the alternative Medicaid funding approaches that states have explored are provider assessments as tools for leveraging increased Medicaid federal matching funds. Provider assessment plans generate additional federal matching funds to the states for Medicaid reimbursement purposes, and implementation of a provider assessment plan requires approval by CMS in order to qualify for federal matching funds. These plans usually take the form of a bed tax or a quality assessment fee, which were historically required to be imposed uniformly across classes of providers within the state, except that such taxes only applied to Medicaid health plans.

Changes to provider assessment opportunities, the Medicaid programs in states in which our Healthcare Segments operate or in the structure of the federal government's support for those programs can affect the amount of funds available in the programs our Healthcare Segments support. Because funding under our Healthcare Segments' contracts is dependent in part upon federal funding, such funding changes could have a significant effect upon such segments' businesses.

Currently, many of the U.S. states in which our segments operate are facing budgetary shortfalls or changes in budgetary priorities. While many of these states are dealing with budgetary concerns by shifting costs from institutional care to home and community based care such as we provide, there is no assurance that this trend will continue.

Consequently, a significant decline in government expenditures, shift of expenditures or funding away from programs that call for the types of services that we provide, or change in government contracting or funding policies could cause payors to terminate their contracts with our segments or reduce their expenditures under those contracts, either of which could have a negative impact on our segments' operating results.

Our Healthcare Segments are subject to regulations relating to privacy and security of patient and service user information. Failure to comply with privacy and security regulations could result in a material adverse impact on our segments' operating results.

There are numerous federal and state regulations addressing patient information privacy and security concerns. In particular, the federal regulations issued under HIPAA contain provisions that:

- protect individual privacy by limiting the uses and disclosures of patient information;
- require the implementation of security safeguards to ensure the confidentiality, integrity and availability of individually identifiable health information in electronic form; and
- prescribe specific transaction formats and data code sets for certain electronic healthcare transactions.

Compliance with state and federal laws and regulations is costly and requires our segment management to expend substantial time and resources which could negatively impact our segments' results of operations. Further, the HIPAA regulations and state privacy laws expose our segments to increased regulatory risk, as the penalties associated with a failure to comply or with information security breaches, even if unintentional, could have a material adverse effect on our segments' results of operations.

Our Healthcare Segments could be subject to actions for false claims or recoupment of funds pursuant to certain audits if they do not comply with government coding and billing rules, which could have a material adverse impact on our segments' operating results.

If our Healthcare Segments fail to comply with federal and state documentation, coding and billing rules, our segments could be subject to criminal or civil penalties, loss of licenses and exclusion from the Medicare and Medicaid programs, which could have a material adverse impact on our segments' operating results. In billing for our segments' services to third-party payors, our segments must follow complex documentation, coding and billing rules. These rules are based on federal and state laws, rules and regulations, various government pronouncements, and industry practice. Failure to follow these rules could result in potential criminal or civil liability under the federal False Claims Act, under which extensive financial penalties can be imposed or under various state statutes which prohibit the submission of false claims for services covered. Compliance failure could further result in criminal liability under various federal and state criminal or civil statutes. Our segments may be subject to audits conducted by our clients or their proxies that may result in recoupment of funds. In addition, our segments' clients may be subject to certain audits that may result in recoupment of funds from our clients that may, in turn, implicate our segments' services. Our segments' businesses could be adversely affected in the event such an audit results in negative findings and recoupment from or penalties to their customers.

Our Healthcare Segments' contracts are subject to stringent claims and invoice processing regimes which vary depending on the customer and nature of the payment mechanism. Government entities may take the position that if a transport cannot be matched to a healthcare event, or is conducted inconsistently with contractual, regulatory or even policy requirements, payment for such transport may be recouped by such customer.

While our Healthcare Segments carefully and regularly review their documentation, coding and billing practices, the rules are frequently vague and confusing and they cannot assure that governmental investigators, private insurers or private whistleblowers will not challenge their practices. Such a challenge could result in a material adverse effect on our Healthcare Segments' financial position and results of operations.

Our Healthcare Segments' business could be subject to civil penalties and loss of business if we fail to comply with applicable bribery, corruption and other regulations governing business with governments.

Our Healthcare Segments are subject to the federal Anti-Kickback Statute, which prohibits the offer, payment, solicitation or receipt of any form of remuneration in return for referring, ordering, leasing, purchasing or arranging for or recommending the ordering, purchasing or leasing of items or services payable by a federally funded healthcare program. Any of our Healthcare Segments' financial relationships with healthcare providers will be potentially implicated by this statute to the extent Medicare or Medicaid referrals are implicated. Violations of the Anti-Kickback Statute could result in substantial civil or criminal penalties, including criminal fines of up to $100,000 per violation, imprisonment of up to ten years, civil penalties under the Civil Monetary Penalties Law of up to $100,000 per violation, plus three times the remuneration involved, civil penalties under the False Claims Act of up to $22,363 for each claim submitted, plus three times the amounts paid for such claims and exclusion from participation in the Medicaid and Medicare programs. Any such penalties could have a significant negative effect on our Healthcare Segments' operations. Furthermore, the exclusion, if applied to such segments, could result in significant reductions in our revenues, which could materially and adversely affect such segments' businesses, financial condition and results of their operations. In addition, many states have adopted laws similar to the federal Anti-Kickback Statute with similar penalties.

Our Healthcare Segments' businesses could be adversely affected by future legislative changes that hinder or reverse the privatization of non-emergency transportation services.

The market for certain of our Healthcare Segments' services depends largely on government sponsored programs. These programs can be modified or amended at any time. Moreover, part of our growth strategy includes aggressively pursuing opportunities created by government initiatives to privatize the delivery of non-emergency transportation services. In 2017, legislation was proposed in the U.S. Congress, but not passed, which would reduce or eliminate certain non-emergency medical transportation services provided by NET Services as a required Medicaid benefit. If additional privatization initiatives are not proposed or enacted, or if previously enacted privatization initiatives are challenged, repealed or invalidated, there could be a material adverse impact on our Healthcare Segments' operating results.

Changes to the regulatory landscape applicable to Matrix could have a material adverse effect on our results of operations and financial condition.

The CHA services industry is primarily regulated by federal and state healthcare Laws and the requirements of participation and reimbursement of the MA Program established by CMS. From time to time, CMS considers changes to regulatory guidelines

with respect to prospective CHAs or the risk adjusted payment system applicable to Matrix's Medicare Advantage plan customers. CMS could adopt new requirements or guidelines that may, for example, increase the costs associated with CHAs, limit the opportunities and settings available to administer CHAs, or otherwise change the risk adjusted payment system in a way that would adversely impact our business. Further, changes in or adoption of new state laws governing the scope of practice of mid-level practitioners, or more restrictive interpretations of such laws, may restrict Matrix's ability to provide services using nurse practitioners. Any such implementation of additional regulations on the CHA industry by CMS or other regulatory bodies or further regulation of mid-level practitioners could have a material adverse impact on Matrix's revenues and margins, which could have a material adverse impact on our consolidated results of operations.

If our Healthcare Segments fail to comply with physician self-referral laws, to the extent applicable to our operations, they could experience a significant loss of reimbursement revenue.

Our Healthcare Segments may be subject to federal and state statutes and regulations banning payments for referrals of patients and referrals by physicians to healthcare providers with whom the physicians have a financial relationship and billing for services provided pursuant to such referrals if any occur. Violation of these federal and state laws and regulations, to the extent applicable to our Healthcare Segments' operations, may result in prohibition of payment for services rendered, loss of licenses, fines, criminal penalties and exclusion from Medicaid and Medicare programs. To the extent such segments do maintain such financial relationships with physicians, they rely on certain exceptions to self-referral laws that they believe will be applicable to such arrangements. Any failure to comply with such exceptions could result in the penalties discussed above.

As government contractors, our segments are subject to an increased risk of litigation and other legal actions and liabilities.

As government contractors, our segments are subject to an increased risk of investigation, criminal prosecution, civil fraud, whistleblower lawsuits and other legal actions and liabilities that are not as frequently experienced by companies that do not provide government sponsored services. Companies providing government sponsored services can also become involved in public inquiries which can lead to negative media speculation or potential cancellation or termination of contracts. Further, government contract awards are frequently challenged by the losing bidders leading to delays in contract start dates, rebids, or even loss of a previously awarded contract.

Our Healthcare Segments' businesses are subject to licensing regulations and other regulatory provisions, including provisions governing surveys and audits. Changes to, or violations of, these regulations could negatively impact our Healthcare Segments' revenues.

In many of the locations where our segments operate, they are required by local laws to obtain and maintain licenses. The applicable state and local licensing requirements govern the services our segments provide, the credentials of staff, record keeping, treatment planning, client monitoring and supervision of staff. The failure to maintain these licenses or the loss of a license could have a material adverse impact on our segments' businesses and could prevent them from providing services to clients in a given jurisdiction. Our Healthcare Segments' contracts are subject to surveys or audit by their payors or their clients. Our segments are also subject to regulations that restrict their ability to contract directly with a government agency in certain situations. Such restrictions could affect our segments' ability to contract with certain payors and clients, and could have a material adverse impact on our segments' results of operations.

Our Healthcare Segments' contracts are subject to audit and modification by the payors with whom our Healthcare Segments contract, at their sole discretion.

Our Healthcare Segments' businesses depend on their ability to successfully perform under various government funded contracts. Under the terms of these contracts, payors, government agencies or their proxy contractors can review our segments' compliance or performance, as well as our segments' records and general business practices at any time, and may, in their discretion:

- suspend or prevent our segments from receiving new contracts or extending existing contracts because of violations or suspected violations of procurement laws or regulations;
- terminate or modify our segments' existing contracts;
- reduce the amount our segments are paid under our existing contracts; or
- audit and object to our segments' contract related fees.

Any increase in the number or scope of audits could increase our segments' expenses, and the audit process may disrupt the day-to-day operations of our segments' businesses and distract their management. If payors have significant audit findings, or if they make material modifications to our segments' contracts, it could have a material adverse impact on our segments' results of operations.

Our estimated income taxes could be materially different from income taxes that we ultimately pay.

We are subject to income taxation in both the U.S. and, due to our ownership of international entities prior to the WD Services sale, 10 foreign countries, including specific states or provinces where we operate. Our total income tax provision is a function of applicable local tax rates and the geographic mix of our income from continuing and discontinued operations before taxes, which is itself impacted by currency movements. Consequently, the isolated or combined effects of unfavorable movements in tax rates, geographic mix, or foreign exchange rates could reduce our after-tax income.

Our total income tax provision is based on our income and the tax laws in the various jurisdictions in which we operate. Significant judgment and estimation is required in determining our annual income tax expense and in evaluating our tax positions and related matters. In the ordinary course of our business, there are many transactions and calculations for which the ultimate tax determinations are uncertain or otherwise subject to interpretation. In addition, we make judgments regarding the applicability of tax treaties and the appropriate application of transfer pricing regulations. In the event one taxing jurisdiction disagrees with another taxing jurisdiction with respect to the amount or applicability of a particular type of tax, or the amount or availability of a particular type of tax refund or credit, we could experience temporary or permanent double taxation and increased professional fees to resolve such taxation matters.

Our determination of our income tax liability is always subject to review by applicable tax authorities, and we have been audited by various jurisdictions in prior years. Although we believe our income tax estimates and related determinations are reasonable and appropriate, relevant taxing authorities may disagree. The ultimate outcome of any such audits and reviews could be materially different from the estimates and determinations reflected in our historical income tax provisions and accruals. Any adverse outcome of any such audit or review could have an adverse effect on our financial condition and the results of our operations.

Risks Related to Our Indebtedness

Restrictive covenants in our Credit Agreement may limit our current and future operations, particularly our ability to respond to changes in our business or to pursue our business strategies.

The terms contained in the agreements that govern certain of our indebtedness, including our Amended and Restated Credit and Guaranty Agreement (as amended, supplemented, or modified, the "Credit Agreement"), and the agreements that govern any future indebtedness of ours, may include a number of restrictive covenants that impose significant operating and financial restrictions, including restrictions on our ability to take actions that we believe may be in our best interest. These agreements, among other things, limit our ability to:

- incur additional debt;
- provide guarantees in respect of obligations of other persons;
- issue redeemable stock and preferred stock;
- pay dividends or distributions or redeem or repurchase capital stock;
- make loans, investments and capital expenditures;
- enter into transactions with affiliates;
- create or incur liens;
- make distributions from our subsidiaries;
- sell assets and capital stock of our subsidiaries;
- make acquisitions; and
- consolidate or merge with or into, or sell substantially all of our assets to, another person.

A breach of the covenants or restrictions could result in a default under the applicable agreements that govern our indebtedness. Such default may preclude us from drawing from our senior secured credit facility (the "Credit Facility") or allow the creditors to accelerate the related debt and may result in the acceleration of any other debt that we may incur to which a cross acceleration or cross-default provision applies. In the event our lenders accelerate the repayment of our borrowings, we cannot assure that we and our subsidiaries would have sufficient assets to repay such indebtedness.

Loss of available financing or an inability to renew, repay or refinance our debt could have an adverse effect on our financial condition and results of operations.

At December 31, 2018, our available credit under the Credit Facility was $187.7 million. If our cash on hand is insufficient, or we are unable to generate sufficient cash flows in the future, to cover our cash flow and liquidity needs and service our debt, we may be required to seek additional sources of funds, including refinancing all or a portion of our existing or future debt,

incurring additional debt to maintain sufficient cash flow to fund our ongoing operating needs, pay interest and fund anticipated expenditures. In addition, the Credit Facility matures on August 2, 2019. There can be no assurance that any refinancing will be possible or that any additional financing could be obtained on acceptable terms. If we are unable to obtain additional financing, we may (i) be unable to satisfy our obligations under our outstanding indebtedness, (ii) be unable to pursue future business opportunities or fund acquisitions, (iii) find it more difficult to fund future operating costs, tax payments or general corporate expenditures and (iv) become vulnerable to adverse general economic, capital markets and industry conditions. Any of these circumstances could have a material adverse effect on our financial position, liquidity and results of operations.

We may incur substantial additional indebtedness in the future, which could impair our financial condition.

We may incur substantial additional indebtedness in the future to fund activities including but not limited to share repurchases, acquisitions, cash dividends and business expansion. Any existing and future indebtedness increases the risk that we may be unable to generate cash sufficient to pay amounts due in respect of such indebtedness. Future substantial indebtedness could have other important consequences on our business. For example, it could:

- make it more difficult for us to satisfy our obligations;
- make it more difficult to renew or enter into new contracts with existing and potential future clients;
- limit our ability to borrow additional amounts to fund working capital, capital expenditures, debt service requirements, execution of our business strategy or acquisitions and other purposes;
- require us to dedicate a substantial portion of our cash flow from operations to pay principal and interest on our debt, which would reduce the funds available to us for other purposes;
- restrict our ability to dispose of assets and use the proceeds from any such dispositions;
- restrict our ability to raise debt or equity capital to be used to repay other indebtedness when it becomes due;
- make us more vulnerable to adverse changes in general economic, industry and competitive conditions, as well as in government regulation and to our business;
- expose us to risks inherent in interest rate fluctuations because some of our borrowings are at variable rates of interest, which could result in higher interest expense in the event of increases in interest rates; and
- make it more difficult to satisfy our financial obligations.

Our ability to satisfy and manage our debt obligations depends on our ability to generate cash flow and on overall financial market conditions. To some extent, this is subject to prevailing economic and competitive conditions and to certain financial, business and other factors, many of which are beyond our control. Our business may not generate sufficient cash flow from operations to permit us to pay principal, premium, if any, or interest on our debt obligations. If we are unable to generate sufficient cash flow from operations to service our debt obligations and meet our other cash needs, we may be forced to reduce or delay capital expenditures, sell or curtail assets or operations, seek additional capital, or seek to restructure or refinance our indebtedness. If we must sell or curtail our assets or operations, it may negatively affect our ability to generate revenue.

Risks Related to Our Capital Stock

Our annual operating results and stock price may be volatile or may decline significantly regardless of our operating performance.

Our annual operating results and the market price for our Common Stock may fluctuate significantly in response to a number of factors, many of which we cannot control, including:

- changes in rates or coverage for services by payors;
- changes in Medicaid, Medicare or other U.S. federal or state rules, regulations or policies;
- market conditions or trends in our industry or the economy as a whole;
- increased competition in any of our segments, including through insourcing of services by our clients and new entrants to the market;
- other events or factors, including those resulting from war, incidents of terrorism, natural disasters or responses to these events;
- changes in tax law; and
- changes in accounting principles.

In addition, the stock markets, and in particular, NASDAQ, have experienced considerable price and volume fluctuations that have affected and continue to affect the market prices of equity securities of many companies. In the past, stockholders have instituted securities class action litigation following periods of market volatility. If we become involved in securities litigation, we could incur substantial costs, and our resources and the attention of management could be diverted from our business.

The Company depends on its subsidiaries for cash to fund all of its operations and expenses, including to make future dividend payments, if any.

Our operations are conducted entirely through our subsidiaries and our ability to generate cash to fund all of our operations and expenses, to pay dividends or to meet any debt service obligations is highly dependent on the earnings and the receipt of funds from our subsidiaries via dividends or intercompany loans. We do not currently expect to declare or pay dividends on our Common Stock for the foreseeable future; however, to the extent that we determine in the future to pay dividends on our Common Stock, none of our subsidiaries will be obligated to make funds available to us for the payment of dividends. Further, the agreement governing our Credit Agreement significantly restricts the ability of our subsidiaries to pay dividends, make loans or otherwise transfer assets to us. In addition, Delaware law may impose requirements that may restrict our ability to pay dividends to holders of our Common Stock.

If securities or industry analysts do not publish research or publish misleading or unfavorable research about our business, our stock price and trading volume could decline.

The trading market for our Common Stock will depend in part on the research and reports that securities or industry analysts publish about us or our business. If one or more analysts downgrade our stock or publish misleading or unfavorable research about our business, our stock price would likely decline. If one or more of these analysts ceases coverage of our company or fails to publish reports on us regularly, demand for our stock could decrease, which could cause our stock price or trading volume to decline.

Future sales of shares by existing stockholders could cause our stock price to decline.

Sales of substantial amounts of our Common Stock in the public market, or the perception that these sales could occur, could cause the market price of our Common Stock to decline. As of February 22, 2019, we had 12,833,846 outstanding shares of Common Stock which are freely transferable without restriction or further registration under the Securities Act, unless held by or purchased by our "affiliates" as that term is defined in Rule 144 under the Securities Act. Shares of our Common Stock held by or purchased by our affiliates are restricted securities within the meaning of Rule 144 under the Securities Act, but will be eligible for resale subject to applicable volume, means of sale, holding period and other limitations of Rule 144 under the Securities Act.

As of December 31, 2018, shares of our Preferred Stock were convertible into 2,010,045 shares of Common Stock. On May 5, 2018, we filed a registration statement under the Securities Act relating to (i) 3,574,300 shares of Common Stock, consisting of 1,653,755 shares of Common Stock and 1,920,545 shares of Common Stock issuable upon the conversion of shares of Preferred Stock and (ii) 765,916 shares of Preferred Stock, for the sale by Coliseum Capital Co-Invest, L.P., Coliseum Capital Partners, L.P., Coliseum Capital Partners II, L.P. and Blackwell Partners, LLC - Series A (collectively, the "Coliseum Stockholders") of such securities, which was declared effective on June 15, 2018.

In August 2016, we filed a registration statement under the Securities Act to register additional shares of Common Stock to be issued under our equity compensation plans and, as a result, all shares of Common Stock acquired upon exercise of stock options granted under our plans will also be freely tradable under the Securities Act, unless purchased by our affiliates. As of December 31, 2018, there were stock options outstanding to purchase a total of 908,588 shares of our Common Stock and there were 52,131 shares of our Common Stock subject to restricted stock awards. In addition, 1,356,820 shares of our Common Stock are reserved for future issuances under the plan.

The terms of our Preferred Stock contain restrictive covenants that may impair our ability to conduct business and we may not be able to maintain compliance with the obligations under our outstanding Preferred Stock which could have a material adverse effect on our future results of operations and our stock price.

On February 11, 2015 and March 12, 2015, we issued $65.5 million and $15.8 million, respectively, of Preferred Stock. The terms of the Preferred Stock require us to pay mandatory quarterly dividends, either in cash or through an increase in the stated principal value of such stock. Our ability to satisfy and manage our obligations under our outstanding Preferred Stock depends, in part, on our ability to generate cash flow and on overall financial market conditions. Additionally, the terms of our Preferred Stock contain operating and financial covenants that limit management's discretion with respect to certain business matters. Among other things, these covenants, subject to certain limitations and exceptions, restrict our ability to incur additional debt, sell or otherwise dispose of our assets, make acquisitions, and merge or consolidate with other entities. As a result of these covenants and restrictions, we may be limited in how we conduct our business, which could have a material adverse effect on our future results of operations and our stock price.

Future offerings of debt or equity securities that would rank senior to our Common Stock, may adversely affect the market price of our Common Stock.

If, in the future, we decide to issue debt or equity securities that rank senior to our Common Stock, it is likely that such securities will be governed by an indenture or other instrument containing covenants restricting our operating flexibility. Additionally, any convertible or exchangeable securities that we issue in the future may have rights, preferences and privileges more favorable than those of our Common Stock and may result in dilution to owners of our Common Stock. We and, indirectly, our stockholders, will bear the cost of issuing and servicing such securities. Because our decision to issue debt or equity securities in any future offering will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing or nature of our future offerings. Thus, holders of our Common Stock will bear the risk of our future offerings reducing the market price of our Common Stock and diluting the value of their stock holdings in us.

Fulfilling our obligations incident to being a public company, including with respect to the requirements of and related rules under the Sarbanes-Oxley Act of 2002, is expensive and time-consuming, and any delays or difficulties in satisfying these obligations could have a material adverse effect on our future results of operations and our stock price.

We are subject to the reporting and corporate governance requirements, under the listing standards of NASDAQ and the Sarbanes-Oxley Act of 2002 (the "Sarbanes-Oxley Act"), that apply to issuers of listed equity, which impose certain significant compliance costs and obligations upon us. Being a publicly listed company requires a significant commitment of additional resources and management oversight resulting in increased operating costs. These requirements also place additional demands on our finance and accounting staff and on our financial accounting and information systems. Other expenses associated with being a public company include increases in auditing, accounting and legal fees and expenses, investor relations expenses, increased directors' fees and director and officer liability insurance costs, registrar and transfer agent fees and listing fees, as well as other expenses. As a public company, we are required, among other things, to define and expand the roles and the duties of our Board of Directors ("Board") and its committees and institute more comprehensive compliance and investor relations functions.

If we fail to maintain effective internal control over financial reporting in the future, the accuracy and timing of our financial reporting may be adversely affected. Preparing our consolidated financial statements involves a number of complex manual and automated processes, which are dependent upon individual data input or review and require significant management judgment. One or more of these elements may result in errors that may not be detected and could result in a material misstatement of our consolidated financial statements. If a material misstatement occurs in the future, we may fail to meet our future reporting obligations. For example, we may fail to file periodic reports in a timely manner or may need to restate our financial results, either of which may cause the price of our Common Stock to decline.

If the accounting estimates we make, and the assumptions on which we rely, in preparing our financial statements prove inaccurate, our actual results may be adversely affected.

Our financial statements have been prepared in accordance with GAAP. The preparation of these financial statements requires us to make estimates and judgments about, among other things, taxes, revenue recognition, contingent obligations, NET Services transportation expense, recoverability of long-lived assets and doubtful accounts. In addition, the implementation of ASU No. 2014-09, Revenue from Contracts with Customers (Topic 606), which was effective for the Company beginning January 1, 2018, required a significant level of judgment and estimation. These estimates and judgments affect the reported amounts of our assets, liabilities, revenue and expenses, the amounts of charges accrued by us, and related disclosure of contingent assets and liabilities. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances and at the time they are made. If our estimates or the assumptions underlying them are not correct, we may need to accrue additional charges or reduce the value of assets that could adversely affect our results of operations, leading to a loss in investor confidence in our ability to manage our business and our stock price could decline.

Anti-takeover provisions in our second amended and restated certificate of incorporation and amended and restated by-laws could discourage, delay or prevent a change of control of our company and may affect the trading price of our Common Stock.

Our second amended and restated certificate of incorporation and amended and restated bylaws include a number of provisions that may be deemed to have anti-takeover effects, including provisions governing when and by whom special meetings of our stockholders may be called, and provisions that may discourage, delay or prevent a change in our management or control over us that stockholders may consider favorable. In addition, in the event of certain change of control transactions, holders of Preferred Stock may be entitled under the governing certificate of designations to be paid both (i) the liquidation preference per share then in effect plus certain unpaid dividends and (ii) a pro rata portion of the transaction consideration on an as-converted

basis. As a result of these provisions, holders of our Common Stock may not receive the full benefit of any premium to the market price of our Common Stock offered by a bidder in a takeover context.

Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our Common Stock if the provisions are viewed as discouraging takeover attempts in the future. Our second amended and restated certificate of incorporation and amended and restated by-laws may also make it difficult for stockholders to replace or remove our management. These provisions may facilitate management entrenchment that may delay, deter, render more difficult or prevent a change in our control, which may not be in the best interests of our stockholders.

We do not expect to pay dividends on our Common Stock and, consequently, your ability to achieve a return on your investment will depend on appreciation in the price of our Common Stock.

We currently do not expect to declare and pay dividends on our Common Stock for the foreseeable future. We currently intend to invest our future earnings, if any, to fund our growth, to develop our business, for working capital needs and for general corporate purposes. Therefore, you are not likely to receive any dividends on your Common Stock for the foreseeable future and the success of an investment in shares of our Common Stock will depend upon any future appreciation in their value. There is no guarantee that shares of our Common Stock will appreciate in value or even maintain the price at which stockholders have purchased their shares.

Item 1B. ***Unresolved Staff Comments.***

None.

Item 2. ***Properties.***

Our principal executive office is located in Stamford, Connecticut. As of February 22, 2019, we leased space in approximately 40 locations. The lease terms vary and we believe are generally at market rates. We believe that our properties are adequate for our current business needs, and believe that we can obtain adequate space, if needed, to meet our foreseeable business needs.

Item 3. ***Legal Proceedings.***

From time-to-time, we may become involved in legal proceedings arising in the ordinary course of our business. We cannot predict with certainty the potential for or outcome of any future litigation. Regardless of the outcome of any particular litigation and the merits of any particular claim, litigation can have a material adverse impact on our company due to, among other reasons, any injunctive relief granted which could inhibit our ability to operate our business, amounts paid as damages or in settlement of any such matter, diversion of management resources and defense costs.

On January 21, 2019, the United States District Court for the Southern District of Ohio unsealed a qui tam complaint, filed in December 2015, against Mobile Care Group, Inc., Mobile Care Group of Ohio, LLC, Mobile Care EMS & Transport, Inc. and LogistiCare Solutions, LLC ("LogistiCare") by the relators Brandee White, Laura Cunningham, and Jeffery Wisier (the "Relators") alleging violations of the federal False Claims Act by presenting claims for payment to government healthcare programs knowing that the prerequisites for such claims to be paid had not been met. The Relators seek to recover damages, fees and costs under the federal False Claims Act including treble damages, civil penalties and attorneys' fees. In addition, the Relators seek reinstatement to their jobs with the Mobile Care entities. None of the Relators was employed by LogistiCare. Prior to January 21, 2019, LogistiCare had no knowledge of the complaint. The federal government has declined to intervene against LogistiCare. The Company intends to defend the litigation vigorously and believes that the case will not have a material adverse effect on its business, financial condition or results of operations.

Item 4. ***Mine Safety Disclosures.***

Not applicable.

PART II

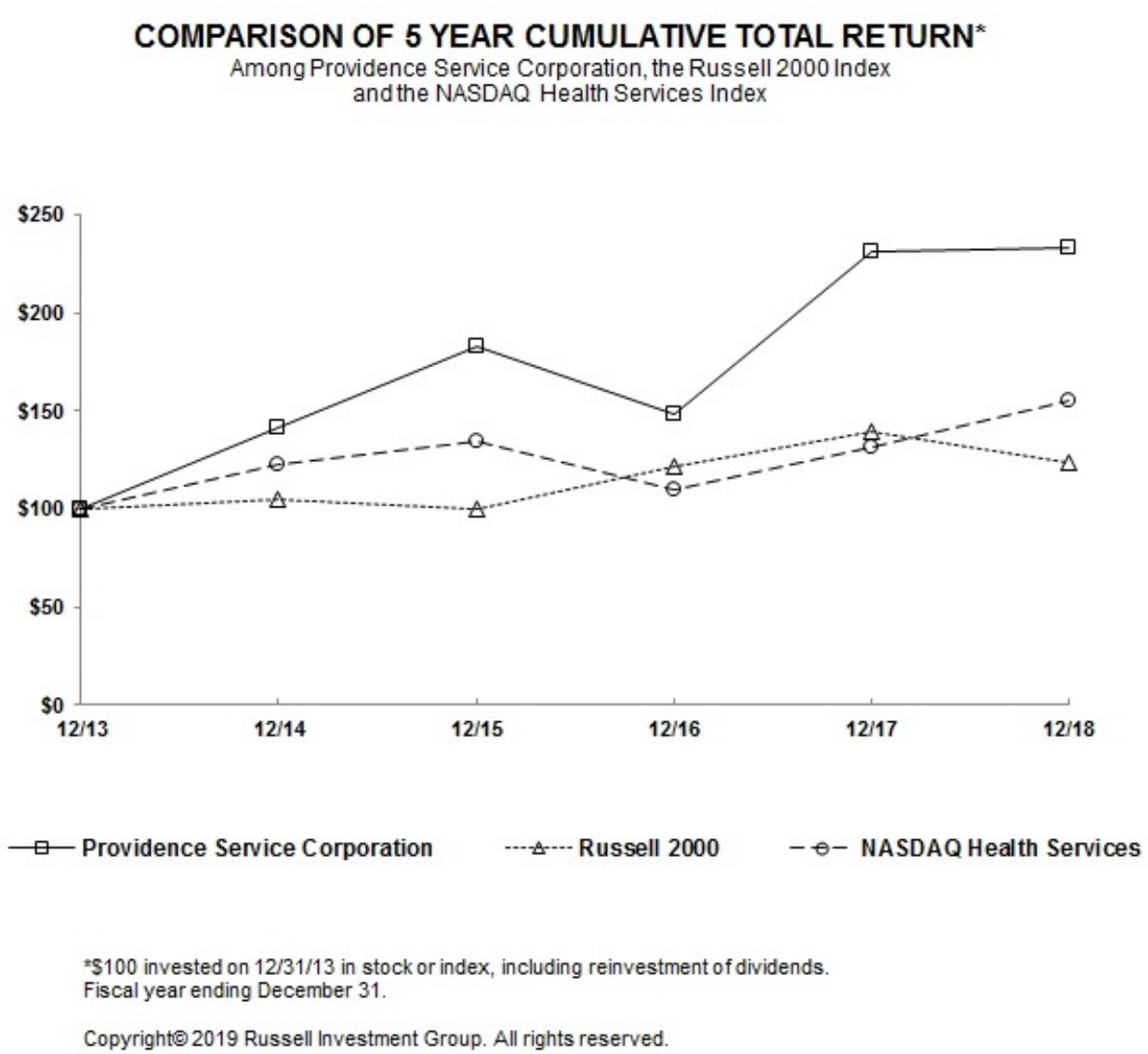
Item 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.***

Market for our Common Stock

Our Common Stock, our only class of common equity, has been quoted on NASDAQ under the symbol "PRSC" since August 19, 2003. Prior to that time there was no public market for our Common Stock. As of February 22, 2019, there were 26 holders of record of our Common Stock.

Stock Performance Graph

The following graph shows a comparison of the cumulative total return for our Common Stock, NASDAQ Health Services Index and Russell 2000 Index assuming an investment of $100 in each on December 31, 2013.



Dividends

We have not paid any cash dividends on our Common Stock and currently do not expect to pay dividends on our Common Stock. In addition, our ability to pay dividends on our Common Stock is limited by the terms of our Credit Agreement and our Preferred Stock. The payment of future cash dividends, if any, will be reviewed periodically by the Board and will depend upon,

among other things, our financial condition, funds from operations, the level of our capital and development expenditures, any restrictions imposed by present or future debt or equity instruments, and changes in federal tax policies, if any.

Issuer Purchases of Equity Securities

Period	Total Number of Shares of Common Stock Purchased (1)	Average Price Paid per Share	Total Number of Shares of Common Stock Purchased as Part of Publicly Announced Program (2)	Maximum Dollar Value of Shares of Common Stock that May Yet Be Purchased Under Program (2) (in thousands)
Fourth quarter:				
October 1, 2018 to October 31, 2018	—	$ —	—	$ 81,177
November 1, 2018 to November 30, 2018	226	$ 67.66	—	$ 81,177
December 1, 2018 to December 31, 2018	968	$ 65.70	—	$ 81,177
Total	1,194	$ 66.07	—	

(1) Includes shares that were acquired from employees in connection with the settlement of income tax and related benefit withholding obligations arising from vesting in restricted stock awards.

(2) On October 26, 2016, our Board authorized a new repurchase program, under which the Company may repurchase up to $100.0 million in aggregate value of the Company's Common Stock during the twelve-month period following October 26, 2016. Through October 26, 2017, a total of 770,808 shares were purchased through this plan for $30.4 million, excluding commission payments.

On November 2, 2017, our Board approved the extension of the Company's prior stock repurchase program, authorizing the Company to engage in a repurchase program to repurchase up to $69.6 million (the amount remaining from the $100.0 million repurchase amount authorized in 2016) in aggregate value of our Common Stock through December 31, 2018. Subsequently, on March 29, 2018, the Board authorized an increase in the amount available for stock repurchases under the Company's existing stock repurchase program by $77.8 million, and extended the existing stock repurchase program through June 30, 2019. Purchases under the repurchase program may be made from time-to-time through a combination of open market repurchases (including Rule 10b5-1 plans), privately negotiated transactions, and accelerated share repurchase transactions, at the discretion of the Company's officers, and as permitted by securities laws, covenants under existing bank agreements, and other legal requirements. As of December 31, 2018, a total of 1,018,989 shares were purchased through the extended plan approved on November 2, 2017, for $66.3 million, excluding commission payments. For additional information, see Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations – Liquidity and Capital Resources".

Item 6. ***Selected Financial Data.***

We have derived the following selected financial data from the consolidated financial statements and related notes. The information set forth below is not necessarily indicative of future results. This information should be read in conjunction with our consolidated financial statements and the related notes, and Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations", all of which are included elsewhere in this Annual Report on Form 10-K.

Significant transactions which occurred during the periods presented include the acquisition of Ingeus effective May 30, 2014, which primarily comprised our WD Services segment; the investment in Mission Providence, a joint venture in Australia, which commenced operations in 2014 but was sold on September 29, 2017; our equity interest in Matrix effective October 19, 2016, which was originally acquired on October 23, 2014, comprised our HA Services segment through October 19, 2016; and the acquisition of Circulation effective September 21, 2018, which is included in our NET Services segment. The operations of HA Services, Human Services, which was sold effective November 1, 2015, and WD Services, which was sold effective December 21, 2018, have been presented as discontinued operations for all periods presented.

	Year Ended December 31,				
	2018	2017	2016	2015	2014
	(1)(2)(3)(4)(11)	(5)(6)(7)(8)(11)	(7)(9)(11)	(10)	(12)
	(dollars and shares in thousands, except per share data)				
Statement of operations data:					
Service revenue, net	$ 1,384,965	$ 1,318,220	$ 1,233,842	$ 1,082,951	$ 884,117
Operating expenses:					
Service expense	1,284,603	1,223,627	1,131,963	987,352	803,681
General and administrative expense	46,098	43,491	39,527	40,598	45,566
Asset impairment charge	14,175	—	1,415	—	—
Depreciation and amortization	15,813	13,618	12,780	10,221	8,808
Total operating expenses	1,360,689	1,280,736	1,185,685	1,038,171	858,055
Operating income	24,276	37,484	48,157	44,780	26,062
Non-operating expense:					
Interest expense, net	1,783	1,204	1,515	2,312	10,472
Other income	—	(5,363)	—	—	—
Equity in net loss (gain) of investees	6,158	(13,445)	1,789	—	—
Gain on measurement of cost method investment	(6,577)	—	—	—	—
Income from continuing operations, before income taxes	22,912	55,088	44,853	42,468	15,590
Provision for income taxes	4,684	4,003	17,972	15,718	8,053
Income from continuing operations, net of tax	18,228	51,085	26,881	26,750	7,537
(Loss) income from discontinued operations, net of tax	(37,053)	2,735	62,965	56,444	12,738
Net (loss) income	(18,825)	53,820	89,846	83,194	20,275
Net (gain) loss from discontinued operations attributable to noncontrolling interests	(156)	(451)	2,082	502	—
Net (loss) income attributable to Providence	$ (18,981)	$ 53,369	$ 91,928	$ 83,696	$ 20,275
Diluted (loss) earnings per common share:					
Continuing operations	$ 0.92	$ 2.97	$ 1.34	$ 1.22	$ 0.50
Discontinued operations	(2.86)	0.15	3.87	3.18	0.85
Total	$ (1.94)	$ 3.12	$ 5.21	$ 4.40	$ 1.35
Weighted-average number of common shares outstanding:					

Diluted	13,033	13,673	14,779	16,116	15,019

	As of December 31,				
	2018	2017	2016	2015	2014
	(2)(3)(11)		(9)		
	(dollars in thousands)				
Balance sheet data:					
Cash and cash equivalents	$ 5,678	$ 52,798	$ 72,262	$ 79,756	$ 121,538
Total assets	572,246	704,090	685,279	1,050,202	1,168,934
Long-term obligations, including current portion	1,071	2,984	3,611	300,071	574,613
Other liabilities	182,785	287,543	306,428	382,423	372,907
Convertible preferred stock	77,392	77,546	77,565	77,576	—
Total stockholders' equity	310,998	336,017	297,675	290,132	221,414

(1) General and administrative expense for the year ended December 31, 2018 includes $1.7 million in acquisition costs related to the acquisition of Circulation and $8.4 million in restructuring and related costs related to the Organizational Consolidation.

(2) In conjunction with the acquisition of Circulation and an analysis of the technology capabilities and scalability of the Circulation platform, we determined we would not continue the development of our NextGen technology. We also determined we would not place any of the developed NextGen technology into service, and recorded an asset impairment charge of $13.5 million related to our NET Services segment during the fourth quarter of 2018. In addition, we had previously recorded an impairment charge of $0.7 million during the second quarter of 2018 in relation to the decision to abandon specific development work intended to synchronize data across applications of the proprietary NextGen systems, based on the determination of an alternative method to accomplish this task.

(3) On September 21, 2018, we acquired all of the outstanding equity of Circulation. The purchase price was comprised of cash consideration of $45.1 million paid to Circulation's equity holders (including holders of vested Circulation stock options), other than Providence. Our initial investment in Circulation was $3.0 million. As a result of the transaction, the fair value of this pre-acquisition interest increased to $9.6 million, and thus we recognized a gain of $6.6 million.

(4) On December 21, 2018, we completed the sale of our WD Services segment. Included in (loss) income from discontinued operations, net of tax, for 2018 is a loss, net of tax, on the WD Services sale of $1.1 million. We additionally sold our Ingeus France operations, effective July 17, 2018 and recorded a loss on the sale of $0.7 million. We also incurred an impairment charge of $9.2 million for the adjustment of the carrying value of the assets and liabilities of Ingeus France to its estimated fair value when it was initially recorded as held for sale during 2018, which is included in (loss) income from discontinued operations, net of tax.

(5) Other income for the year ended December 31, 2017 includes the receipt of the Haverhill Litigation settlement of $5.4 million. See further information on the Haverhill Litigation in Note 20, *Commitments and Contingencies,* in the accompanying consolidated financial statements.

(6) (Loss) income from discontinued operations, net of tax, for the year ended December 31, 2017 includes a gain on sale of equity investment of $12.4 million related to the sale of the Company's equity interest in Mission Providence. The investment in Mission Providence was part of the WD Services segment.

(7) (Loss) income from discontinued operations, net of tax, for the years ended December 31, 2017 and 2016 include losses of $6.0 million and $5.6 million, respectively, related to potential indemnification claims for our historical Human Services segment.

(8) The year ended December 31, 2017 includes a net tax benefit of $15.9 million related to the enactment of the Tax Reform Act (as defined below) during the fourth quarter of 2017 due to the re-measurement of deferred tax liabilities by Providence as a result of the reduction in the U.S. corporate tax rate. Providence realized a benefit of $19.3 million, partially offset by $3.4 million of increased tax expense resulting from additional equity in net gain of Matrix, due to Matrix's re-measurement of its deferred tax liabilities. In addition, the tax provision was adversely impacted by tax expense of $3.6 million related to the Company's 2015 Holding Company LTI Program (the "HoldCo LTIP"), for which expense was incurred for financial

reporting purposes, but no shares were issued due to the market condition of the award not being satisfied and thus no tax deduction was realized.

(9) On October 19, 2016, we completed the Matrix Transaction. Included in (loss) income from discontinued operations, net of tax, for 2016 is a gain on the transaction, net of tax, totaling $109.4 million. In conjunction with the completion of this transaction, we fully repaid the amounts outstanding on our term loans and Credit Facility in 2016.

(10) On November 1, 2015, we completed the sale of our Human Services segment. Included in (loss) income from discontinued operations, net of tax, for 2015 is a gain on the sale of the Human Services segment, net of tax, totaling $100.3 million.

(11) Equity in net (gain) loss of investees relates to Matrix, which became an equity investment upon the completion of the Matrix Transaction. We recorded $6.2 million in equity in net loss of investees and $13.4 million in equity in net gain of investees in 2018 and 2017, respectively. We recorded $1.8 million in equity in net loss of investees for the period of October 19, 2016 through December 31, 2016. The equity in net gain from Matrix for the year ended December 31, 2017 includes a benefit of $13.6 million related to the re-measurement of deferred tax liabilities arising from a lower U.S. corporate tax rate as a result of the Tax Reform Act. As a result of the increased equity income, Providence incurred higher tax expense of $3.4 million, which is reflected as a component of “Provision for income taxes” in the table above. The investment in Matrix at December 31, 2018 of $161.5 million is included in “Equity investments” in our consolidated balance sheet.

(12) 2014 includes $4.5 million of financing fees that were deferred and fully expensed within interest expense in the fourth quarter of 2014 in relation to bridge financing commitments and $3.0 million of third-party financing fees that are included in general and administrative expense.

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with Item 6. "Selected Financial Data" and our consolidated financial statements and related notes included in Item 8. "Financial Statements and Supplementary Data" of this report. This discussion and analysis contains forward-looking statements that involve risks, uncertainties and other factors that may cause actual results to differ materially from those projected in any forward-looking statements, as discussed in "Disclosure Regarding Forward-Looking Statements". These risks and uncertainties include but are not limited to those set forth in Item 1A. "Risk Factors".

Overview of Our Business

Please refer to *Item 1. "Business"* of this Annual Report on Form 10-K for a discussion of our services and corporate strategy.

We own subsidiaries and investments primarily engaged in the provision of healthcare services in the United States. Our NET Services segment, which primarily operates under the brands LogistiCare and Circulation, is the largest manager of NET programs for state governments and MCOs in the United States. On September 21, 2018, we completed the acquisition of Circulation, which offers a full suite of logistics solutions to manage NET programs across all areas of healthcare, powered by its HIPAA-compliant digital platform. Circulation's technology expands LogistiCare's capabilities to manage transportation benefits, integrating all transportation capabilities while proactively monitoring for fraud waste and abuse and emphasizing member convenience and satisfaction.

Our Matrix Investment segment consists of a minority investment in Matrix, a nationwide provider of home and mobile-based healthcare services for health plans in the United States, including CHAs, quality gap closure visits, "level of service" needs assessments, and post-acute and chronic care management, providing such services through a network of community-based clinicians and a fleet of mobile health clinics with advanced diagnostics capabilities.

Our Corporate and Other segment includes the Company's executive, accounting, finance, internal audit, tax, legal, public reporting, and corporate development functions, as well as the results of the Company's captive insurance company. On April 11, 2018, the Company announced the Organizational Consolidation. LogistiCare will retain its name and continue to be headquartered in Atlanta, GA, and the Company will continue to be named The Providence Service Corporation and be listed on NASDAQ under the ticker symbol "PRSC". The Organizational Consolidation is expected to be complete by the second quarter of 2019.

Business Outlook and Trends

Our performance is affected by a number of trends that drive the demand for our services. In particular, the markets in which we operate are exposed to various trends such as healthcare industry and demographic dynamics. Over the long term, we believe there are numerous factors that could affect growth within the industries in which we operate, including:

- an aging population, which will increase demand for healthcare services and transportation;
- a movement towards value-based versus fee for service care and budget pressure on governments, both of which may increase the use of private corporations to provide necessary and innovative services;
- increasing demand for in-home care provision, driven by cost pressures on traditional reimbursement models and technological advances enabling remote engagement;
- technological advancements, which may be utilized by us to improve service and lower costs, but also by others which may increase industry competitiveness; and
- proposals by the President of the United States and Congress to change the Medicaid program, including considering converting the Medicaid program to a block grant format or capping the federal contribution to state Medicaid programs to a fixed amount per beneficiary, and CMS' grant of waivers to states relative to the parameters of their Medicaid programs. Enactment of adverse legislation, regulation or agency guidance, or litigation challenges to ACA, state Medicaid programs, or other governmental programs may reduce the eligibility or demand for our services, our ability to conduct some or all of our business and/or reimbursement rates for services performed within our segments.

On December 21, 2018, the Company completed the WD Services Sale, except for the segment's employment services operations in Saudi Arabia. Our contractual counterparties in Saudi Arabia, including an entity owned by the Saudi Arabian government, assumed these operations beginning January 1, 2019. The total cash consideration from the sale was approximately $46.5 million, with the buyer retaining existing WD Services cash of $21.0 million. In addition to the purchase consideration, the

Company expects to be able to realize cash tax benefits of approximately $51.9 million as a result of the transaction, including approximately $34.3 million in tax refunds by the fourth quarter of 2019 in relation to its 2018 tax returns and loss carrybacks, which is inclusive of $0.6 million of tax that would have been otherwise due in the fourth quarter of 2018. The remaining cash tax benefit of $17.6 million is expected to be realized as an offset to tax payments over the following three years, based upon the Company's current estimate of taxable income. In addition, $1.1 million of benefits related to future capital loss is available, which amount was reserved as of December 31, 2018.

On September 21, 2018, the Company completed the acquisition of Circulation, which offers a full suite of logistics solutions to manage non-emergency transportation across all areas of healthcare, powered by its HIPAA-compliant digital platform. Circulation enables administration of transportation benefits, proactively monitors for fraud waste and abuse, and integrates all transportation capabilities, while emphasizing patient convenience and satisfaction. Circulation's proprietary platform simplifies ordering, improves reliability and efficiency, and reduces transportation spend. We believe the acquisition advances our central mission of reducing transportation as a barrier to healthcare, and will help deliver a differentiated user experience and provide a core technology and analytics platform that better positions us for growth. Following the acquisition and an analysis of the technology capabilities and scalability of the Circulation platform, we determined we will utilize the Circulation platform to service our legacy and new contracts, which resulted in an impairment charge of $13.5 million to NextGen. See further information on the impairment in Note 7, *Property and Equipment,* in the accompanying consolidated financial statements. Also, in connection with the acquisition of Circulation, the Company established a management incentive plan ("MIP"), whereby certain key employees of Circulation may be entitled to cash payments if certain financial measures are met based upon cumulative NET Services EBITDA; less the assumption of former Corporate and Other segment costs; less cumulative CAPEX ("MIP Financial Performance") for the performance period January 1, 2019 to December 31, 2021 as compared to the baseline, as determined by the Board. To the extent amounts are earned, the payout date is within 30 days following the finalization of the Company's audited financial statements for the fiscal year ending December 31, 2021. Payout is subject to the participant remaining employed by the Company through December 31, 2021. The amount that can be earned through the MIP ranges from $12.5 million to $237.5 million, based on a range of value of the MIP Financial Performance of $272.5 million to $395.5 million. As of December 31, 2018, the Company has accrued $1.4 million, reflected in "Other long-term liabilities" in the consolidated balance sheet, towards its estimate of the expected payout under the MIP.

On June 11, 2018, the Company entered into a Share Purchase Agreement to sell the shares of Ingeus France for a de minimis amount. The sale was effective on July 17, 2018, after court approval. As a result, an impairment charge of $9.2 million was recorded during the year ended December 31, 2018, and a loss, primarily related to the release of the effects of historic cumulative translation adjustments, of $0.7 million was recorded during the year ended December 31, 2018.

Revenues and Expenses

NET Services

NET Services primarily contracts with state Medicaid agencies and MCOs for the coordination of their members' non-emergency transportation needs. Most contracts are capitated, which means we are paid on a per-member, per-month basis for each eligible member. For most contracts, we arrange for transportation of members through our network of independent transportation providers, whereby we negotiate rates and remit payment to the transportation providers. However, for certain contracts, we assume no risk for the transportation network, credentialing and/or payments to these providers. For these contracts, we only provide administrative management services to support the customers' efforts to serve its clients.

Classification of Operating Expenses

Our "Service expense" line item includes the majority of the operating expenses of NET Services as well as our captive insurance company, with the exception of certain costs which are classified as "General and administrative expense". Service expense also excludes asset impairment charges and depreciation and amortization expenses. In the discussion below, we present the breakdown of service expense by the following major categories: purchased services, payroll and related costs, other operating expenses and stock-based compensation. Purchased services include the amounts we pay to third-party service providers and are typically dependent upon service volume. Payroll and related costs include all personnel costs of our segments. Other operating expenses include general overhead costs, excluding facilities and related charges, of our segments. Stock-based compensation represents the stock-based compensation expense associated with stock grants to employees of our segments.

Our "General and administrative expense" primarily includes the operating expenses of our corporate office, excluding depreciation and amortization, as well as acquisition related charges and facility related charges of NET Services.

Critical Accounting Policies and Estimates

Critical accounting policies and estimates are those that we believe are important in the preparation of our consolidated financial statements because they require that we use judgment and estimates in applying those policies. We prepare our consolidated financial statements and accompanying notes in accordance with GAAP. Preparation of the consolidated financial statements and accompanying notes requires that we make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities as of the date of the consolidated financial statements as well as revenue and expenses during the periods reported. We base our estimates on historical experience, where applicable, and other assumptions that we believe are reasonable under the circumstances. Actual results may differ from our estimates under different assumptions or conditions.

There are certain critical estimates that we believe require significant judgment in the preparation of our consolidated financial statements. We consider an accounting estimate to be critical if:

- it requires us to make an assumption because information was not available at the time or it included matters that were highly uncertain at the time the estimate is made; and
- changes in the estimate or different estimates that could have been selected may have had a material impact on our financial condition or results of operations.

For more information on each of these policies, see Note 2, *Significant Accounting Policies and Recent Accounting Pronouncements*, to our consolidated financial statements. We discuss information about the nature and rationale for our critical accounting estimates below.

Accrued Transportation Costs

We accrue the cost of transportation expense within NET Services based on request for services and the amount we expect to be billed by transportation providers, as we generally only pay transportation providers for completed trips based upon documentation submitted after services have been provided. The transportation accrual requires significant judgment, as the accrual is based upon contractual rates and mileage estimates, as well as an estimated rate for unknown cancellations, as members may have requested transportation but not notified us of cancellation. Based upon historical experience and contract terms, we estimate the amount of expense incurred for invoices which have not yet been submitted as of period end. Actual expense could be greater or less than the amounts estimated due to changes in member or transportation provider behavior.

Business Combinations

We assign the value of the consideration transferred to acquire a business to the tangible assets and identifiable intangible assets acquired and liabilities assumed on the basis of their fair values at the date of acquisition. Any excess purchase price paid over the fair value of the net tangible and intangible assets acquired is allocated to goodwill. When determining the fair values of assets acquired and liabilities assumed, management makes significant estimates and assumptions, especially with respect to intangible assets. Critical estimates in valuing certain intangible assets include but are not limited to future expected cash flows from customer relationships, developed technology and trade names, and discount rates. Management's estimates of fair value are based upon assumptions believed to be reasonable, but which are inherently uncertain and unpredictable. As a result, actual results may differ significantly from estimates.

Recoverability of Goodwill and Definite-Lived Intangible Assets

Goodwill. In accordance with ASC 350, *Intangibles-Goodwill and Other*, we review goodwill for impairment annually, or more frequently, if events and circumstances indicate that an asset may be impaired. Such circumstances could include, but are not limited to: (1) the loss or modification of significant contracts, (2) a significant adverse change in legal factors or in business climate, (3) unanticipated competition, (4) an adverse action or assessment by a regulator, or (5) a significant decline in the Company's stock price. We perform the annual goodwill impairment test for all reporting units as of October 1.

First, we perform qualitative assessments for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If the qualitative assessment suggests that it is more likely than not that the fair value of a reporting unit is less than its carrying value amount, we then perform a quantitative assessment and compare the fair value of the reporting unit to its carrying value.

We adopted ASU No. 2017-04, *Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment* ("ASU 2017-04") effective April 1, 2017. ASU 2017-04 removes the requirement to compare the implied fair value of goodwill with its carrying amount as part of step two of the goodwill impairment test. Instead, if we deem it necessary to perform the quantitative goodwill impairment test in an annual or interim period, we recognize an impairment charge equal to the excess, if any, of a reporting unit's carrying amount over its fair value, not to exceed the total amount of goodwill allocated to the reporting unit.

Long-Lived Assets Including Intangibles. In accordance with ASC 360, *Property, Plant, and Equipment*, we review the carrying value of long-lived assets or groups of assets to be used in operations whenever events or changes in circumstances indicate that the carrying amount of the assets may be impaired. Factors that may necessitate an impairment assessment include, among others, significant adverse changes in the extent or manner in which an asset or group of assets is used, significant adverse changes in legal factors or the business climate that could affect the value of an asset or group of assets or significant declines in the observable market value of an asset or group of assets. The presence or occurrence of those events indicates that an asset or group of assets may be impaired. In those cases, we assess the recoverability of an asset or group of assets by determining whether the carrying value of the asset or group of assets exceeds the sum of the projected undiscounted cash flows expected to result from the use and eventual disposition of the assets over the remaining economic life of the asset or the primary asset in the group of assets. If such testing indicates the carrying value of the asset or group of assets is not recoverable, we estimate the fair value of the asset or group of assets using appropriate valuation methodologies, which would typically include an estimate of discounted cash flows. If the fair value of those assets or groups of assets is less than carrying value, we record an impairment loss equal to the excess of the carrying value over the estimated fair value.

The use of different estimates or assumptions in determining the fair value of our goodwill and intangible assets may result in different values for those assets, which could result in an impairment or, in the period in which an impairment is recognized, could result in a materially different impairment charge.

Income Taxes

We record income taxes under the liability method. Deferred tax assets and liabilities reflect our estimation of the future tax consequences of temporary differences between the carrying amounts of assets and liabilities for book and tax purposes. We determine deferred income taxes based on the differences in accounting methods and timing between financial statement and income tax reporting. Accordingly, we determine the deferred tax asset or liability for each temporary difference based on the enacted tax rates expected to be in effect when we realize the underlying items of income and expense. We consider many factors when assessing the likelihood of future realization of our deferred tax assets, including our recent earnings experience by jurisdiction, expectations of future taxable income, and the carryforward periods available to us for tax reporting purposes, as well as other relevant factors. We may establish a valuation allowance to reduce deferred tax assets to the amount we believe is more likely than not to be realized. Due to inherent complexities arising from the nature of our businesses, future changes in income tax law, tax sharing agreements or variances between our actual and anticipated operating results, we make certain judgments and estimates. Therefore, actual income taxes could materially vary from these estimates.

We record liabilities to address uncertain tax positions we have taken in previously filed tax returns or that we expect to take in a future tax return. The determination for required liabilities is based upon an analysis of each individual tax position, taking into consideration whether it is more likely than not that our tax position, based on technical merits, will be sustained upon examination. For those positions for which we conclude it is more likely than not it will be sustained, we recognize the largest amount of tax benefit that is greater than 50 percent likely of being realized upon ultimate settlement with the taxing authority. The difference between the amount recognized and the total tax position is recorded as a liability. The ultimate resolution of these tax positions may be greater or less than the liabilities recorded.

On December 22, 2017, the Tax Reform Act was enacted, which significantly changes U.S. tax law by, among other things, lowering corporate income tax rates, implementing a territorial tax system and imposing a repatriation tax on deemed repatriated earnings of foreign subsidiaries. The Tax Reform Act permanently reduces the U.S. corporate income tax rate from a maximum of 35% to a flat 21% rate, effective January 1, 2018. The Tax Reform Act also provides for a one-time deemed repatriation of post-1986 undistributed foreign subsidiary earnings and profits through the year ended December 31, 2017.

On December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118 ("SAB 118") to address the application of GAAP in situations when a registrant does not have the necessary information available, prepared, or analyzed (including computations) in reasonable detail to complete the accounting for certain income tax effects of the Tax Reform Act. We recognized the provisional tax impacts related to deemed repatriated earnings and the benefit for the revaluation of deferred tax assets and liabilities, and included these amounts in our consolidated financial statements for the year ended December 31, 2017. The financial

reporting impact of the Tax Reform Act was completed in the fourth quarter of 2018 and an additional benefit of $0.3 million was recorded.

Reinsurance and Self-Insurance Liabilities

We historically reinsured a substantial portion of our automobile, general and professional liability and workers' compensation costs under reinsurance programs through our wholly-owned subsidiary, Social Services Providers Captive Insurance Company ("SPCIC"), a licensed captive insurance company domiciled in the State of Arizona. In conjunction with the policy renewals on May 16, 2017, SPCIC did not renew the expiring policies. However, SPCIC continues to resolve claims under the historical policy years. In addition, under the current policies, the Company retains liability up to the policy deductibles. In addition, we maintain self-funded health insurance programs for employees with a stop-loss umbrella policy with a third-party insurer to limit the maximum potential liability for individual claims and for a maximum potential claim liability based on member enrollment. We utilize independent actuarial reports to determine the expected losses and in order to record the appropriate entries associated with our historical reinsurance programs, our retained exposure for the deductibles under our current policies, and self-funded health insurance programs. We regularly analyze our reserves for incurred but not reported claims, and for reported but not paid claims related to our reinsurance and self-funded insurance programs. We believe our reserves are adequate. However, significant judgment is involved in assessing these reserves such as evaluating historical paid claims, average lag times between the claims' incurred date, reported dates and paid dates, and the frequency and severity of claims. There may be differences between actual settlement amounts and recorded reserves and any resulting adjustments are recorded once a probable amount is known.

Revenue Recognition

NET Services provides non-emergency transportation services pursuant to contractual commitments over defined service delivery periods. For most contracts, NET Services arranges for transportation of members through its network of independent transportation providers, whereby it remits payment to the transportation providers. However, for certain contracts, NET Services only provides administrative management services to support the customers' efforts to serve its clients, and the amount of revenue recognized is based upon the management fee earned.

These contracts typically include single performance obligations under which NET Services stands ready to deliver management, fulfillment and record-keeping related to non-emergency transportation services. Transportation management services include, but are not limited to, fraud, waste, and abuse and utilization review programs as well as compliance controls. NET Services' performance obligations consist of a series of distinct services that are substantially the same and which are transferred to the customer in the same manner. In most cases, NET Services is the principal in its arrangements because it controls the services before transferring those services to the customer.

NET Services primarily uses the 'as invoiced' practical expedient to recognize revenue because it typically has the right to consideration from customers in an amount that corresponds directly with the value of its performance to date. This is consistent with NET Services' historical revenue recognition policy. NET Services recognizes revenue for some of its contracts that include variable consideration using a time-elapsed measure when the fees earned relate directly to services performed in the period. Because most contracts include termination for convenience clauses with required notice periods of less than one year, most NET Services contracts are deemed to be short-term in nature.

Some of NET Services' contracts include provisions whereby it must provide certain levels of service or face potential penalties or be required to refund fees paid by the customer. For those contracts, NET Services records a provision to reduce revenue to reflect the amount to which it expects it will ultimately be entitled.

Deferred Revenue

At times we may receive funding for certain services in advance of services being rendered. These amounts are reflected in the consolidated balance sheets as "Deferred revenue" until the services are rendered.

Stock-Based Compensation

Our primary forms of employee stock-based compensation are stock option awards and restricted stock awards, including certain awards which vest based upon performance conditions. We measure the value of stock option awards on the date of grant at fair value using the appropriate valuation techniques, including the Black-Scholes and Monte Carlo option-pricing models. We recognize the fair value as stock-based compensation expense on a straight-line basis over the requisite service period, which is typically the vesting period. The pricing models require various highly judgmental assumptions including volatility and expected option term. If any of the assumptions used in the models change significantly, stock-based compensation expense may differ materially in the future from that recorded in the current period. We do not record stock-based compensation expense net of

estimated forfeitures and the tax effects of awards are treated as discrete items in the period in which tax windfalls or shortfalls occur. See additional discussion included in Note 2, *Significant Accounting Policies and Recent Accounting Pronouncements*, to our consolidated financial statements.

Our tax rate is subject to quarterly volatility from the effects of stock award exercises and vesting activities, including the adverse impact on our income tax provision for awards which result in a tax deduction less than the amount recorded for financial reporting purposes based upon the fair value of the award at the grant date.

Restructuring, Redundancy and Related Reorganization Costs

We accrue for severance and other employee separation costs when it is probable that benefits would be paid and the amounts are reasonably estimable. The amounts used in determining severance accruals are based on an estimate of the salaries and related benefit costs payable and are included in accrued expenses to the extent they have not been paid.

Results of Operations

Segment reporting. Our operations are organized and reviewed by management along our segment lines. We operate in one principal business segment, NET Services. Our investment in Matrix is also a reportable segment referred to as the "Matrix Investment". Segment results are based on how our chief operating decision maker manages our business, makes operating decisions and evaluates operating performance. The operating results of our principal business segment include revenue and expenses incurred by the segment, as well as an allocation of direct expenses incurred by our corporate division on behalf of the segment, which primarily relate to insurance and stock-based compensation allocations. Indirect expenses, including unallocated corporate functions and expenses, such as executive, accounting, finance, internal audit, tax, legal, public reporting, certain strategic and corporate development functions and the results of the Company's captive insurance company and elimination entries recorded in consolidation are reflected in "Corporate and Other".

Discontinued operations. During the periods presented, the Company completed the following transactions, which resulted in the presentation of the operations as Discontinued Operations.

- On November 1, 2015, the Company completed the sale of its Human Services segment. In addition to the results through the sale date, the Company has recorded additional expenses related to legal proceedings related to an indemnified legal matter.

- On October 19, 2016, affiliates of Frazier Healthcare Partners purchased a 53.2% equity interest in Matrix with Providence retaining a 46.8% equity interest at the time of the transaction. Prior to the closing of the Matrix Transaction, the financial results of Matrix were included in the Company's HA Services segment.

- On December 21, 2018, the Company completed the sale of substantially all of the operating subsidiaries of its WD Services segment to APM and APM UK Holdings Limited, an affiliate of APM, except for the segment's employment services operations in Saudi Arabia. The Company's contractual counterparties in Saudi Arabia, including an entity owned by the Saudi Arabian government, assumed these operations beginning January 1, 2019. Additionally, on June 11, 2018, the Company entered into a Share Purchase Agreement to sell Ingeus France for a de minimis amount. The sale was effective on July 17, 2018, after court approval.

Year ended December 31, 2018 compared to year ended December 31, 2017

The following table sets forth results of operations and the percentage of consolidated total revenues represented by items in our consolidated statements of operations for 2018 and 2017 (in thousands):

	Year ended December 31,			
	2018		2017	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	1,384,965	100.0 %	1,318,220	100.0 %
Operating expenses:				
Service expense	1,284,603	92.8 %	1,223,627	92.8 %
General and administrative expense	46,098	3.3 %	43,491	3.3 %
Asset impairment charge	14,175	1.0 %	—	— %
Depreciation and amortization	15,813	1.1 %	13,618	1.0 %
Total operating expenses	1,360,689	98.2 %	1,280,736	97.2 %
Operating income	24,276	1.8 %	37,484	2.8 %
Non-operating expense:				
Interest expense, net	1,783	0.1 %	1,204	0.1 %
Other income	—	— %	(5,363)	(0.4)%
Equity in net loss (gain) of investees	6,158	0.4 %	(13,445)	(1.0)%
Gain on remeasurement of cost method investment	(6,577)	(0.5)%	—	— %
Income from continuing operations before income taxes	22,912	1.7 %	55,088	4.2 %
Provision for income taxes	4,684	0.3 %	4,003	0.3 %
Income from continuing operations	18,228	1.3 %	51,085	3.9 %
(Loss) income from discontinued operations, net of tax	(37,053)	(2.7)%	2,735	0.2 %
Net (loss) income	(18,825)	(1.4)%	53,820	4.1 %
Net (income) loss from discontinued operations attributable to noncontrolling interest	(156)	— %	(451)	— %
Net (loss) income attributable to Providence	(18,981)	(1.4)%	53,369	4.0 %

Service revenue, net. Consolidated service revenue, net for 2018 increased $66.7 million, or 5.1%, compared to 2017 due to an increase in revenue of NET Services.

Total operating expenses. Consolidated operating expenses for 2018 increased $80.0 million, or 6.2%, compared to 2017. Operating expenses for 2018 compared to 2017 included an increase in expenses attributable to NET Services of $76.0 million and Corporate and Other of $4.0 million. NET Services' operating expenses include asset impairment charges of $14.2 million for 2018.

Operating income. Consolidated operating income for 2018 decreased $13.2 million compared to 2017 due to an increase in the operating loss for Corporate and Other of $4.0 million in 2018 as compared to 2017, and a decrease in operating income of NET Services in 2018 as compared to 2017 of $9.3 million.

Interest expense, net. Consolidated interest expense, net for 2018 increased $0.6 million, or 48.1%, compared to 2017, and remained consistent as a percentage of revenue. The increase was attributable to borrowings on the revolving line of credit during the second half of 2018 used to fund the Circulation acquisition, which were repaid as of December 31, 2018.

Other income. Other income in 2017 of $5.4 million represents the settlement received from the Haverhill Litigation.

Equity in net (gain) loss of investees. Our equity in net (gain) loss of investees for 2018 of $6.2 million represents equity in net loss for Matrix. Our equity in net gain of investees for 2017 of $13.4 million represents equity in net gain for Matrix. We began reporting Matrix as an equity investment effective October 19, 2016, upon the completion of the Matrix Transaction, and we record our ownership percentage of Matrix's profit or loss in net loss or gain of investees. Included in Matrix's 2018 full standalone net loss of $20.0 million (which is not consolidated with Providence's) are depreciation and amortization of $43.1 million, interest expense of $25.9 million, integration related costs of $6.5 million, equity compensation of $2.7 million, management fees paid to Matrix's shareholders of $4.9 million, merger and acquisition diligence related costs of $2.3 million and income tax benefit of $7.2 million. Included in Matrix's 2017 full standalone net income of $26.7 million (which is not consolidated with Providence's) are depreciation and amortization of $33.5 million, interest expense of $14.8 million, transaction bonuses and other transaction related costs of $3.5 million, equity compensation of $2.6 million, management fees paid to Matrix's shareholders of $2.3 million and income tax benefit of $29.6 million. Matrix's significant income tax benefit in 2017 primarily related to the re-measurement of deferred tax liabilities arising from a lower U.S. corporate tax rate as a result of the Tax Reform Act.

Gain on remeasurement of cost method investment. On September 21, 2018, we acquired all of the outstanding equity of Circulation. The purchase price was comprised of cash consideration of $45.1 million paid to Circulation's equity holders (including holders of vested Circulation stock options), other than Providence. Our initial investment in Circulation was $3.0 million. As a result of the transaction, the fair value of this pre-acquisition interest increased to $9.6 million, and thus we recognized a gain of $6.6 million.

Provision for income taxes. Our effective tax rate from continuing operations for 2018 was 20.4%. The effective tax rate was relatively consistent with the U.S. federal statutory rate of 21%, reflecting the benefit of stock option exercises and tax credits, partially offset by the impact of state income tax.

Our effective tax rate from continuing operations for 2017 was 7.3%. The effective tax rate was lower than the U.S. federal statutory rate of 35% primarily due to the impact of the Tax Reform Act. The tax provision includes a benefit of $15.9 million related to the enactment of the Tax Reform Act during the fourth quarter of 2017, consisting of a net tax benefit of $19.3 million from the re-measurement of deferred tax liabilities from the lower U.S. corporate tax rate, partially offset by additional tax expense of $3.4 million due to an increase in our equity in net gain of Matrix as a result of Matrix's re-measurement of deferred tax liabilities. In addition, the Company incurred tax expense of $3.6 million related to the HoldCo LTIP, for which expense was recorded for financial reporting purposes based upon fair value of the award at the grant date, but no shares were issued due to the market condition of the award not being satisfied. This tax expense was the result of the adoption of Accounting Standards Update No. 2016-09, *Compensation - Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting* ("ASU 2016-09"), which subjects our tax rate to quarterly volatility from the effects of stock award exercises and vesting activities, including the adverse impact on our income tax provision for awards which result in a tax deduction less than the amount recorded for financial reporting purposes.

(Loss) income from discontinued operations, net of tax. (Loss) income from discontinued operations, net of tax, includes the activity of our former WD Services segment and our former Human Services segment. For 2018, the loss from discontinued operations, net of tax, for our former WD Services segment was of $37.0 million. Included in the loss was a loss on disposition, net of tax, of $1.8 million as well as an asset impairment charge of $9.2 million related to the sale of WD Services operations in France in the second quarter of 2018. For 2017, income from discontinued operations, net of tax for our WD Services segment was $8.7 million, which included a gain on sale of our equity interest in Mission Providence of $12.4 million.

For 2018, the loss from discontinued operations, net of tax for our Human Services segment was $0.1 million, which primarily reflects a reduction of the accrued settlement amount for indemnified legal matters, based on the final settlement agreement, offset by the related income tax impact. For 2017, the loss from discontinued operations, net of tax for our Human Services segment was $6.0 million, which primarily related to the accrual of a contingent liability of $9.0 million related to the settlement of indemnification claims and associated legal costs of $0.7 million, partially offset by a related tax benefit.

Net (income) loss from discontinued operations attributable to noncontrolling interests. Net (income) loss from discontinued operations attributable to noncontrolling interests primarily relates to a minority interest held by a third-party operating partner in our company servicing the offender rehabilitation contract in our historical WD Services segment.

Segment Results. The following analysis includes discussion of each of our segments.

NET Services

NET Services financial results are as follows for 2018 and 2017 (in thousands):

	Year Ended December 31,			
	2018		2017	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	1,384,965	100.0%	1,318,220	100.0%
Service expense	1,285,029	92.8%	1,227,426	93.1%
General and administrative expense	14,247	1.0%	11,779	0.9%
Asset impairment charge	14,175	1.0%	—	—%
Depreciation and amortization	15,026	1.1%	13,275	1.0%
Operating income	56,488	4.1%	65,740	5.0%

Service revenue, net. Service revenue, net for NET Services in 2018 increased $66.7 million, or 5.1%, compared to 2017. The increase was primarily related to the impact of new contracts, including managed care organization ("MCO") contracts in Illinois, Indiana, Oregon and New York and new state contracts in Texas and West Virginia, which contributed $112.8 million of revenue for 2018, as well as net increased revenue from existing contracts of $39.2 million, due to the net impact of membership and rate changes, including the impact of increased rates agreed after 2017 on certain contracts related to increased costs to serve the contracts, which was partially offset by the impact of a retroactive rate adjustment recorded in 2017 related to increased utilization activity under a significant contract. Revenue additionally increased $2.2 million due to revenue generated from Circulation in the fourth quarter of 2018. These increases were partially offset by the impact of contracts we no longer serve, including state contracts in New York and Connecticut, certain MCO contracts in Florida and Louisiana, and decreased membership in Virginia, which resulted in a decrease in revenue of $72.0 million. In addition, the adoption of ASC 606 resulted in a decrease in revenue of $15.5 million in 2018 as compared to revenue under the previous accounting standard, as one contract is now accounted for on a net basis.

Service expense. Service expense is comprised of the following for 2018 and 2017 (in thousands):

	Year Ended December 31,			
	2018		2017	
	$	Percentage of Revenue	$	Percentage of Revenue
Purchased services	1,055,278	76.2%	1,009,518	76.6%
Payroll and related costs	179,175	12.9%	165,666	12.6%
Other operating expenses	49,626	3.6%	51,720	3.9%
Stock-based compensation	950	0.1%	522	—%
Total service expense	1,285,029	92.8%	1,227,426	93.1%

Service expense for 2018 increased $57.6 million, or 4.7%, compared to 2017. The increase in service expense was primarily due to higher purchased services and payroll and related costs. Purchased services expense increased primarily as a result of new contracts, which was partially offset by the impact of terminated contracts. Purchased services as a percentage of revenue decreased from 76.6% in 2017 to 76.2% in 2018. This was due primarily to lower transportation costs on a per trip basis in certain geographies as a result of ongoing initiatives to better align the rates we pay to our transportation provider partners with local market conditions and the fees paid to us by our customers. Transportation costs on a per trip basis fluctuate from period to period.

Payroll and related costs as a percentage of revenue increased from 12.6% in 2017 to 12.9% in 2018 due to increased corporate staffing, temporary labor and increased health insurance expenses, as well as the impact from the acquisition of Circulation. Other operating expenses decreased for 2018 as compared to 2017 primarily attributable to a decrease in costs targeted at operational improvement from $6.3 million in 2017 to $2.8 million in 2018. This decrease was partially offset by increased software and hardware maintenance costs associated with new technology initiatives.

General and administrative expense. General and administrative expenses in 2018 increased $2.5 million, or 21.0%, as compared to 2017, primarily due to $1.7 million of transaction expenses related to the acquisition of Circulation in 2018, as well as increased facility costs resulting from the overall growth of our operations.

Asset impairment charge. Following the acquisition of Circulation and an analysis of the technology capabilities and scalability of the Circulation platform, we determined we would not continue the development of NextGen. We also determined we would not place any of the developed NextGen into service and recorded an asset impairment charge of $13.5 million related to our NET Services segment during the fourth quarter of 2018. We had previously recorded an impairment charge of $0.7 million during the second quarter of 2018 in relation to the decision to abandon specific development work intended to synchronize data across applications of the proprietary NextGen system, based on the determination of an alternative method to accomplish this task.

Depreciation and amortization expense. Depreciation and amortization expenses increased $1.8 million compared to 2017, primarily due to the addition of long-lived assets relating to information technology projects, as well as amortization expense related to the intangible assets acquired with the Circulation acquisition. As a percentage of revenue, depreciation and amortization increased to 1.1% for 2018 from 1.0% for 2017.

Corporate and Other

Corporate and Other includes the headcount and professional service costs incurred at the Providence corporate level, our captive insurance company, and elimination entries to account for inter-segment transactions. Corporate and Other financial results are as follows for 2018 and 2017 (in thousands):

	Year Ended December 31,	
	2018	**2017**
	$	**$**
Service expense	(426)	(3,799)
General and administrative expense	31,851	31,712
Depreciation and amortization	787	343
Operating loss	(32,212)	(28,256)

Operating loss. Corporate and Other operating loss in 2018 increased by $4.0 million, or 14.0%, as compared to 2017. Included in "General and administrative expense" for 2018 are $8.4 million of expenses relating to the Organizational Consolidation, including retention, recruitment and accelerated stock-based compensation expenses. Additionally, included in "Depreciation and amortization" is $0.4 million of accelerated depreciation expense incurred in relation to the Organizational Consolidation. General and administrative expenses for 2018 also include an increase in legal and consulting costs over 2017. Included in both 2018 and 2017 is a reduction in insurance loss reserves in "Service expense" due to favorable claims history of our captive reinsurance program.

The operating loss included expense of less than $0.1 million and $2.4 million, respectively, of cash settled stock-based compensation for 2018 and 2017, primarily as a result of an increase in the Company's stock price in 2017 as compared to a decrease in 2018. The operating loss included $6.3 million and $7.1 million, respectively, of share settled stock-based compensation, excluding accelerated stock-based compensation expense related to the Organizational Consolidation, for 2018 and 2017. Share settled stock-based compensation expense for 2017 included stock-based compensation for the HoldCo LTIP of $4.7 million.

Costs associated with the resignation of James Lindstrom, a former Chief Executive Officer of the Company, during the year ended December 31, 2017 include cash compensation related items of $0.9 million, stock-based compensation of $0.7 million, and other costs of $0.2 million. These costs are recorded as part of "General and administrative expense".

Year ended December 31, 2017 compared to year ended December 31, 2016

The following table sets forth results of operations and the percentage of consolidated total revenues represented by items in our consolidated statements of operations for 2017 and 2016 (in thousands):

	Year ended December 31,			
	2017		2016	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	1,318,220	100.0 %	1,233,842	100.0%
Operating expenses:				
Service expense	1,223,627	92.8 %	1,131,963	91.7%
General and administrative expense	43,491	3.3 %	39,527	3.2%
Asset impairment charge	—	— %	1,415	0.1%
Depreciation and amortization	13,618	1.0 %	12,780	1.0%
Total operating expenses	1,280,736	97.2 %	1,185,685	96.1%
Operating income	37,484	2.8 %	48,157	3.9%
Non-operating expense:				
Interest expense, net	1,204	0.1 %	1,515	0.1%
Other income	(5,363)	(0.4)%	—	—%
Equity in net (gain) loss of investees	(13,445)	(1.0)%	1,789	0.1%
Income from continuing operations before income taxes	55,088	4.2 %	44,853	3.6%
Provision for income taxes	4,003	0.3 %	17,972	1.5%
Income from continuing operations	51,085	3.9 %	26,881	2.2%
Income from discontinued operations, net of tax	2,735	0.2 %	62,965	5.1%
Net income	53,820	4.1 %	89,846	7.3%
Net (income) loss from discontinued operations attributable to noncontrolling interest	(451)	— %	2,082	0.2%
Net income attributable to Providence	53,369	4.0 %	91,928	7.5%

Service revenue, net. Consolidated service revenue, net for 2017 increased $84.4 million, or 6.8%, compared to 2016 due to an increase in revenue of NET Services.

Total operating expenses. Consolidated operating expenses for 2017 increased $95.1 million, or 8.0%, compared to 2016. Operating expenses for 2017 compared to 2016 included an increase in expenses attributable to NET Services of $95.8 million, which was partially offset by a decrease at Corporate and Other of $0.7 million. 2016 operating expenses include an asset impairment charge of $1.4 million at Corporate and Other.

Operating income. Consolidated operating income for 2017 decreased $10.7 million compared to 2016 due to a decrease in operating income of NET Services in 2017 as compared to 2016 of $11.3 million, which was partially offset by a decrease in the operating loss for Corporate and Other of $0.6 million in 2017 as compared to 2016.

Interest expense, net. Consolidated interest expense, net for 2017 decreased $0.3 million compared to 2016, and remained constant as a 0.1% of revenue.

Other income. Other income in 2017 of $5.4 million represents the settlement received from the Haverhill Litigation.

Equity in net (gain) loss of investees. Our equity in net (gain) loss of investees for 2017 includes equity in net gain for Matrix of $13.4 million. Our equity in net loss of investees for 2016 includes equity in net loss for Matrix of $1.8 million. We

began reporting Matrix as an equity investment effective October 19, 2016, upon the completion of the Matrix Transaction, and we record our ownership percentage of Matrix's profit or loss in net loss or gain of investees. Included in Matrix's 2017 full standalone net income of $26.7 million (which is not consolidated with Providence's) are depreciation and amortization of $33.5 million, interest expense of $14.8 million, transaction bonuses and other transaction related costs of $3.5 million, equity compensation of $2.6 million, management fees paid to Matrix's shareholders of $2.3 million, merger and acquisition diligence related costs of $0.7 million and income tax benefit of $29.6 million. Matrix's significant income tax benefit in 2017 primarily related to the re-measurement of deferred tax liabilities arising from a lower U.S. corporate tax rate as a result of the Tax Reform Act. Included in Matrix's 2016 full standalone net loss of $4.2 million (which is not consolidated with Providence's) are depreciation and amortization of $6.4 million, interest expense of $2.9 million, transaction bonuses and other transaction related costs of $6.4 million, equity compensation of $0.4 million, management fees paid to Matrix's shareholders of $0.4 million and income tax benefit of $2.8 million.

Provision for income taxes. Our effective tax rate from continuing operations for 2017 was 7.3%. The effective tax rate was lower than the U.S. federal statutory rate of 35% primarily due to the impact of the Tax Reform Act. The tax provision includes a benefit of $15.9 million related to the enactment of the Tax Reform Act during the fourth quarter of 2017, consisting of a net tax benefit of $19.3 million from the re-measurement of deferred tax liabilities from the lower U.S. corporate tax rate, partially offset by additional tax expense of $3.4 million due to an increase in our equity in net gain of Matrix as a result of Matrix's re-measurement of deferred tax liabilities. In addition, the Company incurred tax expense of $3.6 million related to the HoldCo LTIP, for which expense was recorded for financial reporting purposes based upon fair value of the award at the grant date, but no shares were issued due to the market condition of the award not being satisfied. This tax expense was the result of the adoption of ASU 2016-09, which subjects our tax rate to quarterly volatility from the effects of stock award exercises and vesting activities, including the adverse impact on our income tax provision for awards which result in a tax deduction less than the amount recorded for financial reporting purposes.

Our effective tax rate from continuing operations for 2016 was 40.1%. The effective tax rate was higher than the U.S. federal statutory rate of 35% primarily due to the impact of state taxes.

Income from discontinued operations, net of tax. Income from discontinued operations, net of tax, includes the activity of our former WD Services segment, Human Services segment and our former HA Services segment, composed entirely of our 100% ownership in Matrix until the completion of the Matrix Transaction on October 19, 2016. See Note 23, *Discontinued Operations,* to our consolidated financial statements for additional information.

For 2017, income from discontinued operations, net of tax for our WD Services segment was $8.7 million, which included a gain on sale of our equity interest in Mission Providence of $12.4 million. For 2016, the loss from discontinued operations, net of tax for our WD Services segment was $45.8 million, which included an asset impairment charge of $19.6 million.

For 2017, loss from discontinued operations, net of tax for our Human Services segment was $6.0 million, which primarily related to the accrual of a contingent liability of $9.0 million related to the settlement of indemnification claims and associated legal costs of $0.7 million, partially offset by a related tax benefit. For 2016, the loss from discontinued operations, net of tax for our Human Services segment was $5.6 million, which included an accrual of $6.0 million with respect to potential indemnification claims, legal costs of $1.1 million related to these potential claims and transaction related expenses of $0.8 million, partially offset by a related tax benefit.

Income from discontinued operations, net of tax for our HA Services segment was $114.3 million for 2016, which included a gain on disposition, net of tax, of $109.4 million.

Net (income) loss from discontinued operations attributable to noncontrolling interests. Net (income) loss from discontinued operations attributable to noncontrolling interests primarily relates to a minority interest held by a third-party operating partner in our company servicing the offender rehabilitation contract in our historical WD Services segment.

Segment Results. The following analysis includes discussion of each of our segments.

NET Services

NET Services financial results are as follows for 2017 and 2016 (in thousands):

	Year Ended December 31,			
	2017		2016	
	$	Percentage of Revenue	$	Percentage of Revenue
Service revenue, net	1,318,220	100.0%	1,233,720	100.0%
Service expense	1,227,426	93.1%	1,132,857	91.8%
General and administrative expense	11,779	0.9%	11,406	0.9%
Depreciation and amortization	13,275	1.0%	12,375	1.0%
Operating income	65,740	5.0%	77,082	6.2%

Service revenue, net. Service revenue, net for NET Services in 2017 increased $84.5 million, or 6.8%, compared to 2016. The increase was related to net increased revenue from existing contracts, including successfully renewed contracts, of $82.5 million, due to the net impact of membership and rate changes. Included within net rate changes are the positive impacts of final agreements on rate adjustments related to existing contracts that experienced increased utilization in 2017 as well as the release of previously accrued revenue hold-backs based on certain contract performance requirements on a significant contract. Additionally, the impact of new contracts, including new MCO contracts in Florida and New York, contributed $93.8 million of revenue for 2017. These increases were partially offset by the $91.8 million impact on revenue of contracts we no longer serve, including a contract with the state of New York.

Service expense. Service expense is comprised of the following for 2017 and 2016 (in thousands):

	Year Ended December 31,			
	2017		2016	
	$	Percentage of Revenue	$	Percentage of Revenue
Purchased services	1,009,518	76.6%	927,321	75.2%
Payroll and related costs	165,666	12.6%	162,000	13.1%
Other operating expenses	51,720	3.9%	42,478	3.4%
Stock-based compensation	522	—%	1,058	0.1%
Total service expense	1,227,426	93.1%	1,132,857	91.8%

Service expense for 2017 increased $94.6 million, or 8.3%, compared to 2016. The increase in service expense was primarily attributable to the impact of new MCO contracts in California, Florida and New York. Purchased services as a percentage of revenue increased from 75.2% in 2016 to 76.6% in 2017 primarily attributable to an increase in utilization across multiple contracts. The higher utilization was in part driven by increased Medicaid reimbursement in New Jersey for certain medical services, increasing the demand for transportation services, and increased utilization across multiple MCOs in California. Additionally, due to milder winter weather conditions during the first quarter of 2017, we experienced above expected utilization; however, we experienced lower utilization for contracts in the third quarter of 2017 due in part to the impact of Hurricane Irma. The increase in purchased services as a percentage of revenue caused by increased utilization was partially offset by the successful implementation of initiatives aimed at lowering transportation costs on a per trip and per mile basis as well as the release of a reserve based upon the finalization of a contract amendment with a state customer.

Payroll and related costs as a percentage of revenue decreased from 13.1% in 2016 to 12.6% in 2017 due to efficiencies gained from multiple process improvement initiatives, including those aimed at lowering payroll expense across our reservation and operation center networks, as well as a decrease in chief executive officer compensation expense due to the transition of the chief executive officer position during 2017. Other operating expenses increased for 2017 as compared to 2016 primarily attributable to an incremental $4.1 million of value enhancement and related costs incurred for external resources used in the design and

implementation of NET Services member experience and value enhancement initiatives in 2017, as well as increased software and hardware maintenance costs associated with increased use of information technology.

General and administrative expense. General and administrative expense in 2017 increased $0.4 million, or 3.3%, as compared to 2016, due to increased facility costs resulting from the overall growth of our operations. As a percentage of revenue, general and administrative expense remained constant at 0.9%.

Depreciation and amortization expense. Depreciation and amortization expense increased $0.9 million primarily due to the addition of long-lived assets relating to information technology projects. As a percentage of revenue, depreciation and amortization remained constant at 1.0%.

Corporate and Other

Corporate and Other includes the headcount and professional service costs incurred at the holding company level, at our captive insurance company, and elimination entries to account for inter-segment transactions. Corporate and Other financial results are as follows for 2017 and 2016 (in thousands):

	Year Ended December 31,	
	2017	**2016**
	$	**$**
Service revenue, net	—	122
Service expense	(3,799)	(894)
General and administrative expense	31,712	28,121
Asset impairment charge	—	1,415
Depreciation and amortization	343	405
Operating loss	(28,256)	(28,925)

Operating loss. Corporate and Other operating loss in 2017 decreased by $0.6 million, or 2.3%, as compared to 2016 primarily due a reduction in insurance loss reserves of $3.5 million in 2017, versus $2.5 million in 2016, due to favorable claims history of our captive reinsurance programs, as well as decreased costs of the captive operations due to no longer writing new policies as of May 2017, which is included in “Service expense”, decreased accounting, legal and professional fees included in “General and administrative expense”, and decreased asset impairment charges, as $1.4 million was recorded in 2016 in relation to the sale of a building. These decreases were partially offset by an increase in cash settled stock-based compensation expense of $3.6 million, primarily as a result of an increase in the Company’s stock price in 2017 as compared to a decrease in 2016, an increase in share settled stock-based compensation expense of $2.7 million, primarily related to an increase in expense for the HoldCo LTIP despite this program expiring with no shares due to any employees, expense for stock options issued to a former chief executive officer upon separation from the Company, and a benefit recorded in 2016 for performance based units, with no corresponding benefit in 2017.

General and administrative expense includes stock-based compensation for the HoldCo LTIP of $4.7 million and $3.3 million for 2017 and 2016, respectively. No shares were distributed under the HoldCo LTIP as the volume weighted average of Providence’s stock price over the 90-day trading period ended on December 31, 2017 was less than $56.79. As such, as of December 31, 2017, we accelerated all remaining unrecognized compensation expense for the Holdco LTIP as there was no further requisite service period associated with the award resulting in an acceleration of expense of $1.1 million. General and administrative expense also includes $0.4 million and $1.6 million for 2017 and 2016, respectively, related to a shareholder lawsuit.

Costs associated with the resignation of James Lindstrom during the year ended December 31, 2017 include cash compensation related items of $0.9 million, stock-based compensation of $0.7 million, and other costs of $0.2 million. These costs are recorded as part of “General and administrative expense”.

Seasonality

Our quarterly operating results and operating cash flows normally fluctuate due in part to seasonal factors, uneven demand for services and the timing of new contracts, which impact the amount of revenues earned and expenses incurred. NET Services

experiences fluctuations in demand during the summer and winter. Due to higher demand in the summer months, lower demand during the winter months, and a primarily fixed revenue stream based on a per-member, per-month payment structure, NET Services normally experiences lower operating margins during the summer season and higher operating margins during the winter.

Liquidity and Capital Resources

Short-term capital requirements consist primarily of recurring operating expenses, new contract start-up costs and costs associated with our Organizational Consolidation and other strategic initiatives. We expect to meet our cash requirements through available cash on hand, cash generated from NET Services, and borrowing capacity under our Credit Facility (as defined below).

Cash flow from operating activities was $7.9 million in 2018. Additionally, 2018 included $12.8 million in proceeds from the sale of our WD Services segment and cash outflows of $43.7 million related to the acquisition of Circulation, which are included in cash used in investing activities, and $12.4 million of proceeds from stock option exercises and cash outflows of $56.1 million for repurchases of common stock for treasury, which are included in cash used in financing activities. Our balance of cash, cash equivalents and restricted cash was $12.4 million and $101.6 million at December 31, 2018 and 2017, respectively, which includes cash of discontinued operations.

We had restricted cash of $4.4 million and $6.3 million at December 31, 2018 and 2017, respectively, primarily related to contractual obligations and activities of our captive insurance subsidiary. Given expiring policies under our captive insurance subsidiary were not renewed upon expiration in May 2017, we expect our restricted cash balances to decline over time. These restricted cash amounts are not included in our balance of cash and cash equivalents, although they are included in the cash, cash equivalents and restricted cash balance on the accompanying consolidated statements of cash flows, as a result of the adoption of Accounting Standards Update No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash,* as of January 1, 2018. At both December 31, 2018 and 2017, we had no amounts outstanding under our Credit Facility.

We may, from time to time, access capital markets to raise equity or debt financing for various business reasons, including acquisitions. We may also raise debt financing to fund future repurchases of our Common Stock. The timing, term, size, and pricing of any such financing will depend on investor interest and market conditions, and there can be no assurance that we will be able to obtain any such financing. During the second quarter of 2018, we extended the term of our Credit Facility to expire in August 2019, as further discussed below. At the end of the third quarter of 2018, we borrowed funds on our revolving credit facility to acquire Circulation. As of December 31, 2018, these amounts were fully repaid.

On March 29, 2018, the Company's Board of Directors amended our ongoing stock repurchase program to add an additional $77.8 million of capacity and extend the expiration date of the program from December 31, 2018 to June 30, 2019. As of December 31, 2018, the Company had approximately $81.2 million of share repurchase availability. During the year ended December 31, 2018, the Company repurchased 838,719 shares for $55.8 million.

The accompanying consolidated cash flow statement for all periods presented includes both continuing and discontinued operations. Discontinued operations include the activity of our historical WD Services, Human Services and HA Services segments. The loss from discontinued operations totaled $37.1 million for the year ended December 31, 2018, while income from discontinued operations totaled $2.7 million and $63.0 million for the years ended December 31, 2017 and 2016, respectively. For 2018, the loss from discontinued operations primarily related to the operating loss of our historical WD Services segment, as well as the loss, net of tax, of $1.8 million incurred on the disposition of subsidiaries within this segment. The significant income from discontinued operations during the year ended December 31, 2016 related to the gain on sale of our HA Services segment. Significant non-cash items of our discontinued operations included the following:

	2018	2017	2016
Depreciation	$ 6,711	$ 7,825	$ 11,799
Amortization	5,153	5,026	23,145
Asset impairment charge	9,203	—	19,588
Deferred income taxes	345	(3,940)	45,700

2018 cash flows compared to 2017

Operating activities. Cash provided by operating activities was $7.9 million for 2018, a decrease of $47.1 million compared with 2017. 2018 and 2017 cash flows from operations were driven by net loss of $18.8 million and net income $53.8 million,

respectively, non-cash adjustments to reconcile net income to net cash provided by operating activities of $67.1 million and negative $11.1 million, respectively, and changes in working capital of negative $40.3 million and positive $12.3 million, respectively.

The change in non-cash adjustments to reconcile net income to net cash provided by operating activities was due primarily to the impact of:

- the asset impairment charge incurred in 2018 of $23.4 million, of which $9.2 million is included in discontinued operations related to the sale of WD Services operations in France;
- the impact on deferred taxes and income taxes receivable as a result of the sale of substantially all of the operating subsidiaries in the WD Services segment in 2018 and as a result of the Tax Reform Act passed in 2017;
- the pre-tax loss on sale of subsidiaries of $53.7 million in 2018, which includes a non-cash reclass of $30.0 million from currency translation adjustment;
- the gain on remeasurement of our cost method investment in Circulation of $6.6 million in 2018;
- the gain on sale of Mission Providence of $12.4 million in 2017; and
- the impact of the change in equity in net (gain) loss of investees, which was a loss of $6.1 million in 2018 as compared to a gain of $12.1 million in 2017.

The change in working capital was primarily driven by the following:

- Accounts receivable generated a cash outflow in 2018 of $31.0 million as compared to an inflow of $5.7 million in 2017. The increase in cash outflow of $36.7 million was primarily attributable to NET Services due to the timing of collections from a limited number of payers, which was partially offset by $13.1 million of additional cash inflow from discontinued operations.
- Accounts payable and accrued expenses generated a cash outflow of $21.8 million in 2018, as compared to a cash outflow of $9.1 million in 2017. The increase in cash outflow of $12.7 million is primarily the result of the settlement of indemnified legal claims in 2018, of which $9.0 million was accrued for during 2017, which was partially offset by an increase in cash inflow from discontinued operations of $7.8 million and the impact of changes in the NET Services accrued contract payable balance.
- Accrued transportation costs of NET Services generated a cash inflow of $1.3 million in 2018, as compared to a cash inflow of $11.2 million in 2017. The decrease in cash inflow of $9.9 million is due primarily to the timing of payments to NET Services transportation providers.

Investing activities. Net cash used in investing activities of $45.3 million in 2018 increased by $38.3 million as compared to 2017. The increase was primarily attributable to the purchase of Circulation resulting in cash used for acquisition, net of cash acquired, of $43.7 million, which was partially offset by $12.8 million of proceeds on the sale of WD Services. Additionally, 2017 includes the impact of $15.6 million in proceeds from the sale of our equity investment in Mission Providence. During 2018, we also collected a note receivable for $3.1 million. Additionally in 2017, we made a cost method investment in Circulation for $3.0 million. There was also a decrease in the purchase of property and equipment of $2.4 million. 2018 and 2017 included purchases of property and equipment of $6.7 million and $4.5 million, respectively, by our discontinued operations.

Financing activities. Net cash used in financing activities of $51.6 million in 2018 increased $17.8 million as compared to 2017. During 2018, we repurchased $26.7 million more of our Common Stock than in 2017. In addition, there was an increase in proceeds from Common Stock issued pursuant to stock option exercises of $10.5 million.

2017 cash flows compared to 2016

Operating activities. Cash provided by operating activities was $55.0 million for 2017, an increase of $13.3 million compared with 2016. 2017 and 2016 cash flows from operations were driven by net income of $53.8 million and $89.8 million, respectively, non-cash adjustments to reconcile net income to net cash provided by operating activities of negative $11.1 million and negative $32.9 million, respectively, and changes in working capital of $12.3 million and negative $15.2 million, respectively.

The change in non-cash adjustments to reconcile net income to net cash provided by operating activities was due primarily to the impact of:

- the disposition of HA Services in 2016, resulting in decreased gain on sale of business, depreciation, amortization and deferred taxes in 2017 as compared to 2016;
- the asset impairment charge incurred in 2016 of $21.0 million, which is included in discontinued operations;

- the impact on deferred taxes as a result of the Tax Reform Act passed in 2017;
- the gain on sale of Mission Providence of $12.4 million in 2017, which is included in discontinued operations; and
- the impact of the change in equity in net (gain) loss of investees, which was a gain of $12.1 million in 2017 as compared to a loss of $10.3 million in 2016.

The change in working capital was primarily driven by the following:

- Accounts receivable generated a cash inflow in 2017 of $5.7 million as compared to an outflow of $19.3 million in 2016. The increase in cash inflow of $25.0 million was primarily attributable to NET Services due to the timing of collections as well as an outflow of $3.1 million of HA Services in 2016. These changes were partially offset by cash outflows in 2017 related to an increase in WD Services' receivables in Germany, Saudi Arabia, South Korea and the UK.
- Prepaid expenses and other generated a cash inflow of $15.5 million in 2017, as compared to a cash outflow of $4.1 million in 2016. The increase in cash inflow of $19.5 million was primarily attributable to a decrease in other receivables related to amounts receivable from insurance carriers in respect to certain claims paid by the Company, but reimbursable from the respective insurance carrier, decreased receivables related to our captive insurance company insurance policy rewrite, decreased prepaid value added taxes in the UK, decreased prepayments in WD Services in relation to certain contracts and changes in income tax payments.
- Accounts payable and accrued expenses generated a cash outflow of $9.1 million in 2017, as compared to a cash inflow of $33.4 million in 2016. The decrease in cash inflow of $42.4 million is due primarily to the impact of NET Services accrued contract payments of $21.5 million, as well as the disposition of HA Services, which generated a cash inflow of $10.6 million in 2016. Partially offsetting these impacts is the impact of the increase in the accrued settlement related to our former Human Services segment of $9.0 million during 2017 as compared to an increase of $6.0 million in 2016.
- Accrued transportation costs of NET Services generated a cash inflow of $11.2 million in 2017, as compared to a cash inflow of $8.7 million in 2016. The increase in cash inflow of $2.6 million is due primarily to the timing of payments to NET Services transportation providers and increased volume.
- Income taxes payable on sale of business for 2016 includes a cash outflow of $30.2 million related to the sale of our Human Services segment.

Investing activities. Net cash used in investing activities totaled $7.0 million in 2017, compared to cash provided by investing activities of $318.0 million in 2016. The change was primarily attributable to $371.6 million of proceeds on the Matrix Transaction recorded in 2016, which was partially offset by the impact of $15.6 million in proceeds from the sale of our equity investment in Mission Providence in 2017. Additionally in 2017, we made a cost method investment in Circulation for $3.0 million. There was also a decrease in funding of our equity investment in Mission Providence of $13.7 million and a decrease in the purchase of property and equipment of $21.3 million. 2017 and 2016 included purchases of property and equipment of $4.5 million and $29.0 million, respectively, by our discontinued operations.

Financing activities. Net cash used in financing activities of $33.8 million in 2017 decreased $343.0 million as compared to 2016. During 2016, there was a net repayment of debt of $305.0 million, primarily related to the repayment of debt upon the completion of the Matrix Transaction. Additionally, during 2017, we repurchased $41.0 million less of our Common Stock than in 2016. In addition, there was a decrease in proceeds from Common Stock issued pursuant to stock option exercises of $2.2 million.

Obligations and commitments

Current Credit Facility

We are party to the amended and restated credit and guaranty agreement, dated as of August 2, 2013 (as amended, the "Credit Agreement"), with Bank of America, N.A., as administrative agent, swing line lender and letter of credit issuer, and the other lenders party thereto. The Credit Agreement provides us with a $200.0 million revolving credit facility (the "Credit Facility"), including a sub-facility of $25.0 million for letters of credit. As of December 31, 2018, we had no borrowings and ten letters of credit in the amount of $12.3 million outstanding. At December 31, 2018, our available credit under the revolving credit facility was $187.7 million.

Under the Credit Agreement, the Company has an option to request an increase in the amount of the revolving credit facility or in a term loan facility from time to time (on substantially the same terms as apply to the existing facility) in an aggregate amount of up to $75.0 million with either additional commitments from lenders under the Credit Agreement at such time or new commitments from financial institutions acceptable to the administrative agent in its reasonable discretion, so long

as no default or event of default exists at the time of any such increase. The Company may not be able to access additional funds under this increase option as no lender is obligated to participate in any such increase under the Credit Facility. The Credit Agreement has a maturity date of August 2, 2019. See also "Risk Factors-Risks Related to our Indebtedness-Loss of available financing or an inability to renew, repay or refinance our debt could have an adverse effect on our financial condition and results of operations."

We may prepay any outstanding principal under the Credit Facility in whole or in part, at any time without premium or penalty, subject to reimbursement of the lenders' breakage and redeployment costs in connection with prepayments of London Interbank Offered Rate, or LIBOR, loans. The unutilized portion of the commitments under the Credit Facility may be irrevocably reduced or terminated by us at any time without penalty.

Interest on the outstanding principal amount of any loans accrues, at our election, at a per annum rate equal to LIBOR, plus an applicable margin or the base rate plus an applicable margin. The applicable margin ranges from 2.25% to 3.25% in the case of LIBOR loans and 1.25% to 2.25% in the case of the base rate loans, in each case, based on our consolidated leverage ratio as defined in the Credit Agreement. Interest on any loans is payable quarterly in arrears. In addition, we are obligated to pay a quarterly commitment fee based on a percentage of the unused portion of each lender's commitment under the Credit Facility and quarterly letter of credit fees based on a percentage of the maximum amount available to be drawn under each outstanding letter of credit. The commitment fee and letter of credit fee range from 0.25% to 0.50% and 2.25% to 3.25%, respectively, in each case, based on our consolidated leverage ratio.

The Credit Facility also requires us (subject to certain exceptions as set forth in the Amended and Restated Credit Agreement) to prepay the outstanding loans in an aggregate amount equal to 100% of the net cash proceeds received from certain asset dispositions, debt issuances, insurance and casualty awards and other extraordinary receipts.

Our obligations under the Credit Facility are guaranteed by all of our present and future domestic subsidiaries, excluding certain domestic subsidiaries, which includes our insurance captive. Our obligations under, and each guarantor's obligations under its guaranty of, the Credit Facility are secured by a first priority lien on substantially all of our respective assets, other than our equity investment in Matrix, including a pledge of 100% of the issued and outstanding stock of our domestic subsidiaries, excluding our insurance captive.

The Credit Agreement contains customary affirmative and negative covenants and events of default. The negative covenants include restrictions on our ability to, among other things, incur additional indebtedness, create liens, make investments, give guarantees, pay dividends, repurchase shares, sell assets, and merge and consolidate. We are subject to financial covenants, including consolidated net leverage and consolidated interest coverage covenants. The Company's consolidated net leverage ratio may not be greater than 3.00:1.00 as of the end of any fiscal quarter and the Company's consolidated interest coverage ratio may not be less than 3.00:1.00 as of the end of any fiscal quarter. We were in compliance with all covenants as of December 31, 2018.

Credit Facility Background

On August 2, 2013, we entered into the Credit Agreement with Bank of America, N.A., as administrative agent, swing line lender and letter of credit issuer, SunTrust Bank, as syndication agent, Merrill Lynch, Pierce, Fenner & Smith Incorporated and SunTrust Robinson Humphrey, Inc., as joint lead arrangers and joint book managers and other lenders party thereto. The Credit Agreement provided us with a senior secured credit facility, in aggregate principal amount of $225.0 million, comprised of a $60.0 million term loan facility and a $165.0 million revolving credit facility. The Credit Facility includes sublimits for swingline loans and letters of credit in amounts of up to $10.0 million and $25.0 million, respectively. On August 2, 2013, we borrowed the entire amount available under the term loan facility and $16.0 million under our revolving credit facility and used the proceeds thereof to refinance certain of our existing indebtedness.

On May 28, 2014, we entered into the first amendment to the Credit Agreement (the "First Amendment"). The First Amendment provided for, among other things, an increase in the aggregate amount of the Credit Facility from $165.0 million to $240.0 million and other modifications in connection with the consummation of the acquisition of Ingeus.

On October 23, 2014, we entered into the Second Amendment to the Credit Agreement (the "Second Amendment") to (i) add a new term loan tranche in aggregate principal amount of up to $250.0 million to partly finance the acquisition of Matrix and make certain other modifications in connection with the consummation of the acquisition of Matrix and (ii) add an excess cash flow mandatory prepayment provision.

On September 3, 2015, we entered into the Third Amendment to the Credit Agreement (the "Third Amendment"). Pursuant to the Third Amendment, the lenders under the Credit Agreement consented to Providence's sale of the Human Services segment

and certain other amendments to the terms of the Credit Agreement to reflect such consents.

On August 28, 2016, we entered into the Fourth Amendment and Consent (the "Fourth Amendment") to the Credit Agreement. In accordance with the Fourth Amendment, which provided for the lenders' consent to the Matrix Transaction, a portion of the net cash proceeds received by the Company in connection with the Matrix Transaction was applied to the prepayment of outstanding term loans and revolving loans. Additionally, effective following the repayment of the outstanding term loans in full on October 20, 2016, the Fourth Amendment further (i) reduced the aggregate revolving commitments under the Credit Agreement to $200.0 million, (ii) amended the consolidated net leverage ratio covenant such that the Company's consolidated net leverage ratio may not be greater than 3.00:1.00 as of the end of any fiscal quarter and (iii) replaced the existing consolidated fixed charge coverage ratio covenant with a covenant that the Company's consolidated interest coverage ratio may not be less than 3.00:1.00 as of the end of any fiscal quarter.

On June 7, 2018, we entered into the Fifth Amendment to the Credit Agreement (the "Fifth Amendment") which (i) extended the maturity date of the Credit Agreement to August 2, 2019 and (ii) amended certain covenants under the Credit Agreement to provide for greater operational, financial and strategic flexibility, including the implementation of the Organizational Consolidation.

We may from time to time incur additional indebtedness, obtain additional financing or refinance existing indebtedness, subject to market conditions and our financial condition.

Rights Offering

We completed a rights offering on February 5, 2015, allowing all of the Company's existing common stockholders the non-transferrable right to purchase their pro rata share of $65.5 million of Preferred Stock at a price equal to $100.00 per share (the "Rights Offering"). The Preferred Stock was convertible into shares of our Common Stock at a conversion price equal to $39.88, which was the closing price of our Common Stock on NASDAQ on October 22, 2014.

Stockholders exercised subscription rights to purchase 130,884 shares of the Company's Preferred Stock. Pursuant to the terms and conditions of the Standby Purchase Agreement between the Coliseum Stockholders and the Company, the remaining 524,116 shares of the Company's Preferred Stock were purchased by the Coliseum Stockholders at the $100.00 per share subscription price. The Coliseum Stockholders beneficially owned approximately 94% of our outstanding Preferred Stock after giving effect to the Rights Offering and the Standby Purchase Agreement. The Company received $65.5 million in aggregate gross proceeds from the consummation of the Rights Offering and Standby Purchase Agreement, which it used to repay the related party unsecured subordinated bridge note that was outstanding as of December 31, 2014.

Additionally, on March 12, 2015, the Coliseum Stockholders exercised their right to purchase an additional 150,000 shares of the Company's convertible preferred stock at a $105 per share subscription price.

We may pay a noncumulative cash dividend on each share of Preferred Stock, when, as and if declared by a committee of our Board, at the rate of 5.5% per annum on the liquidation preference then in effect. On or before the third business day immediately preceding each fiscal quarter, we determine our intention whether or not to pay a cash dividend with respect to that ensuing quarter and give notice of our intention to each holder of Preferred Stock as soon as practicable thereafter.

In the event we do not declare and pay a cash dividend, the liquidation preference will be increased to an amount equal to the liquidation preference in effect at the start of the applicable dividend period, plus an amount equal to such then applicable liquidation preference multiplied by 8.5% per annum, computed on the basis of a 365-day year and the actual number of days elapsed from the start of the applicable dividend period to the applicable date of determination.

Cash dividends are payable quarterly in arrears on January 1, April 1, July 1 and October 1 of each year, and, if declared, will begin to accrue on the first day of the applicable dividend period. Payment in kind ("PIK") dividends, if applicable, will accrue and be cumulative on the same schedule as set forth above for cash dividends and will also be compounded at the applicable annual rate on each applicable subsequent dividend date. PIK dividends are paid upon the occurrence of a liquidation event, conversion or redemption in accordance with the terms of the Preferred Stock. Cash dividends were declared each quarter for the years ended December 31, 2018 and 2017 and totaled $4.4 million each year. For information on the treatment of Preferred Stock in the event of a certain change of control transactions, see "Risk Factors–Risks Related to Our Capital Stock–Anti-takeover provisions in our second amended and restated certificate of incorporation and amended and restated by-laws could discourage, delay or prevent a change of control of our company and may affect the trading price of our Common Stock."

Reinsurance and Self-Funded Insurance Programs

Reinsurance

We historically reinsured a substantial portion of our automobile, general and professional liability and workers' compensation costs under reinsurance programs primarily through our wholly-owned captive insurance subsidiary, Social Services Providers Captive Insurance Company, or SPCIC. As of May 16, 2017, SPCIC did not renew the expiring reinsurance policies. SPCIC will continue to resolve claims under the historical policy years.

At December 31, 2018, the cumulative reserve for expected losses since inception of these historical automobile, general and professional liability and workers' compensation reinsurance programs was $0.3 million, $0.8 million and $2.8 million, respectively. Based on an independent actuarial report, our expected losses related to workers' compensation, automobile and general and professional liability in excess of our liability under our associated historical reinsurance programs at December 31, 2018 was $6.6 million. We recorded a corresponding receivable from third-party insurers and liability at December 31, 2018 for these expected losses, which would be paid by third-party insurers to the extent losses are incurred.

Further, we had restricted cash of $4.4 million and $6.3 million at December 31, 2018 and December 31, 2017, respectively, which was primarily restricted to secure the reinsured claims losses under the historical automobile, general and professional liability and workers' compensation reinsurance programs.

Health Insurance

We offer our NET Services, U.S. based WD Services, and corporate employees an option to participate in self-funded health insurance programs. Additionally, we historically offered this option to our HA Services and Human Services segments' employees. During the year ended December 31, 2018, health claims were self-funded with a stop-loss umbrella policy with a third-party insurer to limit the maximum potential liability for individual claims generally to $300,000 per person, subject to an aggregating stop-loss limit of $400,000. In addition, the program has a total stop-loss limit for total claims, in order to limit our exposure to catastrophic claims.

Health insurance claims are paid as they are submitted to the plan administrator. We maintain accruals for claims that have been incurred but not yet reported to the plan administrator, and therefore, have not been paid. The incurred but not reported reserve is based on an established cap and current payment trends of health insurance claims. The liability for the self-funded health plan of $2.2 million as of December 31, 2018 and 2017, was recorded in "Reinsurance liability and related reserve" in our consolidated balance sheets.

We charge our employees a portion of the costs of our self-funded group health insurance programs. We determine this charge at the beginning of each plan year based upon historical and projected medical utilization data. Any difference between our projections and our actual experience is borne by us, up to the stop-loss limit. We estimate potential obligations for liabilities under this program to reserve what we believe to be a sufficient amount to cover liabilities based on our past experience. Any significant increase in the number of claims or costs associated with claims made under this program above what we reserve could have a material adverse effect on our financial results.

Contractual cash Obligations

The following is a summary of our future contractual cash obligations as of December 31, 2018:

	At December 31, 2018				
Contractual cash obligations (000's)	**Total**	**Less than 1 Year**	**1-3 Years**	**3-5 Years**	**After 5 Years**
Capital leases	$ 1,071	$ 718	$ 353	$ —	$ —
Interest (1)	445	445	—	—	—
Purchased services commitment (2)	35,231	13,805	21,419	7	—
Guarantees (3)	42,056	42,056	—	—	—
Letters of credit (3)	12,338	12,338	—	—	—
Operating leases (4)	27,039	8,825	11,046	5,568	1,600
Total	$ 118,180	$ 78,187	$ 32,818	$ 5,575	$ 1,600

(1) Future interest payments have been calculated at the current rates as of December 31, 2018.

(2) The purchased service commitment includes a commitment for transportation services. Our commitment amount represents the minimum obligation we have under this agreement. If the Company does not utilize the minimum level of services specified in the agreement, a penalty provision will apply. However, the minimum obligation is less than our projected use for these periods and payments may be more than the minimum obligation based on actual use.

(3) Guarantees and letters of credit ("LOCs") are commitments that represent funding responsibilities that may require our performance in the event of third-party demands or contingent events. Guarantees include surety bonds we provide to certain customers to protect against potential non-delivery of our non-emergency transportation services. Of the outstanding balance of our stand-by LOCs, $12.3 million directly reduces the amount available to us from our Credit Facility. The surety bonds and LOC amounts in the above table represent the amount of commitment expiration per period.

(4) The operating leases are for office space and related office equipment. We account for these leases on a monthly basis. Certain leases contain periodic rent escalation adjustments and renewal options.

Other than the items described above, we do not have any off-balance sheet arrangements as of December 31, 2018.

Stock repurchase programs

On November 4, 2015, our Board authorized us to engage in a repurchase program to repurchase up to $70.0 million in aggregate value of our Common Stock during the twelve-month period following November 4, 2015. This plan terminated on November 3, 2016. A total of 1,360,249 shares were purchased through this plan for $63.0 million, excluding commission payments.

On October 26, 2016, our Board authorized us to engage in a repurchase program to repurchase up to $100.0 million in aggregate value of our Common Stock during the twelve-month period following October 26, 2016. As of October 26, 2017, we spent $30.4 million, excluding commission payments, to purchase 770,808 shares of our Common Stock under this plan.

On November 2, 2017, the Board approved the extension of the Company's existing stock repurchase program, authorizing the Company to engage in a repurchase program to repurchase up to $69.6 million (the amount remaining from the $100.0 million repurchase amount authorized in 2016) in aggregate value of our Common Stock through December 31, 2018. Subsequently, on March 29, 2018, the Board authorized an increase in the amount available for stock repurchases under the Company's existing stock repurchase program by $77.8 million, and extended the existing stock repurchase program through June 30, 2019. As of December 31, 2018, 1,018,989 shares were purchased under this plan for $66.3 million, excluding commission payments, after it was extended on November 2, 2017.

Purchases under the repurchase program may be made from time-to-time through a combination of open market repurchases (including Rule 10b5-1 plans), privately negotiated transactions, and accelerated share repurchase transactions, at the discretion of our officers, and as permitted by securities laws, covenants under existing bank agreements, and other legal requirements.

Off-balance sheet arrangements

As of December 31, 2018 and 2017, we did not have any relationships with unconsolidated entities or financial partnerships, such as entities referred to as structured finance or special purpose entities, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes.

New Accounting Pronouncements

The new accounting pronouncements that impact our business are included in Note 2, *Significant Accounting Policies and Recent Accounting Pronouncements,* to our consolidated financial statements and are incorporated herein by reference.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk.***

Interest rate risk

We have exposure to interest rate risk mainly related to our revolving credit facility, which has variable interest rates that may increase. We did not have any amounts outstanding on our revolving credit facility at December 31, 2018.

Item 8. ***Financial Statements and Supplementary Data.***

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

Management's Report on Internal Control Over Financial Reporting

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting for the registrant, as such term is defined in Rule 13a-15(f) of the Exchange Act. We designed our internal control over financial reporting to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. Our internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting can provide only reasonable assurance with respect to financial statement preparation and presentation. The design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate. The Company conducts periodic evaluations of its internal controls to enhance, where necessary, its procedures and controls.

We acquired Circulation, Inc. ("Circulation") on September 21, 2018, and we excluded from the assessment of effectiveness of our internal control over financial reporting as of December 31, 2018, Circulation's internal control over financial reporting associated with total assets of $6.1 million (which excludes acquired goodwill and intangible assets) and total revenues of $2.2 million included in the consolidated financial statements of the Company as of and for the year ended December 31, 2018.

We are currently integrating this acquisition into our internal control over financial reporting processes. In executing this integration, we are analyzing, evaluating and, where necessary, making changes in controls and procedures related to this acquisition, which we expect to be completed in fiscal year 2019. We have excluded this acquisition from our assessment of internal control over financial reporting as of December 31, 2018, as permitted by the guidance provided by the staff of the SEC. Other than the changes described above, there were no changes in our internal control over financial reporting during the fiscal quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

The Company, under the supervision and with the participation of its management, including its principal executive officer and principal financial officer, conducted an evaluation of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018, based on the criteria set forth in the Internal Control–Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on such evaluation, the Company concluded that its internal control over financial reporting was effective as of December 31, 2018.

KPMG LLP, an independent registered public accounting firm that audited the Company's consolidated financial statements included in this Annual Report on Form 10-K, has issued an audit report on the effectiveness of the Company's internal control over financial reporting which is presented in Part II, Item 8 of this Annual Report on Form 10-K.

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
The Providence Service Corporation:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of The Providence Service Corporation and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2018, and the related notes and financial statement schedule II (collectively, the "consolidated financial statements"). In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated March 1, 2019 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

We did not audit the financial statements of Mercury Parent, LLC (43.6 percent owned investee company) as of and for the period ended December 31, 2018. The Company's investment in Mercury Parent, LLC as of December 31, 2018 was $161.5 million, and its equity in net loss of Mercury Parent, LLC was $6.2 million for the year ended December 31, 2018. The financial statements of Mercury Parent, LLC were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Mercury Parent, LLC, is based solely on the report of the other auditors.

Change in Accounting Principle

As discussed in Note 2 to the consolidated financial statements, the Company has changed its method of accounting for revenues and related costs in 2018 due to the adoption of Accounting Standards Codification Topic 606, Revenue from Contracts with Customers.

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits and the report of the other auditors provide a reasonable basis for our opinion.

/s/ KPMG LLP

We have served as the Company's auditor since 2008.

Stamford, Connecticut
March 1, 2019

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
The Providence Service Corporation:

Opinion on Internal Control Over Financial Reporting

We have audited The Providence Service Corporation and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2018, and the related notes and financial statement schedule II (collectively, the "consolidated financial statements"), and our report dated March 1, 2019 expressed an unqualified opinion on those consolidated financial statements.

The Company acquired Circulation, Inc. ("Circulation") during 2018, and management excluded from its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018, Circulation's internal control over financial reporting associated with total assets of $6.1 million (which excludes acquired goodwill and intangible assets) and total revenues of $2.2 million included in the consolidated financial statements of the Company as of and for the year ended December 31, 2018. Our audit of internal control over financial reporting of the Company also excluded an evaluation of the internal control over financial reporting of Circulation.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ KPMG LLP

Stamford, Connecticut
March 1, 2019

The Providence Service Corporation
Consolidated Balance Sheets
(in thousands except share and per share data)

	December 31,	
	2018	**2017**
Assets		
Current assets:		
Cash and cash equivalents	$ 5,678	$ 52,798
Accounts receivable, net of allowance of $1,854 in 2018 and $5,262 in 2017	147,756	110,208
Other receivables	4,846	5,749
Prepaid expenses and other	44,167	22,459
Restricted cash	1,482	1,091
Current assets of discontinued operations	7,051	104,024
Total current assets	210,980	296,329
Property and equipment, net	22,965	37,672
Goodwill	135,216	95,215
Intangible assets, net	26,146	14,165
Equity investments	161,503	169,699
Other assets	9,949	11,977
Restricted cash, less current portion	2,886	5,205
Deferred tax asset	2,601	—
Noncurrent assets of discontinued operations	—	73,828
Total assets	$ 572,246	$ 704,090
Liabilities, redeemable convertible preferred stock and stockholders' equity		
Current liabilities:		
Current portion of long-term obligations	$ 718	$ 2,400
Accounts payable	8,828	318
Accrued expenses	39,191	71,643
Accrued transportation costs	84,889	83,588
Deferred revenue	562	3,019
Reinsurance and related liability reserves	5,438	4,319
Current liabilities of discontinued operations	3,257	61,643
Total current liabilities	142,883	226,930
Long-term obligations, less current portion	353	584
Other long-term liabilities	14,970	16,216
Deferred tax liabilities	25,650	39,232
Noncurrent liabilities of discontinued operations	—	7,565
Total liabilities	183,856	290,527
Commitments and contingencies (Note 20)		
Redeemable convertible preferred stock		
Convertible preferred stock, net: Authorized 10,000,000 shares; $0.001 par value; 801,606 and 803,200 issued and outstanding; 5.5%/8.5% dividend rate	77,392	77,546
Stockholders' equity		
Common stock: Authorized 40,000,000 shares; $0.001 par value; 17,784,769 and 17,473,598 issued and outstanding (including treasury shares)	18	17
Additional paid-in capital	334,744	313,955
Retained earnings	187,127	204,818
Accumulated other comprehensive loss, net of tax	—	(25,805)

Treasury shares, at cost, 4,970,093 and 4,126,132 shares	(210,891)	(154,803)
Total Providence stockholders' equity	310,998	338,182
Noncontrolling interest	—	(2,165)
Total stockholders' equity	310,998	336,017
Total liabilities, redeemable convertible preferred stock and stockholders' equity	$ 572,246	$ 704,090

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Consolidated Statements of Operations
(in thousands except share and per share data)

	Year ended December 31,		
	2018	**2017**	**2016**
Service revenue, net	$ 1,384,965	$ 1,318,220	$ 1,233,842
Operating expenses:			
Service expense	1,284,603	1,223,627	1,131,963
General and administrative expense	46,098	43,491	39,527
Asset impairment charge	14,175	—	1,415
Depreciation and amortization	15,813	13,618	12,780
Total operating expenses	1,360,689	1,280,736	1,185,685
Operating income	24,276	37,484	48,157
Other expenses:			
Interest expense, net	1,783	1,204	1,515
Other income	—	(5,363)	—
Equity in net loss (gain) of investees	6,158	(13,445)	1,789
Gain on remeasurement of cost method investment	(6,577)	—	—
Income from continuing operations before income taxes	22,912	55,088	44,853
Provision for income taxes	4,684	4,003	17,972
Income from continuing operations, net of tax	18,228	51,085	26,881
(Loss) income from discontinued operations, net of tax	(37,053)	2,735	62,965
Net (loss) income	(18,825)	53,820	89,846
Net (income) loss from discontinued operations attributable to noncontrolling interest	(156)	(451)	2,082
Net (loss) income attributable to Providence	$ (18,981)	$ 53,369	$ 91,928
Net (loss) income available to common stockholders (Note 16)	$ (25,257)	$ 42,636	$ 76,940
Basic (loss) earnings per common share:			
Continuing operations	$ 0.92	$ 2.99	$ 1.35
Discontinued operations	(2.87)	0.15	3.90
Basic (loss) earnings per common share	$ (1.95)	$ 3.14	$ 5.25
Diluted (loss) earnings per common share:			
Continuing operations	$ 0.92	$ 2.97	$ 1.34
Discontinued operations	(2.86)	0.15	3.87
Diluted (loss) earnings per common share	$ (1.94)	$ 3.12	$ 5.21
Weighted-average number of common shares outstanding:			
Basic	12,960,837	13,602,140	14,666,896
Diluted	13,033,247	13,673,314	14,779,398

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Consolidated Statements of Comprehensive Income
(in thousands)

	Year ended December 31,		
	2018	**2017**	**2016**
Net (loss) income	$ (18,825)	$ 53,820	$ 89,846
Net (income) loss from discontinued operations attributable to noncontrolling interest	(156)	(451)	2,082
Net (loss) income attributable to Providence	(18,981)	53,369	91,928
Other comprehensive income (loss):			
Foreign currency translation adjustments, net of tax	(4,168)	7,117	(16,618)
Reclassification of translation loss realized upon sale of subsidiaries in 2018 and equity investment in 2017	29,973	527	—
Other comprehensive income (loss)	25,805	7,644	(16,618)
Comprehensive income	6,980	61,464	73,228
Comprehensive (income) loss from discontinued operations attributable to noncontrolling interest	(2,165)	(255)	1,968
Comprehensive income attributable to Providence	$ 4,815	$ 61,209	$ 75,196

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Consolidated Statements of Stockholders' Equity
(in thousands except share data)

	Common Stock		Additional Paid-In	Retained	Accumulated Other Comprehensive Loss, Net of	Treasury Stock		Non-Controlling	
	Shares	Amount	Capital	Earnings	Tax	Shares	Amount	Interest	Total
Balance at December 31, 2015	17,186,780	$ 17	$ 293,012	$ 69,209	$ (16,831)	1,895,998	$ (54,823)	$ (452)	$ 290,132
Stock-based compensation	—	—	5,154	—	—	—	—	—	5,154
Exercise of employee stock options, including net tax benefit of $276	105,788	—	3,832	—	—	—	—	—	3,832
Restricted stock issued	22,793	—	—	—	—	2,736	(130)	—	(130)
Stock repurchase plan	—	—	—	—	—	1,579,942	(70,248)	—	(70,248)
Conversion of convertible preferred stock to common stock	300	—	12	—	—	—	—	—	12
Convertible preferred stock dividends	—	—	—	(4,419)	—	—	—	—	(4,419)
Foreign currency translation adjustments, net of tax	—	—	—	—	(16,618)	—	—	114	(16,504)
Noncontrolling interest	—	—	—	—	—	—	—	(2,082)	(2,082)
Net income attributable to Providence	—	—	—	91,928	—	—	—	—	91,928
Balance at December 31, 2016	17,315,661	17	302,010	156,718	(33,449)	3,478,676	(125,201)	(2,420)	297,675
Stock-based compensation	—	—	7,619	—	—	—	—	—	7,619
Exercise of employee stock options	91,400	—	2,423	—	—	5,665	(238)	—	2,185
Restricted stock issued	36,623	—	—	—	—	19,556	(878)	—	(878)
Performance restricted stock issued	3,773	—	(96)	—	—	—	—	—	(96)
Shares issued for bonus settlement and director stipends	25,646	—	1,107	—	—	—	—	—	1,107
Stock repurchase plan	—	—	—	—	—	622,235	(28,486)	—	(28,486)
Conversion of convertible preferred stock to common stock	495	—	20	(1)	—	—	—	—	19
Convertible preferred stock dividends	—	—	—	(4,418)	—	—	—	—	(4,418)
Foreign currency translation adjustments, net of tax	—	—	—	—	7,117	—	—	(196)	6,921
Reclassification of translation loss realized upon sale of equity investments	—	—	—	—	527	—	—	—	527
Noncontrolling interest	—	—	—	—	—	—	—	451	451
Other	—	—	22	—	—	—	—	—	22
Net income attributable to Providence	—	—	—	53,369	—	—	—	—	53,369
Cumulative effect adjustment from change in accounting principle, net of tax	—	—	850	(850)	—	—	—	—	—
Balance at December 31, 2017	17,473,598	17	313,955	204,818	(25,805)	4,126,132	(154,803)	(2,165)	336,017
Cumulative effect adjustment from change in accounting principle, net of tax	—	—	—	5,710	—	—	—	—	5,710
Stock-based compensation	—	—	9,130	—	—	—	—	—	9,130
Exercise of employee stock options	266,293	1	11,669	—	—	—	—	—	11,670
Restricted stock issued	33,582	—	(320)	—	—	5,242	(335)	—	(655)
Performance restricted stock issued	3,110	—	(109)	—	—	—	—	—	(109)
Shares issued for bonus settlement and director stipends	4,193	—	150	—	—	—	—	—	150
Stock repurchase plan	—	—	—	—	—	838,719	(55,753)	—	(55,753)
Conversion of convertible preferred stock to common stock	3,993	—	161	(7)	—	—	—	—	154
Foreign currency translation adjustments, net of tax	—	—	—	—	(4,168)	—	—	1,839	(2,329)
Reclassification of translation loss realized upon sale of foreign	—	—	—	—	29,973	—	—	—	29,973

subsidiary									
Convertible preferred stock dividends	—	—	—	(4,413)	—	—	—	—	(4,413)
Noncontrolling interest	—	—	—	—	—	—	—	326	326
Other	—	—	108	—	—	—	—	—	108
Net loss attributable to Providence	—	—	—	(18,981)	—	—	—	—	(18,981)
Balance at December 31, 2018	17,784,769	$ 18	$ 334,744	$ 187,127	$ —	4,970,093	$ (210,891)	$ —	$ 310,998

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Consolidated Statements of Cash Flows
(in thousands)

	Year ended December 31,		
	2018	2017	2016
Operating activities			
Net (loss) income	$ (18,825)	$ 53,820	$ 89,846
Adjustments to reconcile net (loss) income to net cash provided by operating activities:			
Depreciation	18,769	18,542	21,699
Amortization	8,908	7,927	26,026
Provision for doubtful accounts	6,062	1,372	3,759
Stock-based compensation	8,993	7,543	5,136
Deferred income taxes	(545)	(22,996)	(14,130)
Amortization of deferred financing costs and debt discount	512	682	1,754
Write-off of deferred financing charges	—	—	2,302
Asset impairment charge	23,378	—	21,003
Equity in net (gain) loss of investees	6,072	(12,054)	10,287
Gain on sale of equity investment	—	(12,377)	—
Loss (gain) on sale of business	53,692	—	(167,895)
Gain on remeasurement of cost method investment	(6,577)	—	—
Deferred income taxes and income taxes payable (receivable) on sale of business	(51,861)	—	58,492
Other non-cash charges (credits)	(353)	296	(1,323)
Changes in operating assets and liabilities, net of effects of acquisitions:			
Accounts receivable	(30,997)	5,715	(19,332)
Prepaid expenses and other	14,253	15,457	(4,058)
Reinsurance and related liability reserve	(2,743)	(5,731)	(4,110)
Accounts payable and accrued expenses	(21,799)	(9,064)	33,365
Income taxes payable on gain from sale of business	—	—	(30,153)
Accrued transportation costs	1,301	11,232	8,654
Deferred revenue	(1,975)	(4,691)	(4,019)
Other long-term liabilities	1,634	(629)	4,462
Net cash provided by operating activities	7,899	55,044	41,765
Investing activities			
Purchase of property and equipment	(17,521)	(19,923)	(41,216)
Proceeds from sale of property	—	—	1,039
Proceeds from sale of equity investment	—	15,593	—
Acquisitions, net of cash acquired	(43,711)	—	—
Dispositions or sale of business, net of cash sold	12,780	—	371,580
Purchase of equity investment	—	—	(13,663)
Cost method investments	—	(3,000)	—
Proceeds from note receivable	3,130	—	—
Other investing activities	—	310	239
Net cash (used in) provided by investing activities	(45,322)	(7,020)	317,979
Financing activities			
Preferred stock dividends	(4,413)	(4,418)	(4,419)
Repurchase of common stock, for treasury	(56,088)	(29,364)	(70,378)
Proceeds from common stock issued pursuant to stock option exercise	12,413	1,921	4,108
Proceeds from debt	42,000	—	52,500

Repayment of debt	(42,000)	—	(357,450)
Other financing activities	(3,467)	(1,927)	(1,182)
Net cash used in financing activities	(51,555)	(33,788)	(376,821)
Effect of exchange rate changes on cash	(261)	978	(1,357)
Net change in cash, cash equivalents and restricted cash	(89,239)	15,214	(18,434)
Cash, cash equivalents and restricted cash at beginning of period	101,606	86,392	104,826
Cash, cash equivalents and restricted cash at end of period	$ 12,367	$ 101,606	$ 86,392

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Supplemental Cash Flow Information
(in thousands)

Supplemental cash flow information	Year ended December 31, 2018	2017	2016
Cash included in current assets of discontinued operations held for sale	$ 2,321	$ 42,512	$ 22,666
Cash paid for interest	$ 1,162	$ 987	$ 9,768
Cash paid for income taxes	$ 12,054	$ 18,128	$ 55,827
Proceeds receivable from option exercise	$ —	$ 562	$ —
Purchases of equipment in accounts payable and accrued liabilities	$ —	$ 1,362	$ 983
Note receivable issued for sale of property	$ —	$ —	$ 3,130
Purchase of equipment through capital lease obligation	$ 724	$ 1,474	$ 4,547
Acquisitions:			
Purchase price	$ 54,700	$ —	$ —
Less:			
Cash acquired	(1,302)	—	—
Restricted cash acquired	(110)	—	—
Value of existing ownership in Circulation	(9,577)	—	—
Acquisitions, net of cash acquired	$ 43,711	$ —	$ —

See accompanying notes to the consolidated financial statements

The Providence Service Corporation
Notes to Consolidated Financial Statements
December 31, 2018
(in thousands except share and per share data)

1. Organization and Basis of Presentation

Description of Business

The Providence Service Corporation ("we", the "Company" or "Providence"), owns subsidiaries and investments primarily engaged in the provision of healthcare services in the United States. The Company's NET Services segment, which primarily operates under the brands LogistiCare and Circulation, since its acquisition in September 2018, is the largest manager of non-emergency medical transportation ("NET") programs for state governments and managed care organizations ("MCOs") in the United States ("U.S."). On September 21, 2018, we completed the acquisition of Circulation, Inc. ("Circulation"), which offers a full suite of logistics solutions to manage NET programs across all areas of healthcare, powered by its HIPAA-compliant digital platform. Circulation's technology expands LogistiCare's capabilities to manage transportation benefits, integrating all transportation capabilities while proactively monitoring for fraud, waste and abuse and emphasizing member convenience and satisfaction.

The Company's Matrix Investment segment consists of a minority investment in CCHN Group Holdings, Inc. and its subsidiaries ("Matrix"), a nationwide provider of home and mobile-based healthcare services for health plans in the U.S., including comprehensive health assessments ("CHAs"), quality gap closure visits, "level of service" needs assessments, and post-acute and chronic care management, providing such services through a network of community-based clinicians and a fleet of mobile health clinics with advanced diagnostics capabilities.

The Company's Corporate and Other segment includes the Company's executive, accounting, finance, internal audit, tax, legal, public reporting, and corporate development functions. On April 11, 2018, the Company announced an organizational consolidation plan to integrate substantially all activities and functions performed at the corporate holding company level into LogistiCare (the "Organizational Consolidation"). LogistiCare will retain its name and continue to be headquartered in Atlanta, GA, and the Company will continue to be named The Providence Service Corporation and be listed on NASDAQ Global Select Market ("NASDAQ") under the ticker symbol "PRSC". The Organizational Consolidation is expected to be complete by the second quarter of 2019. See Note 10, *Restructuring and Related Reorganization Costs,* for further information.

Discontinued Operations

During the periods presented, the Company completed the following transactions, which resulted in the presentation of the operations as Discontinued Operations.

- On December 21, 2018, the Company completed the sale of substantially all of the operating subsidiaries of its WD Services segment to Advanced Personnel Management Global Pty Ltd of Australia ("APM") and APM UK Holdings Limited, an affiliate of APM, with the exception of the segment's employment services operations in Saudi Arabia (the "WD Services Sale"). The Company's contractual counterparties in Saudi Arabia, including an entity owned by the Saudi Arabian government, assumed these operations beginning January 1, 2019. Additionally, on June 11, 2018, the Company entered into a Share Purchase Agreement to sell Ingeus France for a de minimis amount. The sale was effective on July 17, 2018, after court approval.

- On October 19, 2016, affiliates of Frazier Healthcare Partners purchased a 53.2% equity interest in Matrix with Providence retaining a 46.8% equity interest (the "Matrix Transaction") at the time of the transaction. Prior to the closing of the Matrix Transaction, the financial results of Matrix were included in the Company's Health Assessment Services ("HA Services") segment.

- On November 1, 2015, the Company completed the sale of its *Human Service*s segment. In addition to the results through the sale date, the Company has recorded additional expenses related to legal proceedings as described in Note 20, *Commitment and Contingencies*, related to an indemnified legal matter.

Basis of Presentation

The Company follows accounting standards set by the Financial Accounting Standards Board ("FASB"). The FASB establishes accounting principles generally accepted in the United States ("GAAP"). Rules and interpretive releases of the Securities

and Exchange Commission ("SEC") under authority of federal securities laws are also sources of authoritative GAAP for SEC registrants. References to GAAP issued by the FASB in these footnotes are to the FASB *Accounting Standards Codification* ("ASC"), which serves as a single source of authoritative non-SEC accounting and reporting standards to be applied by non-governmental entities. All amounts are presented in U.S. dollars, unless otherwise noted.

The Company holds an investment in Matrix which is accounted for using the equity method. The Company does not control the decision-making process or business management practices of Matrix. While the Company has access to certain information and performs certain procedures to review the reasonableness of information, the Company relies on management of Matrix to provide accurate financial information prepared in accordance with GAAP. The Company receives audit reports relating to such financial information from Matrix's independent auditors on an annual basis. The Company is not aware of any errors in or possible misstatements of the financial information provided by Matrix that would have a material effect on the Company's consolidated financial statements.

Reclassifications

The Company has reclassified certain amounts relating to its prior period results to conform to its current period presentation. See Note 2, *Significant Accounting Policies and Recent Accounting Pronouncements*, for additional information on reclassifications.

2. Significant Accounting Policies and Recent Accounting Pronouncements

Principles of Consolidation

The accompanying consolidated financial statements include The Providence Service Corporation, its wholly-owned subsidiaries, and entities it controls, or in which it has a variable interest and is the primary beneficiary of expected cash profits or losses. The Company records its investments in entities that it does not control, but over which it has the ability to exercise significant influence, using the equity method. The Company has eliminated significant intercompany transactions and accounts.

Accounting Estimates

The Company uses estimates and assumptions in the preparation of the consolidated financial statements in accordance with GAAP. Those estimates and assumptions affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the Company's consolidated financial statements. These estimates and assumptions also affect the reported amount of net income or loss during any period. The Company's actual financial results could differ significantly from these estimates. The significant estimates underlying the Company's consolidated financial statements include revenue recognition; allowance for doubtful accounts; accrued transportation costs; accrued restructuring; income taxes; recoverability of current and long-lived assets, including equity method investments; intangible assets and goodwill; loss contingencies; accounting for business combinations, including amounts assigned to definite and indefinite lived intangibles and contingent consideration; loss reserves for reinsurance and self-funded insurance programs; and stock-based compensation.

Cash and Cash Equivalents

Cash and cash equivalents include all cash balances and highly liquid investments with an initial maturity of three months or less. Investments in cash equivalents are carried at cost, which approximates fair value. The Company places its temporary cash investments with high credit quality financial institutions. At times, such investments may be in excess of the federally insured limits.

Accounts Receivable and Allowance for Doubtful Accounts

The Company records accounts receivable amounts at the contractual amount, less an allowance for doubtful accounts. The Company maintains an allowance for doubtful accounts at an amount it estimates to be sufficient to cover the risk that an account will not be collected. The Company regularly evaluates its accounts receivables, especially receivables that are past due, and reassesses its allowance for doubtful accounts based on identified customer collection issues. In circumstances where the Company is aware of a customer's inability to meet its financial obligation, the Company records a specific allowance for doubtful accounts to reduce its net recognized receivable to an amount the Company reasonably expects to collect. Under certain contracts of NET Services, final payment is based on a reconciliation of actual utilization and cost, and the final reconciliation may require a considerable period of time.

The Company's provision for doubtful accounts expense from continuing operations for the years ended December 31, 2018, 2017 and 2016 was $338, $1,347 and $2,892, respectively.

Property and Equipment

Property and equipment are stated at historical cost, net of accumulated depreciation, or at fair value if the assets were initially recorded as the result of a business combination or if the asset was remeasured due to an impairment. Depreciation is calculated using the straight-line method over the estimated useful life of the asset. Maintenance and repairs are expensed as incurred. Gains and losses resulting from the disposition of an asset are reflected in operating expense.

Recoverability of Goodwill

In accordance with ASC 350, *Intangibles-Goodwill and Other*, the Company reviews goodwill for impairment annually, or more frequently, if events and circumstances indicate that an asset may be impaired. Such circumstances could include, but are not limited to: (1) the loss or modification of significant contracts, (2) a significant adverse change in legal factors or in business climate, (3) unanticipated competition, (4) an adverse action or assessment by a regulator, or (5) a significant decline in the Company's stock price. We perform the annual goodwill impairment test for all reporting units as of October 1.

First, we perform qualitative assessments for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If the qualitative assessment suggests that it is more likely than not that the fair value of a reporting unit is less than its carrying value amount, then we perform a quantitative assessment and compare the fair value of the reporting unit to its carrying value.

We adopted ASU No. 2017-04, *Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment* ("ASU 2017-04") effective April 1, 2017. ASU 2017-04 removes the requirement to compare the implied fair value of goodwill with its carrying amount as part of step two of the goodwill impairment test. Instead, if we deem it necessary to perform the quantitative goodwill impairment test in an annual or interim period, we recognize an impairment charge equal to the excess, if any, of a reporting unit's carrying amount over its fair value, not to exceed the total amount of goodwill allocated to the reporting unit.

The Company estimates the fair value of the Company's reporting units using either an income approach, a market valuation approach, a transaction valuation approach or a blended approach. The income approach produces an estimated fair value of a reporting unit based on the present value of the cash flows the Company expects the reporting unit to generate in the future. Estimates included in the discounted cash flow model include the discount rate, which the Company determines based on adjusting an industry-wide weighted-average cost of capital for size, geography, and company specific risk factors, long-term rates of growth and profitability of the Company's business, working capital effects and planned capital expenditures. The market approach produces an estimated fair value of a reporting unit based on a comparison of the reporting unit to comparable publicly traded entities in similar lines of business. The transaction valuation approach produces an estimated fair value of a reporting unit based on a comparison of the reporting unit to publicly available transactional data involving both publicly traded and private entities in similar lines of business. The Company's significant estimates in both the market and transaction approach include the selected similar companies with comparable business factors such as size, growth, profitability, risk and return on investment and the multiples the Company applies to revenue and earnings before interest, taxes, depreciation and amortization ("EBITDA") to estimate the fair value of the reporting unit.

Recoverability of Intangible Assets Subject to Amortization and Other Long-Lived Assets

Intangible assets subject to amortization and other long-lived assets are carried at cost and are amortized or depreciated on a straight-line basis over their estimated useful lives of 3 to 15 years. In accordance with ASC 360, *Property, Plant, and Equipment*, the Company reviews the carrying value of long-lived assets or groups of assets to be used in operations whenever events or changes in circumstances indicate that the carrying amount of the assets may be impaired. Factors that may necessitate an impairment assessment include, among others, significant adverse changes in the extent or manner in which an asset or group of assets is used, significant adverse changes in legal factors or the business climate that could affect the value of an asset or group of assets or significant declines in the observable market value of an asset or group of assets. The presence or occurrence of those events indicates that an asset or group of assets may be impaired. In those cases, the Company assesses the recoverability of an asset or group of assets by determining whether the carrying value of the asset or group of assets exceeds the sum of the projected undiscounted cash flows expected to result from the use and eventual disposition of the assets over the remaining economic life of the asset or the primary asset in the group of assets. If such testing indicates the carrying value of the asset or group of assets is not recoverable, the Company estimates the fair value of the asset or group of assets using appropriate valuation methodologies,

which would typically include an estimate of discounted cash flows. If the fair value of those assets or groups of assets is less than carrying value, the Company records an impairment loss equal to the excess of the carrying value over the estimated fair value.

Accrued Transportation Costs

Eligible members of our customers schedule transportation through the Company's central reservation system. NET Services generally contracts with third-party providers to provide transportation. The cost of transportation is recorded in the month the services are rendered, based upon contractual rates and mileage estimates. Transportation providers provide invoices once the trip is completed. Any trips that have not been invoiced require an accrual, based upon the expected cost as well as an estimate for cancellations, as the Company is generally only obligated to pay the transportation provider for completed trips. These estimates are based upon the historical trend associated with each contract's population and the transportation provider network servicing the program. There may be differences between actual invoiced amounts and estimated costs, and any resulting adjustments are included in expense. Accrued transportation costs were $84,889 and $83,588 at December 31, 2018 and 2017, respectively.

Deferred Financing Costs and Debt Discounts

The Company capitalizes direct expenses incurred in connection with its credit facilities and other borrowings, and amortizes such expenses over the life of the respective credit facility or other borrowings. Fees charged by lenders on the revolving facility and all fees charged by third parties are recorded as deferred financing costs and fees charged by lenders on term loans are recorded as a debt discount. Deferred financing costs, net of amortization, totaling $268 and $388 as of December 31, 2018 and 2017, respectively, are included in "Prepaid expenses and other" on the consolidated balance sheets.

Revenue Recognition

The Company adopted ASU No. 2014-09, *Revenue from Contracts with Customers,* effective January 1, 2018 using the modified retrospective transition method for contracts that were not completed as of January 1, 2018. See *Recent Accounting Pronouncements* below for further information on the adoption.

The Company recognizes revenue as it transfers control of promised services to its customers. The Company generates all of its revenue from contracts with customers. The amount of revenue recognized reflects the consideration to which the Company expects to be entitled in exchange for these services. The Company satisfies substantially all of its performance obligations and recognizes revenue over time instead of at points in time. See further information in Note 3, *Revenue Recognition.*

Stock-Based Compensation

The Company follows the fair value recognition provisions of ASC Topic 718 – *Compensation – Stock Compensation* ("ASC 718"), which requires companies to measure and recognize compensation expense for all share-based payments at fair value.

- The Company calculates the fair value of stock options using the Black-Scholes option-pricing formula. The fair value of non-vested restricted stock grants is determined based on the closing market price of the Company's Common Stock on the date of grant. Stock-based compensation expense charged against income for stock options and stock grants is based on the grant-date fair value. Forfeitures are recorded as they occur. The expense for stock-based compensation awards is amortized on a straight-line basis over the requisite service period, which is typically the vesting period.

- The Company records restricted stock units ("RSUs") that may be settled by the holder in cash, rather than shares, as a liability and remeasures these liabilities at fair value at the end of each reporting period. Upon settlement of these awards, the total compensation expense recorded over the vesting period of the awards will equal the settlement amount, which is based on the Company's stock price on the settlement date.

- Performance-based RSUs vest upon achievement of certain company specific performance conditions. On the date of grant, the Company determines the fair value of the performance-based award using the fair value of the Company's Common Stock at that time and assesses whether it is probable that the performance targets will be achieved. If assessed as probable, the Company records compensation expense for these awards over the requisite service period. At each reporting period, the Company reassesses the probability of achieving the performance targets and the performance period required to meet those targets. The estimation of whether the performance targets will be achieved and of the performance period required to achieve the targets requires judgment, and to the extent actual results or updated estimates differ from the Company's current estimates, the cumulative effect

on current and prior periods of those changes will be recorded in the period estimates are revised, or the change in estimate will be applied prospectively depending on whether the change affects the estimate of total compensation cost to be recognized or merely affects the period over which compensation cost is to be recognized. The ultimate number of shares issued and the related compensation expense recognized will be based on a comparison of the final performance metrics to the specified targets.

- The Company calculates the fair value of market-based stock awards using the Monte-Carlo simulation valuation model. Forfeitures are recorded as they occur. Compensation expense for market-based awards is recognized over the requisite service period regardless of whether the market conditions are expected to be achieved.

Income Taxes

Deferred income taxes are determined by the liability method in accordance with ASC Topic 740 - *Income Taxes*. Under this method, deferred tax assets and liabilities are determined based on differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes and are measured using the enacted tax rates and laws that are expected to be in effect when the differences are expected to reverse. The Company considers many factors when assessing the likelihood of future realization of deferred tax assets, including recent earnings experience by jurisdiction, expectations of future taxable income, and the carryforward periods available for tax reporting purposes, as well as other relevant factors. The Company establishes a valuation allowance to reduce deferred tax assets to the amount that is more likely than not to be realized. Due to inherent complexities arising from the nature of the Company's businesses, future changes in income tax law or variances between the Company's actual and anticipated operating results, the Company makes certain judgments and estimates. Therefore, actual income taxes could materially vary from these estimates.

The Company has recorded a valuation allowance which includes amounts for certain carryforwards and deferred tax assets, as more fully described in Note 19, *Income Taxes,* for which the Company has concluded that it is more likely than not that these carryforwards and deferred tax assets will not be realized in the ordinary course of operations.

The Company recognizes interest and penalties related to income taxes as a component of income tax expense.

The Company accounts for uncertain tax positions based on a two-step process of evaluating recognition and measurement criteria. The first step assesses whether the tax position is more likely than not to be sustained upon examination by the tax authority, including resolution of any appeals or litigation, based on the technical merits of the position. If the tax position meets the more likely than not criteria, the portion of the tax benefit greater than 50% likely to be realized upon settlement with the tax authority is recognized in the consolidated financial statements.

On December 22, 2017, the U.S. bill commonly referred to as the Tax Cuts and Jobs Act ("Tax Reform Act") was enacted as more fully described in Note 19, *Income Taxes*.

Loss Reserves for Certain Reinsurance and Self-Funded Insurance Programs

The Company historically reinsured a substantial portion of its automobile, general and professional liability and workers' compensation costs under reinsurance programs primarily through the Company's wholly-owned subsidiary, Social Services Providers Captive Insurance Company ("SPCIC"), a licensed captive insurance company domiciled in the State of Arizona. As of May 16, 2017, SPCIC did not renew the expiring reinsurance policies. SPCIC will continue to resolve claims under the historical policy years.

The Company utilizes a report prepared by an independent actuary to estimate the gross expected losses related to historical automobile, general and professional and workers' compensation liability reinsurance policies, including the estimated losses in excess of SPCIC's insurance limits, which would be reimbursed to SPCIC to the extent such losses were incurred. As of December 31, 2018 and 2017, the Company had reserves of $3,900 and $6,699, respectively, for the automobile, general and professional liability and workers' compensation reinsurance policies, net of expected receivables for losses in excess of SPCIC's historical insurance limits. The gross reserve as of December 31, 2018 and 2017 of $10,489 and $12,448, respectively, is classified as "Reinsurance liability reserves" and "Other long-term liabilities" in the consolidated balance sheets. The estimated amount to be reimbursed to SPCIC as of December 31, 2018 and 2017 was $6,589 and $5,749, respectively, and is classified as "Other receivables" and "Other assets" in the consolidated balance sheets.

The Company also maintains a self-funded health insurance program with a stop-loss umbrella policy with a third-party insurer to limit the maximum potential liability for individual claims generally to $300 per person, subject to an aggregating stop-loss limit of $400. In addition, the program has a total stop-loss limit for total claims, in order to limit the Company's exposure to

catastrophic claims. With respect to this program, the Company considers historical and projected medical utilization data when estimating its health insurance program liability and related expense. As of December 31, 2018 and 2017, the Company had $2,201 and $2,229, respectively, in reserve for its self-funded health insurance programs. The reserves are classified as "Reinsurance and related liability reserves" in the consolidated balance sheets.

The Company utilizes analysis prepared by third-party administrators and independent actuaries based on historical claims information with respect to the general and professional liability coverage, workers' compensation coverage, automobile liability, automobile physical damage, and health insurance coverage to determine the amount of required reserves.

The Company regularly analyzes its reserves for incurred but not reported claims, and for reported but not paid claims related to its reinsurance and self-funded insurance programs. The Company believes its reserves are adequate. However, significant judgment is involved in assessing these reserves, such as assessing historical paid claims, average lag times between the claims' incurred date, reported dates and paid dates, and the frequency and severity of claims. There may be differences between actual settlement amounts and recorded reserves and any resulting adjustments are included in expense once a probable amount is known.

Restructuring and Related Reorganization Costs

On April 11, 2018, the Company announced the Organizational Consolidation. The Company accrued for severance and other employee separation costs under this plan when it was probable that benefits would be paid and the amount was reasonably estimable. The amounts used in determining severance accruals are based on an estimate of the salaries and related benefit costs payable and are included in accrued expenses to the extent they have not been paid. See further information in Note 10, *Restructuring and Related Reorganization Costs*.

Discontinued Operations

In determining whether a group of assets disposed (or to be disposed) of should be presented as a discontinued operation, the Company makes a determination of whether the criteria for held-for-sale classification is met and whether the disposition represents a strategic shift that has (or will have) a major effect on the entity's operations and financial results. If these determinations can be made affirmatively, the results of operations of the group of assets being disposed of (as well as any gain or loss on the disposal transaction) are aggregated for separate presentation apart from continuing operating results of the Company in the consolidated financial statements. See Note 23, *Discontinued Operations,* for a summary of discontinued operations.

Earnings Per Share

The Company computes basic earnings per share by taking net income attributable to the Company available to common stockholders divided by the weighted average number of common shares outstanding during the period, including restricted stock and stock held in escrow if such shares are participating securities. Diluted earnings per share includes the potential dilution that may occur from stock-based awards and other stock-based commitments using the treasury stock or the as-if converted methods, as applicable. For additional information on how the Company computes earnings per share, see Note 16, *Earnings Per Share*.

Recent Accounting Pronouncements

The Company adopted the following accounting pronouncements during the year ended December 31, 2018:

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers* (Topic 606) ("ASU 2014-09"). ASU 2014-09 introduced FASB Accounting Standards Codification Topic 606 ("ASC 606"), which replaced historical revenue recognition guidance and is intended to improve and converge with international standards the financial reporting requirements for revenue from contracts with customers. The core principle of ASC 606 is that an entity should recognize revenue for the transfer of goods or services equal to the amount that it expects to be entitled to receive for those goods or services. ASC 606 also requires additional disclosures about the nature, timing and uncertainty of revenue and cash flows arising from customer contracts, including significant judgments and changes in judgments. ASU 2014-09 allows for adoption either on a full retrospective basis to each prior reporting period presented or on a modified retrospective basis with the cumulative effect of initially applying the new guidance recognized at the date of initial application. The Company adopted ASU 2014-09 effective January 1, 2018 using the modified retrospective transition method for contracts that were not completed as of January 1, 2018.

The Company recognized the cumulative effect of initially applying the new revenue standard as an adjustment to the opening balance of retained earnings. These impacts related to our WD Services segment, which has since met the criteria for classification as discontinued operations. Upon adoption of ASU 2014-09, the cumulative effect of the changes made to the Company's consolidated balance sheet as of January 1, 2018 were as follows:

	Balance at December 31, 2017	Adjustments due to ASU 2014-09	Balance at January 1, 2018
Assets			
Current assets of discontinued operations	$ 104,024	$ 11,182	$ 115,206
Liabilities			
Current liabilities of discontinued operations	61,643	5,442	67,085
Noncurrent liabilities of discontinued operations	7,565	30	7,595
Equity			
Retained earnings, net of tax	204,818	5,710	210,528

The impact of applying the new revenue recognition guidance on the Company's consolidated statement of operations for the year ended December 31, 2018 was as follows:

	Year ended December 31, 2018	
	As Reported	Pro forma as if the previous accounting guidance was in effect
Service revenue, net	$ 1,384,965	$ 1,400,453
Service expense	1,284,603	1,300,091
Operating income	24,276	24,276

There was no impact of applying the new revenue recognition guidance on the Company's consolidated balance sheet at December 31, 2018, as any assets and liabilities impacted by the guidance were sold in the WD Services Sale. The comparative information has not been restated and continues to be reported under the accounting standards in effect for those periods. See further information in Note 3, *Revenue Recognition*.

In August 2016, the FASB issued ASU No. 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments* ("ASU 2016-15"). ASU 2016-15 provides guidance for eight targeted changes with respect to how cash receipts and cash payments are classified in the statements of cash flows, with the objective of reducing diversity in practice. ASU 2016-15 is effective for financial statements issued for fiscal years beginning after December 15, 2017, with early adoption permitted. The Company adopted ASU 2016-15 on January 1, 2018. The adoption did not have a significant impact on the Company's consolidated financial statements.

In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash* ("ASU 2016-18"). ASU 2016-18 requires that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. ASU 2016-18 is effective for public entities for fiscal years beginning after December 15, 2017, and interim periods within those fiscal years. Early adoption is permitted, including adoption in an interim period; however, any adjustments must be reflected as of the beginning of the fiscal year that includes that interim period. ASU 2016-18 must be adopted retrospectively. The Company adopted ASU 2016-18 on January 1, 2018. As a result of the adoption of ASU 2016-18, the Company recast its consolidated statement of cash flows for the years ended December 31, 2017 and 2016. The recast resulted in an increase in cash used in investing activities of $7,834 for the year ended December 31, 2017. The recast resulted in a decrease in cash provided by investing activities of $5,926 for the year ended December 31, 2016. See additional information in Note 4, *Cash, Cash Equivalents and Restricted Cash.*

In May 2017, the FASB issued ASU No. 2017-09, *Compensation–Stock Compensation (Topic 718): Scope of Modification Accounting* ("ASU 2017-09"). ASU 2017-09 provides guidance about which changes to the terms of a share-based payment award should be accounted for as a modification. A change to an award should be accounted for as a modification unless the fair value of the

modified award is the same as the original award, the vesting conditions do not change, and the classification as an equity or liability instrument does not change. This guidance is effective for fiscal years beginning after December 15, 2017. Early

adoption is permitted. The Company adopted ASU 2017-09 on January 1, 2018. The adoption of ASU 2017-09 did not have a material impact on the Company's consolidated financial statements.

Recent accounting pronouncements that were not yet adopted by the Company through December 31, 2018 are as follows:

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)* ("ASU 2016-02"). ASU 2016-02 introduced FASB Accounting Standards Codification Topic 842 ("ASC 842"), which will replace ASC 840, *Leases*. In July 2018, the FASB issued ASU No. 2018-10, *Codification Improvements to Topic 842 (Leases)* ("ASU 2018-10"), which provides narrow amendments to clarify how to apply certain aspects of the new lease standard. Additionally, in July 2018, the FASB issued ASU No. 2018-11, *Leases (Topic 842): Targeted Improvements* ("ASU 2018-11"). ASU 2018-11 provides a new transition method and a practical expedient for separating components of a contract.

ASC 842 is effective for publicly held entities for fiscal years beginning after December 15, 2018, including interim periods within those fiscal years. Early adoption is permitted. Lessees may apply a modified retrospective transition approach for leases existing at, or entered after, the beginning of the earliest comparative period presented in the financial statements, or lessees may initially apply the new lease standard at the adoption date and recognize a cumulative-effect adjustment to the opening balance of retained earnings in the period of adoption.

The Company has not entered into significant lease agreements in which it is the lessor; however, the Company does have lease agreements in which it is the lessee. Under ASC 842, lessees will be required to recognize a lease liability and right-of-use asset for all leases (with the exception of short-term leases) at the commencement date. The Company will apply the modified retrospective transition method and elect the transition option to use the effective date of January 1, 2019 as the date of initial application. The Company will recognize the cumulative effect of the transition adjustment as of the effective date and will not provide any new lease disclosures for periods before the effective date. With respect to the practical expedients, the Company will elect the package of practical expedients and the practical expedient not to separate lease and non-lease components. The Company will not apply the use of hindsight practical expedient. Based on the Company's current portfolio of leases, the Company expects $24,000 to $28,000 of additional leased assets and liabilities will be recognized on its consolidated balance sheet. The Company does not expect a material impact on the statement of operations.

In June 2016, the FASB issued ASU No. 2016-13, *Financial Instruments - Credit Losses (Topic 326)* ("ASU 2016-13"). The amendments in ASU 2016-13 will supersede or clarify much of the existing guidance for reporting credit losses for assets held at amortized cost basis and available for sale debt securities. The amendments in ASU 2016-13 affect loans, debt securities, trade receivables, net investments in leases, off balance sheet credit exposures, reinsurance receivables, and any other financial assets not excluded from the scope that have the contractual right to receive cash. ASU 2016-13 is effective for financial statements issued for fiscal years beginning after December 15, 2019, with early adoption permitted for fiscal years beginning after December 15, 2018. The Company is currently evaluating the impact of ASU 2016-13 on its consolidated financial statements.

In August 2018, the FASB issued ASU No. 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework-Changes to the Disclosure Requirements for Fair Value Measurement* ("ASU 2018-13"). ASU 2018-13 removes certain disclosures, modifies certain disclosures and added additional disclosures. The standard is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019, with early adoption permitted. Certain disclosures in ASU 2018-13 would need to be applied on a retrospective basis and others on a prospective basis. The Company is currently evaluating the impact of ASU 2018-13 on its consolidated financial statements.

In August 2018, the FASB issued ASU No. 2018-15, *Intangibles-Goodwill and Other-Internal-Use Software: Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract* ("ASU 2018-15"), which will align the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. The standard is effective for fiscal years beginning after December 15, 2019, with early adoption permitted. The Company is currently evaluating the impact of ASU 2018-15 on its consolidated financial statements.

In August 2018, the SEC adopted the final rule under SEC Release No. 33-10532, Disclosure Update and Simplification, amending certain disclosure requirements that were redundant, duplicative, overlapping, outdated or superseded. In addition, the amendments expanded the disclosure requirements on the analysis of stockholders' equity for interim financial statements. Under the amendments, an analysis of changes in each caption of stockholders' equity presented in the balance sheet must be provided in a note or separate statement. The analysis should present a reconciliation of the beginning balance to the ending balance of each period for which a statement of comprehensive income is required to be filed. The final rule is effective on November 5, 2018. The Company will adopt this new rule beginning with its financial reporting for the quarter ending March 31, 2019. Upon adoption,

the Company will include its Consolidated Statements of Stockholders' Equity with each filing of a Quarterly Report on Form 10-Q.

3. Revenue Recognition

Under ASC 606, the Company recognizes revenue as it transfers control of promised services to its customers. The Company generates all of its revenue from contracts with customers. The amount of revenue recognized reflects the consideration to which the Company expects to be entitled in exchange for these services. The Company satisfies substantially all of its performance obligations and recognizes revenue over time instead of at points in time.

Disaggregation of Revenue

The following table summarizes disaggregated revenue from contracts with customers for the year ended December 31, 2018 by contract type for NET Services:

State Medicaid agency contracts	$	732,261
Managed care organization contracts		652,704
Total NET Services revenue, net	$	1,384,965

Capitated contracts	$	1,096,822
Non-capitated contracts		288,143
Total NET Services revenue, net	$	1,384,965

NET Services provides non-emergency transportation services pursuant to contractual commitments over defined service delivery periods. For most contracts, NET Services arranges for transportation of members through its network of independent transportation providers, whereby it remits payment to the transportation providers. However, for certain contracts, NET Services only provides administrative management services to support the customers' efforts to serve its clients, and the amount of revenue recognized is based upon the management fee earned.

These contracts typically include single performance obligations under which NET Services stands ready to deliver management, fulfillment and record-keeping related to non-emergency transportation services. Transportation management services include, but are not limited to, fraud, waste, and abuse and utilization review programs as well as compliance controls. NET Services' performance obligations consist of a series of distinct services that are substantially the same and which are transferred to the customer in the same manner. In most cases, NET Services is the principal in its arrangements because it controls the services before transferring those services to the customer.

NET Services primarily uses the 'as invoiced' practical expedient to recognize revenue because it typically has the right to consideration from customers in an amount that corresponds directly with the value of its performance to date. This is consistent with NET Services' historical revenue recognition policy. NET Services recognizes revenue for some of its contracts that include variable consideration using a time-elapsed measure when the fees earned relate directly to services performed in the period. Because most contracts include termination for convenience clauses with required notice periods of less than one year, most NET Services contracts are deemed to be short-term in nature.

Some of NET Services' contracts include provisions whereby it must provide certain levels of service or face potential penalties or be required to refund fees paid by the customer. For those contracts, NET Services records a provision to reduce revenue to reflect the amount to which it expects it will ultimately be entitled.

The only financial impact for NET Services of adopting ASU 2014-09 was the determination it is the agent under one of its contracts based on the new guidance, whereas it previously considered itself the principal in the arrangement. Consequently, NET Services now recognizes revenue under the specific contract on a net basis, which resulted in reduced revenue and service expense of $15,488 during the year ended December 31, 2018.

During the year ended December 31, 2018, NET Services recognized $5,685 from performance obligations satisfied in previous periods due to the resolution of contractual adjustments agreed with the customer.

Related Balance Sheet Accounts

Accounts receivable, net - The following table provides information about accounts receivable, net as of December 31, 2018 and 2017:

	December 31, 2018	December 31, 2017
Accounts receivable	$ 101,340	$ 73,416
NET Services' reconciliation contract receivable	48,270	42,054
Allowance for doubtful accounts	(1,854)	(5,262)
	$ 147,756	$ 110,208

NET Services accrued contract payments - Includes liabilities related to certain contracts of NET Services for which final payment is based on a reconciliation of actual utilization and cost, and the final reconciliation may require a considerable period of time. The balance is included in "Accrued expenses" in the consolidated balance sheets. The balance at December 31, 2018 and 2017 totaled $9,756 and $17,487, respectively.

Deferred revenue - Includes funds received for certain services in advance of services being rendered. The balance of current deferred revenue at December 31, 2018 and December 31, 2017 totaled $562 and $3,019, respectively. The balance of noncurrent deferred revenue was $963 at December 31, 2018, and is included in "Other long-term liabilities" on the consolidated balance sheet. The decrease in the total deferred revenue balance from December 31, 2017 to December 31, 2018 is primarily driven by cash payments received or due in advance of satisfying our performance obligations. During the year ended December 31, 2018, $3,019 of revenue deferred as of December 31, 2017 was recognized.

Practical Expedients, Exemptions and Other Matters

We do not incur significant sales commission expenses. Any amounts are expensed as incurred. These costs are recorded within service expense in the consolidated statements of operations.

The Company generally expects the period of time from when it transfers a promised service to a customer and when the customer pays for the service to be one year or less, and thus we do not have a significant financing component for our contracts with customers.

We do not disclose the value of unsatisfied performance obligations for (i) contracts with an original expected length of one year or less; (ii) contracts for which we recognize revenue at the amount to which we have the right to invoice for services performed; or (iii) contracts for which the variable consideration is allocated entirely to a wholly unsatisfied performance obligation or to a wholly unsatisfied promise to transfer a distinct good or service that forms part of a single performance obligation, and the terms of the variable consideration relate specifically to our efforts to transfer the distinct service or to a specific outcome from transferring the distinct service.

4. Cash, Cash Equivalents and Restricted Cash

The following table provides a reconciliation of cash, cash equivalents and restricted cash reported within the consolidated balance sheets to the amounts shown in the consolidated statements of cash flows:

	December 31,	
	2018	2017
Cash and cash equivalents	$ 5,678	$ 52,798
Restricted cash, current	1,482	1,091
Current assets of discontinued operations	2,321	42,512
Restricted cash, less current portion	2,886	5,205
Cash, cash equivalents and restricted cash	$ 12,367	$ 101,606

Restricted cash primarily relates to amounts held in trusts for reinsurance claims losses under the Company's captive insurance operation for historical workers' compensation, general and professional liability and auto liability reinsurance programs, as well as amounts restricted for withdrawal under our self-insured medical and benefits plans. Current assets of discontinued

operations principally reflects the cash position of WD Services operations in Saudi Arabia, which was not sold as part of the WD Services Sale. Such cash will be used to fund the shut-down costs of this operation as needed.

5. Equity Investment

Matrix

Prior to the closing of the Matrix Transaction on October 19, 2016, the financial results of Matrix were included in the Company's HA Services segment. Subsequent to the closing of the Matrix Transaction, the Company owned a 46.8% noncontrolling interest in Matrix. As of December 31, 2018, the Company owned a 43.6% noncontrolling interest in Matrix. Pursuant to a Shareholder's Agreement, affiliates of Frazier Healthcare Partners hold rights necessary to control the fundamental operations of Matrix. The Company accounts for this investment in Matrix under the equity method of accounting and the Company's share of Matrix's income or losses are recorded as "Equity in net loss (gain) of investees" in the accompanying consolidated statements of operations.

The carrying amount of the assets included in the Company's consolidated balance sheets and the maximum loss exposure related to the Company's interest in Matrix as of December 31, 2018 and 2017 totaled $161,503 and $169,699, respectively.

Summary financial information for Matrix on a standalone basis is as follows:

	December 31,	
	2018	2017
Current assets	$ 61,565	$ 37,563
Long-term assets	719,450	597,613
Current liabilities	27,619	27,718
Long-term liabilities	373,159	240,513

	Year ended December 31, 2018	Year ended December 31, 2017	October 19, 2016 through December 31, 2016
Revenue	$ 282,067	$ 227,872	$ 41,635
Operating (loss) income	(1,186)	11,870	(4,079)
Net (loss) income	(19,962)	26,665	(4,200)

Included in Matrix's standalone net loss of $19,962 for the year ended December 31, 2018 are depreciation and amortization of $43,119, integration costs of $6,524, equity compensation of $2,698, management fees paid to Matrix's shareholders of $4,887, merger and acquisition due diligence related costs of $2,341, transaction related costs of $1,010, interest expense of $25,942, including debt transaction costs and the write-off of deferred financing fees of $3,748, and an income tax benefit of $7,166.

Included in Matrix's standalone net income of $26,665 for the year ended December 31, 2017 are depreciation and amortization of $33,512, transaction related expenses of $3,537, which includes $2,679 of transaction incentive compensation, equity compensation of $2,639, management fees paid to Matrix's shareholders of $2,331, acquisition related costs of $412, interest expense of $14,818 and an income tax benefit of $29,613. The income tax benefit primarily related to the re-measurement of deferred tax liabilities arising from a lower U.S. corporate tax rate as a result of the Tax Reform Act.

Included in Matrix's standalone net loss of $4,200 for the year ended December 31, 2016 are depreciation and amortization of $6,356, transaction related expenses of $6,367, which includes $4,033 of transaction incentive compensation, equity compensation of $407, management fees paid to Matrix's shareholders of $396, interest expense of $2,949 and an income tax benefit of $2,828.

See Note 23, *Discontinued Operations*, for Matrix's January 1, 2016 through October 19, 2016 results of operations.

6. Prepaid Expenses and Other

Prepaid expenses and other were comprised of the following:

	December 31,	
	2018	2017
Prepaid income taxes	$ 35,207	$ 254
Escrow funds	—	10,000
Prepaid insurance	1,308	1,765
Note receivable	—	3,224
Prepaid rent	828	722
Other	6,824	6,494
Total prepaid expenses and other	$ 44,167	$ 22,459

Escrow funds at December 31, 2017 represented amounts related to indemnification claims from the sale of the Human Services segment. The escrow funds were used during the year ended December 31, 2018 to satisfy a portion of the Company's settlement of indemnification claims. See Note 20, *Commitments and Contingencies*, for further information.

7. Property and Equipment

Property and equipment consisted of the following:

	Estimated Useful Life (years)			December 31,	
				2018	2017
Computer and telecom equipment	3	—	5	$ 29,883	$ 27,742
Software	3	—	5	24,318	22,256
Leasehold improvements	Shorter of 7 years or lease term			8,078	7,599
Furniture and fixtures	5	—	10	1,942	2,351
Automobiles	5			3,666	3,209
Construction and development in progress	N/A			299	12,579
				68,186	75,736
Less accumulated depreciation				45,221	38,064
Total property and equipment, net				$ 22,965	$ 37,672

Depreciation expense from continuing operations was $12,058, $10,717 and $9,900 for the years ended December 31, 2018, 2017 and 2016, respectively.

Following the acquisition of Circulation and an analysis of the technology capabilities and scalability of the Circulation platform, the Company determined it would not continue the development of the LCAD NextGen technology ("NextGen"). The Company also determined it would not place any of the developed NextGen technology into service, and recorded an asset impairment charge of $13,496 related to its NET Services segment during the fourth quarter of 2018. In addition, the Company had previously recorded an impairment of $679 during the second quarter of 2018 in relation to the decision to abandon specific development work intended to synchronize data across applications of the proprietary NextGen systems, based on the determination of an alternative method to accomplish this task. The total impairment charge of $14,175 is reflected in "Asset impairment charge" in the consolidated statement of operations for the year ended December 31, 2018. As of December 31, 2017, construction in progress was primarily comprised of the software development costs for NextGen.

8. Goodwill and Intangibles

Impairment

The Company did not record any goodwill or intangible asset impairment charges for continuing operations for the years ended December 31, 2018, 2017 and 2016.

Goodwill

There were no changes in goodwill from December 31, 2016 to December 31, 2017. Changes in goodwill were as follows for the period from December 31, 2017 to December 31, 2018:

	NET Services
Balances at December 31, 2017	
Goodwill	$ 191,215
Accumulated impairment losses	(96,000)
	95,215
Acquisition of Circulation	40,001
Balances at December 31, 2018	
Goodwill	231,216
Accumulated impairment losses	(96,000)
	$ 135,216

The total amount of goodwill from continuing operations that was deductible for income tax purposes related to acquisitions as of December 31, 2018 and 2017 was $29 for each year.

Intangible Assets

Intangible assets are comprised of acquired customer relationships, trademarks and trade names, and developed technology. Intangible assets consisted of the following:

		December 31,			
		2018		2017	
	Estimated Useful Life (Yrs)	Gross Carrying Amount	Accumulated Amortization	Gross Carrying Amount	Accumulated Amortization
Customer relationships	15	$ 43,800	$ (32,515)	$ 43,800	$ (29,635)
Developed technology of Circulation	5	14,100	(705)	—	—
Customer relationships of Circulation	3	1,400	(117)	—	—
Trademarks and trade names of Circulation	3	200	(17)	—	—
Total		$ 59,500	$ (33,354)	$ 43,800	$ (29,635)

The weighted-average amortization period at December 31, 2018 for intangibles was 12.3 years. No significant residual value is estimated for these intangible assets. Amortization expense from continuing operations was $3,755, $2,901 and $2,881 for the years ended December 31, 2018, 2017 and 2016, respectively.

The Company acquired Circulation in September 2018, which resulted in the increase of intangible assets from December 31, 2017 to December 31, 2018. See additional discussion of the Circulation acquisition in Note 22, *Acquisitions*.

The total amortization expense is estimated to be as follows for the next five years as of December 31, 2018:

Year	Amount
2019	$ 6,234
2020	6,234
2021	6,101
2022	5,461
2023	2,116
Total	$ 26,146

9. Accrued Expenses

Accrued expenses consisted of the following:

	December 31,	
	2018	2017
Accrued compensation and related	$ 11,050	$ 18,816
NET Services accrued contract payments	9,756	17,487
Accrued settlement	—	15,000
Accrued cash settled stock-based compensation	3,719	3,938
Income taxes payable	—	1,959
Other	14,666	14,443
Total accrued expenses	$ 39,191	$ 71,643

The accrued settlement at December 31, 2017 represented amounts related to indemnification claims from the sale of the Human Services segment, which was completed on November 1, 2015. The settlement was finalized during the year ended December 31, 2018, which resulted in the payment of the accrued settlement amount, in which $10,000 was released from an escrow account and $4,475 was paid in cash. See Note 20, *Commitments and Contingencies*, for further information.

10. Restructuring and Related Reorganization Costs

Corporate and Other

On April 11, 2018, the Company announced the Organizational Consolidation, which involves transferring all job responsibilities previously performed by employees of the holding company to LogistiCare, and closing the current corporate offices in Stamford, Connecticut and Tucson, Arizona. The Company adopted an employee retention plan designed to incentivize current holding company level employees to remain employed with the Company during the transition. The employee retention plan became effective on April 9, 2018 and covers the holding company level employees and provides for certain payments and benefits to be provided to the employees if they remain employed with the Company through a retention date established for each individual, subject to a fully executed retention letter. The Organizational Consolidation is expected to be completed by the end of the second quarter of 2019.

As of December 31, 2018, the Company estimates that it will incur aggregate pre-tax restructuring charges of approximately $12,200 through June 30, 2019 in connection with the Organizational Consolidation discussed above. These charges include approximately $7,100 related to retention and personnel costs, $2,000 related to acceleration of stock-based compensation, $600 related to accelerated depreciation and $2,500 related to other costs, including lease termination and recruiting costs. A total of $8,797 restructuring and related costs has been incurred during the year ended December 31, 2018 related to the Organizational Consolidation. These costs include $5,098 of retention and personnel costs, $1,731 of accelerated stock-based compensation expense, $436 of accelerated depreciation and $1,532 of other costs, primarily related to recruiting and legal costs. These costs are recorded as “General and administrative expense” and “Depreciation and amortization” in the accompanying consolidated statements of operations. The Company’s estimate is subject to change, as it is based upon assumptions for the sublease of office space in Stamford, Connecticut and Tucson, Arizona, as well as other factors.

Summary of Liability for Corporate and Other Restructuring and Related Charges

	January 1, 2018	Costs Incurred	Cash Payments	December 31, 2018
Retention and personnel liability	$ —	$ 5,098	$ (3,142)	$ 1,956
Other liability	—	1,532	(1,134)	398
Total	$ —	$ 6,630	$ (4,276)	$ 2,354

The total restructuring liability at December 31, 2018 includes $2,124 classified as "Accrued expenses" and $230 classified as "Accounts payable" in the consolidated balance sheet.

11. Debt

The Company's debt was as follows:

	December 31, 2018	December 31, 2017
$200,000 revolving loan, LIBOR plus 2.25% - 3.25% with interest payable at least once every three months through August 2019	$ —	$ —
Capital lease obligations	1,071	2,984
	1,071	2,984
Less current portion of debt	718	2,400
Total debt, less current portion	$ 353	$ 584

Annual maturities of revolving loan and capital lease obligations as of December 31, 2018 are as follows:

Year	Amount
2019	$ 718
2020	308
2021	45
Total	$ 1,071

Credit Facility

The Company is a party to the amended and restated credit and guaranty agreement, dated as of August 2, 2013 (as amended, the "Credit Agreement"), with Bank of America, N.A., as administrative agent, swing line lender and letter of credit issuer, and the other lenders party thereto. The Credit Agreement provides the Company with a $200,000 revolving credit facility (the "Credit Facility"), including a sub-facility of $25,000 for letters of credit. On June 7, 2018, the Company and certain of its subsidiaries entered into the Fifth Amendment to the Amended and Restated Credit and Guaranty Agreement (the "Amendment"), amending the Amended and Restated Credit and Guaranty Agreement dated as of August 2, 2013 (as amended to date, the "Credit Agreement"), by and among the Company, the guarantors from time to time party thereto, the lenders from time to time party thereto and Bank of America, N.A. as administrative agent. The Amendment (i) extended the maturity date of the Credit Agreement to August 2, 2019 and (ii) amended certain covenants under the Credit Agreement to provide for greater operational, financial and strategic flexibility, including the implementation of the Company's Organizational Consolidation.

As of December 31, 2018, the Company had borrowings of $0 and ten letters of credit outstanding in the amount of $12,338 under the revolving credit facility. At December 31, 2018, the Company's available credit under the revolving credit facility was $187,662. Under the Credit Agreement, the Company has an option to request an increase in the amount of the revolving credit facility from time to time (on substantially the same terms as apply to the existing facilities) in an aggregate amount of up to $75,000 with either additional commitments from lenders under the Credit Agreement at such time or new commitments from

financial institutions acceptable to the administrative agent in its reasonable discretion, so long as no default or event of default exists at the time of any such increase. The Company may not be able to access additional funds under this increase option as no lender is obligated to participate in any such increase under the Credit Facility. The Credit Agreement has a maturity date of August 2, 2019.

Interest on the outstanding principal amount of loans accrues, at the Company's election, at a per annum rate equal to LIBOR, plus an applicable margin, or the base rate as defined in the agreement plus an applicable margin. The applicable margin ranges from 2.25% to 3.25% in the case of LIBOR loans and 1.25% to 2.25% in the case of the base rate loans, in each case, based on the Company's consolidated leverage ratio as defined in the Credit Agreement. Interest on the loans is payable quarterly in arrears. In addition, the Company is obligated to pay a quarterly commitment fee based on a percentage of the unused portion of each lender's commitment under the Credit Facility and quarterly letter of credit fees based on a percentage of the maximum amount available to be drawn under each outstanding letter of credit. The commitment fee and letter of credit fee range from 0.25% to 0.50% and 2.25% to 3.25%, respectively, in each case, based on the Company's consolidated leverage ratio.

The Company's obligations under the Credit Facility are guaranteed by all of the Company's present and future domestic subsidiaries, excluding certain domestic subsidiaries which include the Company's insurance captive and the Company's investment in Matrix. The Company's obligations under, and each guarantor's obligations under its guaranty of, the Credit Facility are secured by a first priority lien on substantially all of the Company's respective assets, including a pledge of 100% of the issued and outstanding stock of the Company's domestic subsidiaries, excluding the Company's insurance captive.

The Credit Agreement contains customary affirmative and negative covenants and events of default. The negative covenants include restrictions on the Company's ability to, among other things, incur additional indebtedness, create liens, make investments, give guarantees, pay dividends, sell assets, and merge and consolidate. The Company is subject to financial covenants, including consolidated net leverage and consolidated interest coverage covenants.

Capital Leases

We have capital leases for information technology hardware and software with termination dates ranging from January 2018 through October 2020. The terms of the leases are between 12 and 36 months, with interest recorded at an incremental borrowing rate of 3.28%. At December 31, 2018, $1,894 represents the hardware and software under capital leases and $673 represents the related accumulated depreciation.

12. Convertible Preferred Stock, Net

The Company completed a rights offering on February 5, 2015 (the "Rights Offering") providing all of the Company's existing common stockholders the non-transferrable right to purchase their pro rata share of $65,500 of convertible preferred stock at a price equal to $100.00 per share ("Preferred Stock"). The Preferred Stock is convertible into shares of Providence's common stock, $0.001 par value per share ("Common Stock") at a conversion price equal to $39.88 per share, which was the closing price of the Company's Common Stock on NASDAQ on October 22, 2014.

Stockholders exercised subscription rights to purchase 130,884 shares of the Company's Preferred Stock. Pursuant to the terms and conditions of the Standby Purchase Agreement (the "Standby Purchase Agreement") between Coliseum Capital Partners, L.P., Coliseum Capital Partners II, L.P., Blackwell Partners, LLC - Series A and Coliseum Capital Co-Invest, L.P. (collectively, the "Coliseum Stockholders") and the Company, the remaining 524,116 shares of the Company's Preferred Stock were purchased by the Coliseum Stockholders at the $100.00 per share subscription price. The Company received $65,500 in aggregate gross proceeds from the consummation of the Rights Offering and Standby Purchase Agreement. Additionally, on March 12, 2015, the Coliseum Stockholders exercised their right to purchase an additional 150,000 shares of the Company's Preferred Stock, at a purchase price of $105.00 per share or a total purchase price of $15,750, of the same series and having the same conversion price as the Preferred Stock sold in the Rights Offering.

The Company may pay a noncumulative cash dividend on each share of Preferred Stock, if and when declared by a committee of its Board of Directors ("Board"), at the rate of five and one-half percent (5.5%) per annum on the liquidation preference then in effect. On or before the third business day immediately preceding each fiscal quarter, the Company must determine its intention whether or not to pay a cash dividend with respect to that ensuing quarter and will give notice of its intention to each holder of Preferred Stock as soon as practicable thereafter.

In the event the Company does not declare and pay a cash dividend, the Company will declare a payment-in-kind ("PIK") dividend by increasing the liquidation preference of the convertible Preferred Stock to an amount equal to the liquidation preference in effect at the start of the applicable dividend period, plus an amount equal to the liquidation preference then in effect multiplied

by eight and one-half percent (8.5%) per annum, computed on the basis of a 365-day year and the actual number of days elapsed from the start of the applicable dividend period to the applicable date of determination.

All holders of the Company's Preferred Stock are able to convert their Preferred Stock into shares of Common Stock at a rate of approximately 2.51 shares of Common Stock for each share of Preferred Stock. As of December 31, 2018, a total of 3,394 shares of Preferred Stock have been converted to 8,503 shares of Common Stock.

Cash dividends are payable quarterly in arrears on January 1, April 1, July 1 and October 1 of each year, and commenced on April 1, 2015, and, if declared, begin to accrue on the first day of the applicable dividend period. PIK dividends, if applicable, accrue cumulatively on the same schedule as set forth above for cash dividends and are also compounded at the applicable annual rate on each applicable subsequent dividend date. Cash dividends on redeemable convertible preferred stock totaling $4,413, or $5.50 per share, $4,418, or $5.50 per share, and $4,419, or $5.50 per share, were distributed to convertible preferred stockholders for the years ended December 31, 2018, 2017 and 2016, respectively.

The Preferred Stock is accounted for outside of stockholders' equity as it may be redeemed upon certain change in control events that are not solely in the control of the Company. Dividends are recorded in stockholders' equity and consist of the 5.5%/8.5% dividend. Certain other provisions apply in certain change in control events.

The following table summarizes the Preferred Stock activity for the years ended December 31, 2018 and 2017:

	Dollar Value	Share Count
Balance at December 31, 2016	$ 77,565	803,398
Conversion to common stock	(20)	(198)
Allocation of issuance costs	1	—
Balance at December 31, 2017	$ 77,546	803,200
Conversion to common stock	(161)	(1,594)
Allocation of issuance costs	7	—
Balance at December 31, 2018	$ 77,392	801,606

As of December 31, 2018 and 2017, the outstanding shares of Preferred Stock were convertible into 2,010,045 and 2,014,042 shares of Common Stock, respectively.

13. Stockholders' Equity

At December 31, 2018 and 2017 there were 17,784,769 and 17,473,598 shares of the Company's Common Stock issued, respectively, including 4,970,093 and 4,126,132 treasury shares at December 31, 2018 and 2017, respectively.

Subject to the rights specifically granted to holders of any then outstanding shares of the Company's Preferred Stock, the Company's common stockholders are entitled to vote together as a class on all matters submitted to a vote of the Company's common stockholders, and are entitled to any dividends that may be declared by the Board. The Company's common stockholders do not have cumulative voting rights. Upon the Company's dissolution, liquidation or winding up, holders of the Company's Common Stock are entitled to share ratably in the Company's net assets after payment or provision for all liabilities and any preferential liquidation rights of the Company's Preferred Stock then outstanding. The Company's common stockholders do not have preemptive rights to purchase shares of the Company's stock. The issued and outstanding shares of the Company's Common Stock are not subject to any redemption provisions and are not convertible into any other shares of the Company's capital stock. The rights, preferences and privileges of holders of the Company's Common Stock will be subject to those of the holders of any shares of the Company's Preferred Stock the Company may issue in the future.

The following table reflects the total number of shares of the Company's Common Stock reserved for future issuance as of December 31, 2018:

Shares of common stock reserved for:	
Exercise of stock options and restricted stock awards	960,719
Conversion of preferred stock to common stock	2,010,045
Total shares of common stock reserved for future issuance	2,970,764

Share Repurchases

On November 4, 2015, the Board authorized the Company to engage in a repurchase program to repurchase up to $70,000 in aggregate value of the Company's Common Stock during the twelve-month period following November 4, 2015. This plan terminated on November 3, 2016. A total of 1,360,249 shares were purchased through this plan for $62,981, excluding commission payments.

On October 26, 2016, the Board authorized a new repurchase program, under which the Company may repurchase up to $100,000 in aggregate value of the Company's Common Stock during the twelve-month period following October 26, 2016. Through October 26, 2017, a total of 770,808 shares were purchased through this plan for $30,360, excluding commission payments.

On November 2, 2017, the Board approved the extension of the Company's October 26, 2016 stock repurchase program, authorizing the Company to engage in a repurchase program to repurchase up to $69,640 (the amount remaining from the $100,000 repurchase amount authorized in 2016) in aggregate value of our Common Stock through December 31, 2018. Subsequently, on March 29, 2018, the Board authorized an increase in the amount available for stock repurchases under the Company's existing stock repurchase program by $77,800, and extended the existing stock repurchase program through June 30, 2019. As of December 31, 2018, 1,018,989 shares were purchased under this plan after it was extended on November 2, 2017 for $66,256, excluding commission payments.

During the years ended December 31, 2018, 2017 and 2016, the Company withheld 5,242, 19,556 and 2,736 shares, respectively, from employees to cover the settlement of income tax and related benefit withholding obligations arising from vesting of restricted stock awards. In addition, during the years ended December 31, 2018 and 2017, the Company withheld 12,676 and 5,665 shares, respectively, from employees to cover the settlement of income tax and related benefit withholding obligations and the exercise price upon the exercise of stock options.

14. Stock-Based Compensation and Similar Arrangements

The Company provides stock-based compensation to employees, non-employee directors, consultants and advisors under the Company's 2006 Long-Term Incentive Plan ("2006 Plan"). The 2006 Plan allows the flexibility to grant or award stock options, stock appreciation rights, restricted stock, unrestricted stock, stock units including restricted stock units and performance awards to eligible persons.

The following table summarizes the activity under the 2006 Plan as of December 31, 2018:

	Number of shares of the Company's Common Stock authorized for issuance	Number of shares of the Company's Common Stock remaining for future grants	Number of shares of the Company's Common Stock subject to	
			Stock Options	Stock Grants
2006 Plan	5,400,000	1,356,820	908,588	52,131

The following table reflects the amount of stock-based compensation, for share settled awards issued to employees and non-employee directors, recorded in each financial statement line item for the years ended December 31, 2018, 2017 and 2016:

	Year Ended December 31,		
	2018	2017	2016
Service expense	$ 950	$ 434	$ 841
General and administrative expense	8,037	7,052	4,324
Equity in net loss (gain) of investees	137	76	18
(Loss) income from discontinued operations, net of tax	6	57	(29)
Total stock-based compensation	$ 9,130	$ 7,619	$ 5,154

Stock-based compensation included in service expense is related to the NET Services segment, whereas the amount included in equity in net loss (gain) of investees is related to the Matrix Investment segment, as a member of Matrix management continues to hold Providence equity awards.

The amounts above exclude tax benefits of $1,888, $2,885 and $2,072 for the years ended December 31, 2018, 2017 and 2016, respectively.

Stock Options

During the year ended December 31, 2016, the Company did not grant any stock options. The fair value of each stock option awarded to employees is estimated on the date of grant using the Black-Scholes option-pricing formula based on the following assumptions for the years ended December 31, 2018 and 2017:

	Year Ended December 31,					
	2018			2017		
Expected dividend yield	0.0%			0.0%		
Expected stock price volatility	26.47%	—	39.83%	19.5%	—	42.95%
Risk-free interest rate	2.26%	—	2.91%	1.0%	—	2.23%
Expected life of options (years)	1.29	—	6.50	0.03	—	6.50

The risk-free interest rate was based on the U.S. Treasury security rate in effect as of the date of grant which corresponds to the expected life of the award. The expected stock price volatility was based on the Company's historical data. The expected lives of options were based on the Company's historical data, a simplified method for plain vanilla options, or the Company's best estimate where appropriate. The simplified method was used for plain vanilla options for which the Company did not have sufficient historical data to use in determining the expected life.

In connection with the Organizational Consolidation, on April 9, 2018, the Company entered into an agreement with R. Carter Pate for his continued employment as the Company's Interim CEO through June 30, 2019. The agreement also provided for a grant of unvested options to purchase up to 394,000 shares of the Company's common stock, at a price of $71.67 per share, which was the closing price of the Company's common stock on the grant date. The options are subject to vesting as follows: (i) 50% of the options will become vested if Mr. Pate remains employed by the Company through June 30, 2019 (the "Time-Vesting Options"), (ii) 25% of the options will become vested on March 31, 2019 if the Company has achieved its budget for its 2018 fiscal year, subject to certain adjustments, and Mr. Pate is then employed, and (iii) 25% of the options will become vested on March 31, 2019 subject to Mr. Pate's achievement of other performance metrics if Mr. Pate is then employed. In recognition of certain holding company employees' essential contributions to the success of the Company, and to encourage further alignment with the Company's long-term interests through the ownership of equity, Mr. Pate voluntarily set aside 98,500 of the options granted to him, representing 25% of his total award. The value of the awards of $1,273 was fully expensed in the three months ended June 30, 2018. The Compensation Committee of the Board granted cash bonuses to employees based upon their performance throughout the Organizational Consolidation process in December 2018 in relation to the options voluntarily set aside by Mr. Pate.
In accordance with the terms of the agreement and actual performance to budget, only half of the options related to the budget performance criteria in (ii) above will vest.

In addition, the Time-Vesting Options will become fully vested upon a "change in control" (as defined in the 2006 Plan) or a termination of Mr. Pate's employment by the Company without "cause" (as defined in the Company's 2015 Holding Company LTI Program) or for "good reason" (as defined in the Option Agreement). Once vested, the options will remain exercisable until April 8, 2021, unless terminated earlier due to a termination of Mr. Pate's employment for "cause".

Also, in connection with the Organizational Consolidation and his appointment as Interim CFO, on April 9, 2018, William Severance received an option to purchase 13,710 shares of common stock at a price of $71.67 per share, which was the closing price of the Company's common stock on the grant date. The options will become fully exercisable on May 10, 2019, subject to Mr. Severance's continued employment with the Company, and if not exercised will expire on December 31, 2020.

During the fourth quarter of 2017, James Lindstrom resigned from the Company as Chief Executive Officer ("CEO") and board member of the Company. As a result of Mr. Lindstrom's resignation as CEO, a separation agreement was entered into between the Company and Mr. Lindstrom. As a result of this separation agreement, Mr. Lindstrom was granted 125,000 stock options with an exercise price of $61.33 per share that were immediately vested. 75,000 of these options were exercised during the year ended December 31, 2018, the remaining options expired on December 31, 2018.

During the year ended December 31, 2018, the Company issued 266,293 shares of its Common Stock in connection with the exercise of employee stock options under the Company's 2006 Plan.

The following table summarizes the stock option activity for the year ended December 31, 2018:

	Year ended December 31, 2018			
	Number of Shares Under Option	Weighted-average Exercise Price	Weighted-average Remaining Contractual Term	Aggregate Intrinsic Value
Balance at beginning of period, January 1	606,695	$ 48.70		
Granted	750,993	66.73		
Exercised	(278,969)	44.82		
Forfeited/Canceled	(120,131)	68.81		
Expired	(50,000)	61.33		
Outstanding at end of period, December 31	908,588	$ 61.44	2.40	$ 4,348
Vested or expected to vest at end of period, December 31	871,651	$ 61.01	2.49	$ 4,348
Exercisable at end of period, December 31	263,897	$ 50.28	1.98	$ 2,570

The weighted-average grant date fair value for options granted, total intrinsic value and cash received by the Company related to options exercised during the years ended December 31, 2018, 2017 and 2016 were as follows:

	Year ended December 31,		
	2018	2017	2016
Weighted-average grant date fair value per share	$ 15.08	$ 9.05	$ —
Options exercised:			
Total intrinsic value	$ 6,805	$ 2,010	$ 979
Cash received	$ 12,413	$ 1,921	$ 4,108

Stock Option Modifications

As part of the Company's retention plan associated with the Organizational Consolidation, the Company provided that unvested stock-based awards to employees subject to the retention plan will vest in full upon their termination dates so long as those employees fulfill their service obligation to the Company under the retention plan. As such, the vesting terms of 11,035 stock options

were modified. Additionally, the exercise terms of the respective unvested stock options were modified to allow for exercise through December 31, 2020. As a result of the modifications, the Company revalued the awards as of April 9, 2018,

and is expensing the unrecognized stock-based compensation cost, based on the new fair value, through the termination date of each relevant employee. Additional expense incurred during the year ended December 31, 2018, as a result of the modification, totaled $168. See Note 10, *Restructuring and Related Reorganization Costs,* for additional information.

During the fourth quarter of 2017, as a result of the separation agreement between the Company and Mr. Lindstrom, Mr. Lindstrom's outstanding stock options from his grants of 11,319 on August 6, 2015 and 9,798 on March 15, 2017 were modified to accelerate the vesting date of both awards to November 15, 2017 and allow exercise of the stock options until December 31, 2018. As a result of the modification to the terms of the original stock options granted to Mr. Lindstrom, the Company recognized an accelerated expense of $83 on the award for the year ended December 31, 2017.

Restricted Stock Awards

During the year ended December 31, 2018, the Company granted 20,242 shares of restricted stock ("RSAs") to non-employee directors of its Board, executive officers and certain key employees. The awards primarily vest in three equal installments on the first, second and third anniversaries of the date of grant.

During the year ended December 31, 2018, the Company issued 27,894 shares of its Common Stock to non-employee directors, executive officers and key employees upon the vesting of certain RSAs granted in 2017, 2016 and 2015 under the Company's 2006 Plan.

The following table summarizes the activity of the shares and weighted-average grant date fair value of the Company's unvested restricted Common Stock during the year ended December 31, 2018:

	Shares	Weighted-average grant date fair value
Non-vested at beginning of period, January 1	64,779	$ 44.82
Granted	20,242	$ 66.07
Vested	(27,894)	$ 46.39
Forfeited or cancelled	(9,799)	$ 46.83
Non-vested at end of period, December 31	47,328	$ 52.56

As of December 31, 2018, there was $7,604 of unrecognized compensation cost related to unvested share settled stock options and RSAs granted under the 2006 Plan. The cost is expected to be recognized over a weighted-average period of 1.2 years. The total fair value of stock options and RSAs vested was $4,428, $3,550 and $1,383 for the years ended December 31, 2018, 2017 and 2016, respectively.

Restricted Stock Award Modifications

As part of the Company's retention plan associated with the Organizational Consolidation, the Company provided that unvested stock-based awards to employees subject to the retention plan will vest in full upon their termination dates so long as those employees fulfill their service obligation to the Company under the retention plan. As such, the vesting terms of 7,286 restricted stock awards were modified. As a result of the modifications, the Company revalued the awards as of April 9, 2018, and is expensing the unrecognized stock-based compensation cost, based on the new fair value, through the termination date of each relevant employee. Additional expense incurred during the year ended December 31, 2018, as a result of the modification, totaled $290. See Note 10, *Restructuring and Related Reorganization Costs,* for additional information.

Restricted Stock Units

During the year ended December 31, 2016, the Company granted 5,930 restricted stock units to a key employee, related to the terms of a separation agreement, that vested on January 3, 2017. The units were settled through a cash payment of $304 during the year ended December 31, 2017. The award was classified as a liability, and the expense recorded was based upon the Company's closing stock price at the end of each reporting period and the completed requisite service period.

Deferred Share Units

During the year ended December 31, 2018, the Company granted 4,803 deferred share units to a director that vested on June 8, 2018, but will not be released until March 3, 2019. The units were fully expensed during the year ended December 31, 2018 and had a grant date fair value of $75.51 per share.

Cash Settled Awards

During the years ended December 31, 2018, 2017 and 2016, respectively, the Company issued 2,017, 3,097 and 3,360 stock equivalent units ("SEUs"), which settle in cash upon vesting, to Coliseum Capital Partners, L.P., in lieu of a grant to Christopher Shackelton, Chairman of the Board, for his service on the Board, which vest one-third upon each anniversary of the vesting date. The fair value of the SEUs is based on the closing stock price on the last day of the period and the completed requisite service period. The Company recorded $209, $235 and $287 of expense for SEUs during the years ended December 31, 2018, 2017 and 2016, respectively.

During the year ended December 31, 2014, the Company issued 200,000 stock option equivalent units ("SOEUs"), with an exercise price of $43.81 per share, which settle in cash, to Coliseum Capital Partners, L.P in lieu of a grant to Christopher Shackelton, for other services rendered. All 200,000 SOEUs were outstanding and exercisable at December 31, 2018. This award vested one-third upon grant, one-third on June 30, 2015 and one-third on June 30, 2016. No additional SOEUs were granted during the years ended December 31, 2018, 2017 and 2016. The Company recorded benefits of $191 and $1,517 for SOEUs during the years ended December 31, 2018 and 2016, respectively, and expense of $2,146 during the year ended December 31, 2017. The benefits and expense are included in "General and administrative expense" in the consolidated statements of operations. The fair value of the SOEUs was estimated as of December 31, 2018, 2017 and 2016 using the Black-Scholes option-pricing formula and amortized over the option's graded vesting periods with the following assumptions:

	Year ended December 31,								
	2018			2017			2016		
Expected dividend yield	0.0%			0.0%			0.0%		
Expected stock price volatility	27.82%	—	30.59%	23.36%	—	32.09%	35.71%	—	41.8%
Risk-free interest rate	2.50%	—	2.61%	1.75%	—	1.95%	1.11%	—	1.64%
Expected life of options (in years)	0.75	—	1.75	0.75	—	2.75	1.00	—	3.00

As of December 31, 2018 and 2017, the Company had a short-term liability of $3,719 and $3,938, respectively, in "Accrued expenses" in the consolidated balance sheets related to unexercised vested and unvested cash settled share-based payment awards. The cash settled share-based compensation expense in total excluded a tax benefit of $908 for the year ended December 31, 2017. The cash settled share-based compensation benefit in total excluded a tax expense of $4 and $492 for the years ended December 31, 2018 and 2016. The unrecognized compensation cost for SEUs is expected to be recognized over a weighted average period of 0.7 years; however, the total expense for both SEUs and SOEUs will continue to be adjusted until the awards are settled.

Holdco Long-Term Incentive Plan

On August 6, 2015 (the "Award Date"), the Compensation Committee of the Board adopted the 2015 Holding Company LTI Program ("HoldCo LTIP") under the 2006 Plan. Under the program, executives would receive shares of Providence common stock based on the shareholder value created in excess of an 8.0% compounded annual return between the Award Date and December 31, 2017 (the "Extraordinary Shareholder Value"). The Award Date value was calculated on the basis of the Providence stock price equal to the volume weighted average of the common share price over the 90-day trading period ending on the Award Date. The Extraordinary Shareholder Value was calculated on the basis of the Providence stock price equal to the volume weighted average of the common share price over the 90-day trading period ending on December 31, 2017. A pool for use in the allocation of awards was created equal to 8.0% of the Extraordinary Shareholder Value.

It was determined that no shares would be distributed under the Holdco LTIP as the calculation of the pool amount was zero. $4,738 and $3,319 of expense are included in "General and administrative expense" in the consolidated statements of operations for the years ended December 31, 2017 and 2016, respectively.

These awards were classified as equity and the fair value of the awards was calculated using a Monte-Carlo simulation valuation model. The fair value of the awards granted in 2016 were estimated using the following assumptions:

	Year ended December 31, 2016		
Forward interest rate	0.24%	—	2.71%
Expected Volatility		40.0%	
Dividend Yield		—%	
Fair Value of Total Pool		$12,870	

15. Long-Term Incentive Plans

The Company established Long-Term Incentive Plans ("LTIPs") for the Company's operating segments during the fourth quarter of 2015. The awards pay in cash, however up to 50% of the award may be paid in unrestricted stock if the recipient elects this option when the LTIP offer letter is received. In addition, at the discretion of the Company, the recipients may be able to elect unrestricted stock in lieu of cash compensation at a later date. The LTIPs reward participants based on certain measures of free cash flow and EBITDA results adjusted as specified in the plan document. The awards vest in three installments: 60% of the award will pay out immediately following December 31, 2017, 25% one year following the performance period (i.e. December 31, 2018) and 15% two years following the performance period (i.e. December 31, 2019). Payout is subject to the participant remaining employed by the Company.

During 2017, the Company revised the structure of the NET Services long-term incentive plan. As a result, the Company finalized the amount payable under the plan at $2,956. The total value will be paid to the awarded participants per the terms of the original agreement and thus the remaining unamortized expense relating to this plan continues to be recognized over the remaining service period. For the years ended December 31, 2018, 2017, and 2016, a benefit of $253, expense of $816 and expense of $1,513, respectively, is included in "Service expense" in the consolidated statements of operations related to this plan. At December 31, 2018 and 2017, the liability for long-term incentive plans of the Company's operating segments of $630 and $2,657, respectively, is reflected in "Accrued expenses" and "Other long-term liabilities" in the consolidated balance sheets.

The Board approved the LogistiCare 2017 Senior Executive LTI Plan (the "LogistiCare LTIP") for executive management and key employees of NET Services during the three months ending March 31, 2018. The LogistiCare LTIP pays in cash, however up to 50% of the award may be paid in unrestricted stock if the recipient elects this option prior to the award payment date. The LogistiCare LTIP rewards participants based on certain measures of free cash flow and EBITDA results adjusted as specified in the plan document. The awards have a performance period of January 1, 2017 through December 31, 2019, with a payout date within two and a half months of the performance period end date. Payout is subject to the participant remaining employed by the Company on the payment date. The maximum amount that can be earned through the LogistiCare LTIP is $7,000. As of December 31, 2018, 65.5% of the awards have been issued under the LogistiCare LTIP. No expense has been incurred for this plan during the year ended December 31, 2018, as we currently believe that it is not probable the defined measures will be met.

In connection with the acquisition of Circulation, the Company established a management incentive plan ("MIP") that is intended to motivate key employees of Circulation whereby they may be entitled to cash payments if certain financial measures are met based upon cumulative NET Services EBITDA; less the assumption of former Corporate and Other segment costs; less cumulative CAPEX ("MIP Financial Performance") for the performance period January 1, 2019 to December 31, 2021 as compared to the baseline, as determined by the Board. To the extent amounts are earned, the payout date is within 30 days following the finalization of the Company's audited financial statements for the fiscal year ending December 31, 2021. Payout is subject to the participant remaining employed by the Company through December 31, 2021. The amount that can be earned through the MIP ranges from $12,500 to $237,500 based on a range of value of the MIP Financial Performance of $272,500 to $395,500. As of December 31, 2018, the Company has accrued $1,441, reflected in "Other long-term liabilities" in the consolidated balance sheet, towards its estimate of the expected payout under the MIP.

16. Earnings Per Share

The following table details the computation of basic and diluted earnings per share:

	Year ended December 31,		
	2018	2017	2016
Numerator:			
Net (loss) income attributable to Providence	$ (18,981)	$ 53,369	$ 91,928
Less dividends on convertible preferred stock	(4,420)	(4,419)	(4,419)
Less income allocated to participating securities	(1,856)	(6,314)	(10,569)
Net (loss) income available to common stockholders	$ (25,257)	$ 42,636	$ 76,940
Continuing operations	$ 11,953	$ 40,647	$ 19,749
Discontinued operations	(37,210)	1,989	57,191
	$ (25,257)	$ 42,636	$ 76,940
Denominator:			
Denominator for basic earnings per share -- weighted-average shares	12,960,837	13,602,140	14,666,896
Effect of dilutive securities:			
Common stock options	72,410	66,314	105,837
Performance-based restricted stock units	—	4,860	6,665
Denominator for diluted earnings per share -- adjusted weighted-average shares assumed conversion	13,033,247	13,673,314	14,779,398
Basic earnings (loss) per share:			
Continuing operations	$ 0.92	$ 2.99	$ 1.35
Discontinued operations	(2.87)	0.15	3.90
	$ (1.95)	$ 3.14	$ 5.25
Diluted earnings (loss) per share:			
Continuing operations	$ 0.92	$ 2.97	$ 1.34
Discontinued operations	(2.86)	0.15	3.87
	$ (1.94)	$ 3.12	$ 5.21

Income allocated to participating securities is calculated by allocating a portion of net income attributable to Providence, less dividends on convertible stock, to the convertible preferred stockholders on a pro-rata as converted basis; however, the convertible preferred stockholders are not allocated losses.

The following weighted-average shares were not included in the computation of diluted earnings per share as the effect of their inclusion would have been anti-dilutive:

	Year ended December 31,		
	2018	2017	2016
Stock options to purchase common stock	560,547	362,392	22,638
Convertible preferred stock	802,489	803,323	803,442

17. Operating Leases and Service Commitment

Operating Leases

The Company has non-cancelable contractual obligations in the form of operating leases for office space, related office equipment and other facilities. The leases expire in various years and generally provide for renewal options. In the normal course of business, it is expected that these leases will be renewed or replaced by leases on other properties.

Certain operating leases provide for increases in future minimum annual rental payments based on defined increases in the Consumer Price Index, subject to certain minimum increases. Several of these lease agreements contain provisions for periods in which rent payments are reduced. The total amount of rental payments due over the lease term is being charged to rent expense on a straight-line basis over the term of the lease. The cumulative difference between rent expense recorded and the amount paid, for continuing operations, as of December 31, 2018 and 2017 was $2,115 and $2,209, respectively, and is included in "Accrued expenses" and "Other long-term liabilities" in the consolidated balance sheets.

Future minimum payments under non-cancelable operating leases for equipment and property with initial terms of one year or more consisted of the following at December 31, 2018:

	Operating Leases
2019	$ 8,825
2020	6,452
2021	4,594
2022	3,801
2023	1,767
Thereafter	1,600
Total future minimum lease payments	$ 27,039

Rent expense for continuing operations related to operating leases was $10,960, $10,250 and $9,624, for the years ended December 31, 2018, 2017 and 2016, respectively. Also, the lease agreements generally require the Company to pay executory costs such as real estate taxes, insurance, and repairs, which are recorded to expense as incurred.

Service Commitment

The Company has entered into a commitment related to transportation services. The commitment amount represents the minimum obligation the Company has under this agreement. If the Company does not utilize the minimum level of services specified in the agreement, a penalty provision will apply. However, the minimum obligation is less than the Company's projected use for these periods and payments may be more than the minimum obligation based on actual use.

Future minimum payments under this service commitment consisted of the following at December 31, 2018:

	Service Commitment
2019	$ 9,509
2020	19,208
Total future minimum payments	$ 28,717

18. Retirement Plan

The Company maintains a qualified defined contribution plan under Section 401(k) of the Internal Revenue Code of 1986, as amended, for all employees of its NET Services' operating segment and corporate personnel. The Company, at its discretion, may

make a matching contribution to the plan. Any matching contributions vest over 5 years. Unvested matching contributions are forfeitable upon employee termination. Employee contributions are fully vested and non-forfeitable. The Company's

contributions to the plan for continuing operations were $340, $304 and $232, for the years ended December 31, 2018, 2017 and 2016, respectively.

The Company also maintains a Deferred Compensation Rabbi Trust Plan for highly compensated employees of NET Services. This plan was put in place to compensate for the inability of highly compensated employees to take full advantage of the Company's 401(k) plan. Additional information is included in Note 20, *Commitments and Contingencies*.

19. Income Taxes

The federal and state tax provision is summarized as follows:

	Year Ended December 31,		
	2018	**2017**	**2016**
Federal income tax expense (benefit):			
Current	$ 3,462	$ 19,011	$ 20,963
Deferred	(1,157)	(19,762)	(6,545)
Total Federal income tax expense (benefit)	2,305	(751)	14,418
State income tax expense (benefit):			
Current	2,113	4,048	4,501
Deferred	266	706	(947)
Total State income tax expense (benefit)	2,379	4,754	3,554
Total provision for income taxes	$ 4,684	$ 4,003	$ 17,972

A reconciliation of the provision for income taxes with amounts determined by applying the statutory U.S. federal income tax rate to income from continuing operations before income taxes is as follows:

	Year Ended December 31,		
	2018	**2017**	**2016**
Federal statutory rates	21%	35%	35%
Federal income tax at statutory rates	$ 4,812	$ 19,281	$ 15,699
Revaluation of net deferred tax liabilities due to U.S. tax reform	(286)	(19,304)	—
U.S. tax reform impact on equity income of investees	—	(1,646)	—
Change in valuation allowance	36	177	296
Change in uncertain tax positions	108	7	73
State income taxes, net of federal benefit	1,843	3,157	2,399
Compensation expense	235	—	—
Stock compensation	76	3,400	—
Meals and entertainment	74	99	94
Transaction costs	263	159	—
Cost method investment re-measurement gain	(1,381)	—	—
Tax credits	(1,208)	(354)	(947)
Legal expense	—	(805)	522
Other	112	(168)	(164)
Provision for income taxes	$ 4,684	$ 4,003	$ 17,972
Effective income tax rate	20%	7%	40%

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of the Company's deferred tax assets and liabilities of continuing operations are as follows:

	December 31,	
	2018	2017
Deferred tax assets:		
Net operating loss carryforwards	$ 19,485	$ —
Capital loss carryforward	1,072	—
Tax credit carryforwards	840	486
Accounts receivable allowance	227	1,134
Accrued items and reserves	6,817	8,297
Stock compensation	1,480	1,480
Deferred rent	543	572
Deferred revenue	272	—
Other	773	172
	31,509	12,141
Deferred tax liabilities:		
Deferred financing costs	12	38
Prepaids	900	1,439
Property and equipment depreciation	3,492	3,329
Goodwill and intangibles amortization	6,944	3,678
Equity investment	40,577	42,113
Other	—	303
	51,925	50,900
Net deferred tax liabilities	(20,416)	(38,759)
Less valuation allowance	(2,633)	(473)
Net deferred tax liabilities	$ (23,049)	$ (39,232)
Net noncurrent deferred tax assets, net of valuation allowance of $0 for 2018 and 2017	$ 2,601	$ —
Net noncurrent deferred tax liabilities, net of valuation allowance of $2,633 and $473 for 2018 and 2017, respectively	(25,650)	(39,232)
	$ (23,049)	$ (39,232)

At December 31, 2018, the Company had approximately $86,865 of federal net operating loss carryforwards, including $3,055 which will expire primarily in 2037 and $83,810 which can be carried forward indefinitely. In addition, at December 31, 2018, the Company had approximately $26,936 of state net operating loss carryforwards which expire as follows:

2023	$ 2,021
Thereafter	24,915
Total state net operating loss carryforwards	$ 26,936

Approximately $8,600 of the U.S. and state net operating loss carryforwards relate to Circulation, Inc. pre-acquisition tax periods and are subject to change of ownership limitations on their use. These limitations are not expected to restrict the ultimate use of these loss carryforwards.

Realization of the Company's net operating loss carryforwards is dependent on generating sufficient taxable income. Although realization is not assured, management believes it is more likely than not that all of the deferred tax assets will be realized, to the extent they are not covered by a valuation allowance. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

The net change in the total valuation allowance for the year ended December 31, 2018 was $2,160, of which $36 related to current operations, $1,492 related to discontinued operations and $632 related to the balance from the Circulation acquisition. The valuation allowance of $2,633 includes $2,166 for state net operating loss, capital loss and tax credit carryforwards and $467 for stock compensation and accrued liability deferred tax assets for which the Company has concluded that it is more likely than not that these carryforwards and deferred tax assets will not be realized in the ordinary course of operations. The Company will continue to assess the valuation allowance, and to the extent it is determined that the valuation allowance should be changed, an appropriate adjustment will be recorded.

U.S. Tax Reform

On December 22, 2017, the Tax Reform Act was enacted which institutes fundamental changes to the taxation of multinational corporations. The Tax Reform Act includes changes to the taxation of foreign earnings by implementing a dividend exemption system, expansion of the current anti-deferral rules, a minimum tax on low-taxed foreign earnings and new measures to deter base erosion. The Tax Reform Act also includes a permanent reduction in the corporate tax rate to 21%, repeal of the corporate alternative minimum tax, expensing of capital investment, and limitation of the deduction for interest expense. Furthermore, as part of the transition to the new tax system, a one-time transition tax is imposed on a U.S. shareholder's historical undistributed earnings and profits ("E&P") of foreign affiliates. Although the Tax Reform Act is generally effective January 1, 2018, GAAP requires recognition of the tax effects of new legislation during the reporting period that includes the enactment date, which was December 22, 2017.

As a result of the reduction in the U.S. corporate income tax rate, the Company revalued its ending net deferred tax liabilities as of December 31, 2017 and recognized a provisional tax benefit of $20,950. The Company projected net accumulated deficits in foreign E&P; therefore, no provisional tax expense for deemed repatriation was recognized.

On December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118 ("SAB 118") to address the application of GAAP in situations when a registrant does not have the necessary information available, prepared, or analyzed (including computations) in reasonable detail to complete the accounting for certain income tax effects of the Tax Reform Act. In accordance with the SAB 118 guidance, the Company has recognized the provisional tax impacts related to the benefit for the revaluation of deferred tax assets and liabilities in its consolidated financial statements for the year ended December 31, 2017. The financial reporting impact of the Tax Reform Act was completed in the fourth quarter of 2018 and an additional benefit of $286 was recorded.

Unrecognized Tax Benefits

The Company expects no material amount of the unrecognized tax benefits to be recognized during the next twelve months. The Company recognizes interest and penalties as a component of income tax expense. During the years ended December 31, 2018, 2017 and 2016, the Company recognized approximately $47, $65 and $19, respectively, in interest and penalties from continuing operations. The Company had approximately $109 and $83 for the payment of penalties and interest of continuing operations accrued as of December 31, 2018 and 2017, respectively.

A reconciliation of the liability for unrecognized income tax benefits for continuing operations is as follows:

	December 31,		
	2018	**2017**	**2016**
Unrecognized tax benefits, beginning of year	$ 1,115	$ 1,108	$ 271
Balance upon acquisition/disposition	—	—	764
Increase related to prior year positions	104	22	37
Increase related to current year tax positions	160	101	139
Statute of limitations expiration	(157)	(116)	(103)
Unrecognized tax benefits, end of year	$ 1,222	$ 1,115	$ 1,108

The Company is subject to taxation in the U.S. and various state jurisdictions. The statute of limitations is generally three years for the U.S. and between three and four years for the various states in which the Company operates. The tax years that remain open for examination by the U.S. and states principally include the years 2014 to 2017.

20. Commitments and Contingencies

Legal proceedings

In the ordinary course of business, the Company is a party to various lawsuits. Management does not expect these lawsuits to have a material impact on the liquidity, results of operations, or financial condition of the Company.

On January 21, 2019, the United States District Court for the Southern District of Ohio unsealed a qui tam complaint, filed in December 2015, against Mobile Care Group, Inc., Mobile Care Group of Ohio, LLC, Mobile Care EMS & Transport, Inc. and LogistiCare Solutions, LLC ("LogistiCare") by the relators Brandee White, Laura Cunningham, and Jeffery Wisier (the "Relators") alleging violations of the federal False Claims Act by presenting claims for payment to government healthcare programs knowing that the prerequisites for such claims to be paid had not been met. The Relators seek to recover damages, fees and costs under the federal False Claims Act including treble damages, civil penalties and attorneys' fees. In addition, the Relators seek reinstatement to their jobs with the Mobile Care entities. None of the Relators was employed by LogistiCare. Prior to January 21, 2019, LogistiCare had no knowledge of the complaint. The federal government has declined to intervene against LogistiCare. The Company intends to defend the litigation vigorously and believes that the case will not have a material adverse effect on its business, financial condition or results of operations.

Indemnifications related to Haverhill Litigation

The Company indemnified the Coliseum Stockholders from and against any and all losses, claims, damages, expenses and liabilities relating to or arising out of (i) any breach of any representation, warranty, covenant or undertaking made by or on behalf of the Company in the Standby Purchase Agreement and (ii) the transactions contemplated by the Standby Purchase Agreement and the 14.0% Unsecured Subordinated Note in aggregate principal amount of $65,500, except to the extent that any such losses, claims, damages, expenses and liabilities are attributable to the gross negligence, willful misconduct or fraud of such Coliseum Stockholder.

The Company has also indemnified other third parties from and against any and all losses, claims, damages, expenses and liabilities arising out of or in connection with the Company's acquisition of CCHN Group Holdings, Inc. (operating under the tradename Matrix, and formerly included in our HA Services segment) in October 2014 and related financing commitments, except to the extent that any such losses, claims, damages, expenses and liabilities are found in a final, non-appealable judgment by a court of competent jurisdiction to have resulted from the gross negligence, bad faith or willful misconduct of such third parties, or a material breach of such third parties' obligations under the related agreements.

In June 2015, a putative stockholder class action derivative complaint related to such rights offering and acquisition was filed in the Court of Chancery of the State of Delaware captioned Haverhill Retirement System v. Kerley et al., C.A. No. 11149-VCL (the "Haverhill Litigation"). In November 2017, the Company received a payment of $5,363 under the settlement agreement entered into by the parties to the Haverhill Litigation.

The Company recorded $318 and $1,282 of such indemnified legal expenses related to the Haverhill Litigation during the years ended December 31, 2017 and 2016, respectively, which is included in "General and administrative expenses" in the consolidated statements of operations. Of these amounts, $245 and $757 for the years ended December 31, 2017 and 2016, respectively, were indemnified legal expenses of related parties. Other legal expenses of the Company related to the Haverhill Litigation are covered under the Company's insurance policies, subject to applicable deductibles and customary review of the expenses by the carrier. The Company recognized a benefit of $226 for the year ended December 31, 2018, and expense of $8 and $210 for the years ended December 31, 2017 and 2016, respectively. While the carrier typically remits payment directly to the respective law firm, the Company accrues for the cost and records a corresponding receivable for the amount to be paid by the carrier. The Company recognized an insurance receivable of $941 in "Other receivables" in the consolidated balance sheet at December 31, 2017, with a corresponding liability amount recorded to "Accrued expenses".

Other Indemnifications

The Company provided certain standard indemnifications in connection with the sale of the Human Services segment to Molina Healthcare Inc. ("Molina") effective November 1, 2015. Certain representations made by the Company in the related Membership Interest Purchase Agreement (the "Purchase Agreement") including tax representations, survive until the expiration of applicable statutes of limitation. Molina and the Company entered into a settlement agreement regarding indemnification claims by Molina with respect to *Rodriguez v. Providence Community Corrections* (the "Rodriguez Litigation"), a complaint filed in the District Court for the Middle District of Tennessee, Nashville Division, against Providence Community Corrections, Inc. ("PCC"),

an entity sold under the Purchase Agreement. The Company expects to recover a portion of the settlement through insurance coverage, although this cannot be assured.

The Company has provided certain standard indemnifications in connection with its Matrix stock subscription transaction whereby Mercury Fortuna Buyer, LLC ("Subscriber"), Providence and Matrix entered into a stock subscription agreement (the "Subscription Agreement"), dated August 28, 2016. The representations and warranties made by the Company in the Subscription Agreement ended January 19, 2018; however, certain fundamental representations survive through the 36th month following the closing date. The covenants and agreements of the parties to be performed prior to the closing ended January 19, 2018, and all other covenants and agreements survive until the expiration of the applicable statute of limitations in the event of a breach, or for such lesser periods specified therein. The Company is not aware of any indemnification liabilities with respect to Matrix that require accrual at December 31, 2018.

The Company has provided certain standard indemnifications in connection with the sale of substantially all of its WD Services segment to APM, which closed on December 21, 2018. The non-title warranties made by the Company in the related Share Purchase Agreement survive for 18 months following the closing date, and the title-related warranties and tax warranties survive five years from the closing date. The Company is not aware of any indemnification liabilities with respect to the former WD Services segment that require accrual at December 31, 2018.

On May 9, 2018, the Company entered into a registration indemnification agreement with the Coliseum Stockholders, who as of December 31, 2018, collectively held approximately 9.6% of the Company's outstanding common stock and approximately 95.6% of the Company's outstanding Preferred Stock, pursuant to which the Company has agreed to indemnify the Coliseum Stockholders, and the Coliseum Stockholders have agreed to indemnify the Company, against certain matters relating to the registration of the Coliseum Stockholders' securities for resale under the Securities Act.

Deferred Compensation Plan

The Company has one deferred compensation plan for management and highly compensated employees of NET Services as of December 31, 2018. The deferred compensation plan is unfunded, and benefits are paid from the general assets of the Company. The total of participant deferrals, which is reflected in "Other long-term liabilities" in the consolidated balance sheets, was $1,982 and $1,806 at December 31, 2018 and 2017, respectively.

21. Transactions with Related Parties

The Company incurred legal expenses under an indemnification agreement with the Coliseum Stockholders as further discussed in Note 20, *Commitments and Contingencies*. Preferred stock dividends earned by the Coliseum Stockholders during the years ended December 31, 2018 and 2017 totaled $4,213 each year.

Effective June 15, 2018, the Company registered shares of the Company's common stock and Preferred Stock held by the Coliseum Stockholders for resale under the Securities Act and on May 9, 2018, in connection with such registration, the Company entered into a registration indemnification agreement with the Coliseum Stockholders as further discussed in Note 20, *Commitments and Contingencies*.

During the year ended December 31, 2017, the Company made a $566 loan to Mission Providence. The loan was also repaid during the year ended December 31, 2017.

22. Acquisitions

During 2017, the Company made an equity investment in Circulation, which was accounted for as a cost method investment. On September 21, 2018, the Company's subsidiary, LogistiCare, acquired all of the outstanding equity of Circulation, which offers a full suite of logistics solutions to manage non-emergency transportation across all areas of healthcare, powered by its HIPAA-compliant digital platform. Circulation enables administration of transportation benefits, proactively monitors for fraud, waste and abuse, and integrates all transportation capabilities (e.g. outsourced transportation, owned fleets, and other medical logistics services), while emphasizing patient convenience and satisfaction. Circulation's proprietary platform simplifies ordering, improves reliability and efficiency, and reduces transportation spend. The Company believes the acquisition advances LogistiCare's central mission of reducing transportation as a barrier to healthcare and will help deliver a differentiated user experience and provide a core technology and analytics platform that better positions LogistiCare for growth.

The purchase price was comprised of cash consideration of $45,123 paid to Circulation's equity holders (including holders of vested Circulation stock options), other than Providence. Per the terms of the Agreement and Plan of Merger (the "merger agreement"), dated as of September 14, 2018, by and among LogistiCare, the Company, Catapult Merger Sub, a wholly-owned subsidiary of LogistiCare ("Merger Sub"), Circulation and Fortis Advisors LLC, as the representative of Circulation's equity holders, Providence assumed certain unvested Circulation stock options under similar terms and conditions to the existing option awards previously issued by Circulation. The merger agreement also required $1,000 to be paid three years after the closing date of the transaction to each of the two co-founders of Circulation subject to their continued employment or provision of consulting services to LogistiCare. The value of the options assumed and co-founder hold back is accounted for as compensation, over the relevant vesting period, as such amounts are tied to future service conditions.

The Company's initial investment in Circulation was $3,000 in July 2017 to acquire a minority interest. As a result of the transactions pursuant to the merger agreement, the fair value of this pre-acquisition interest increased to $9,577, and thus the Company recognized a gain of $6,577. This gain is recorded as "Gain on remeasurement of cost method investment" on the Company's consolidated statement of operations for the year ended December 31, 2018. The Company determined the fair value of its pre-acquisition equity interest by multiplying the number of shares it held in Circulation pre-acquisition by the per-share consideration validated by reference to the total merger consideration agreed to with other unrelated equity holders in Circulation.

The Company incurred acquisition and related costs for this acquisition of $1,729 during the year ended December 31, 2018. These expenses are primarily included in general and administrative expenses of the NET Services segment in the consolidated statements of operations.

The purchase price of Circulation is calculated as follows:

Cash purchase of common stock	$	45,123
Providence's acquisition date fair value equity interest in Circulation		9,577
Total consideration	$	54,700

The table below presents Circulation's net assets at the date of acquisition based upon the final estimate of respective fair values:

Cash	$	1,302
Accounts receivable		996
Other assets		216
Property and equipment		49
Intangibles		15,700
Goodwill		40,001
Deferred taxes, net		(2,199)
Accounts payable and accrued liabilities		(1,244)
Deferred revenue		(69)
Other non-current liabilities		(52)
Total of assets acquired and liabilities assumed	$	54,700

The goodwill is allocated to the NET Services segment. None of the acquired goodwill is expected to be deductible for tax purposes.

The fair value of intangible assets is as follows:

	Type	Life	Value
Customer relationships	Amortizable	3 years	$ 1,400
Trademarks and trade names	Amortizable	3 years	200
Developed technology	Amortizable	5 years	14,100
			$ 15,700

The amounts of Circulation's revenue and net income included in the Company's consolidated statement of operations for the year ended December 31, 2018, and the unaudited pro forma revenue and net (loss) income attributable to Providence of the combined entity had the acquisition date been January 1, 2017, are:

	Year Ended December 31, 2018
Actual Circulation:	
Revenue	$ 2,205
Net loss	(2,108)

	Year Ended December 31,	
	2018	2017
Pro forma:		
Revenue	$ 1,388,203	$ 1,319,195
Net (loss) income attributable to Providence	(21,541)	49,097
Diluted (loss) earnings per share	$ (2.11)	$ 2.85

The pro forma information above for the year ended December 31, 2018 includes the elimination of acquisition related costs. Adjustments for all periods include expensing the incentive for two co-founders to be paid upon continuing employment, amortization expense based on the estimated fair value and useful lives of intangible assets and related tax effects. The pro forma financial information is not necessarily indicative of the results of operations that would have occurred had the transaction been affected on January 1, 2017.

23. Discontinued Operations

WD Services Segment

On December 21, 2018, the Company completed the sale of substantially all of the operating subsidiaries of its WD Services segment to APM and APM UK Holdings Limited, an affiliate of APM, except for the segment's employment services operations in Saudi Arabia. The Company's contractual counterparties in Saudi Arabia, including an entity owned by the Saudi Arabian government, assumed these operations beginning January 1, 2019.

The total cash consideration of the sale was $46,450, with the buyer retaining existing WD Services cash of $20,993. In addition to the purchase consideration, as a result of closing the transaction before the year end, the Company expects to realize cash tax benefits of approximately $51,861 from the transaction, including approximately $34,275 in tax refunds by the fourth quarter of 2019 in relation to its 2018 tax returns and loss carrybacks, which is inclusive of $646 of tax that would have been otherwise due in the fourth quarter of 2018. The remaining cash tax benefit of $17,586 is expected to be realized as an offset to tax payments over the following three years, based upon the Company's current estimate of taxable income. In addition, $1,072 of benefits related to capital loss carryforwards is available, which amount was reserved as of December 31, 2018.

On June 11, 2018, the Company entered into a Share Purchase Agreement to sell the shares of Ingeus France, its WD Services operation in France, for a de minimis amount. The sale was effective on July 17, 2018, after court approval.

On September 29, 2017, the Company and Mission Australia completed the sale of 100% of the stock of Mission Providence, a joint venture in the WD Services segment, pursuant to a share sale agreement. Upon the sale of Mission Providence, the Company received AUD 20,184, or $15,823 of proceeds, for its equity interest, net of transaction fees. Subsequently, a working capital adjustment was finalized in December 2017 resulting in the return of $229 of the proceeds. The related gain on sale of Mission Providence totaling $12,377 is recorded as "(Loss) income from discontinued operations, net of tax" in the accompanying consolidated statements of operations for the year ended December 31, 2017. Summary financial information for Mission Providence on a standalone basis for the nine months ended September 30, 2017 and the year ended December 31, 2016 is as follows:

	Nine months ended September 30, 2017	Year ended December 31, 2016
Revenue	$ 30,125	$ 36,546
Operating loss	(1,765)	(9,664)
Net loss	(1,934)	(8,843)

In accordance with ASC 205-20, *Presentation of Financial Statements-Discontinued Operations*, ("ASC 205-20") a component of an entity is reported in discontinued operations after meeting the criteria for held for sale classification if the disposition represents a strategic shift that has (or will have) a major effect on the entity's operations and financial results. The Company analyzed the quantitative and qualitative factors relevant to the disposition of the WD Services segment and determined that those held for sale conditions for discontinued operations presentation were met during the fourth quarter of 2018. As such, the historical financial results of the Company's historical WD Services segment, and the related income tax effects have been presented as discontinued operations for all periods presented in the accompanying consolidated financial statements.

HA Services Segment

Effective October 19, 2016, the Company completed the Matrix Transaction. At the closing, (i) cash consideration of $180,614 was paid by the Subscriber to Matrix based upon an enterprise value of $537,500 and (ii) Matrix borrowed approximately $198,000 pursuant to a credit and guaranty agreement providing for term loans in an aggregate principal amount of $198,000 and revolving loan commitments in an aggregate principal amount not to exceed $10,000, which was not drawn at the closing. At the closing, Matrix distributed $381,163 to Providence, in full satisfaction of a promissory note and accumulated interest between Matrix and Providence. At the closing, Providence made a $5,663 capital contribution to Matrix, as described in the Subscription Agreement, as amended, based upon its pro-rata ownership of Matrix, to fund the near-term cash needs of Matrix. On the day that was fifteen days following the closing date, Providence was, to the extent payable pursuant to the terms of the Subscription Agreement, as amended, entitled to receive from Matrix, or required to pay to Matrix, subsequent working capital adjustment payments. Providence received an initial payment of $5,172 from Matrix in November 2016 which is net of the capital contribution of $5,663 described above, based upon the initial working capital calculation as described in the Subscription Agreement. Additionally, in February 2017, the Company received a $75 payment from Matrix representing the final working capital adjustment payment.

In accordance with ASC 205-20, the Company analyzed the quantitative and qualitative factors relevant to the Matrix stock subscription transaction resulting in the Company no longer owning a controlling interest in Matrix, and determined that those held for sale conditions for discontinued operations presentation were met during the third quarter of 2016. As such, the historical financial results of Matrix, the Company's historical HA Services segment, and the related income tax effects have been presented as discontinued operations for all periods presented in the accompanying consolidated financial statements through October 19, 2016.

The Company has continuing involvement with Matrix through its ownership of 43.6% of the equity interests in Matrix as of December 31, 2018, as well as through a management consulting agreement, not to exceed ten years. Prior to the Matrix Transaction, the Company owned 100% of the equity interest in Matrix. Subsequent to the Matrix Transaction, the Company accounts for its investment in Matrix under the equity method of accounting. The Company's share of Matrix's gains and losses subsequent to the Matrix Transaction, which totaled a loss of $6,158, a gain of $13,445 and a loss of $1,789, is recorded as "Equity in net (gain) loss of investees" in its consolidated statement of operations for the years ended December 31, 2018, 2017 and 2016, respectively. Matrix's pretax loss for the year ended December 31, 2018 totaled $27,128. Matrix's pretax loss for the year ended December 31, 2017 totaled $2,948 and included $3,537 of transaction related expenses. Matrix's pretax loss for the period of

October 19, 2016 through December 31, 2016 totaled $7,027 and included $6,367 of transaction related expenses. There have been no cash inflows or outflows from or to Matrix subsequent to the closing of the Matrix Transaction, other than the working capital adjustments discussed above and management and advisory fees associated with its ongoing relationship with Matrix, of which $2,271 and $1,103 were received during the years ended December 31, 2018 and 2017, respectively. $259 and $247 are included in "Other receivables" in the consolidated balance sheets at December 31, 2018 and 2017, respectively, related to management fees receivable.

Human Services Segment

On September 3, 2015, the Company entered into a Purchase Agreement, pursuant to which the Company agreed to sell all of the membership interests in Providence Human Services, LLC and Providence Community Services, LLC, comprising the Company's Human Services segment. During the years ended December 31, 2018, 2017 and 2016, the Company recorded additional expenses and benefits related to the Human Services segment, principally related to legal proceedings as described in Note 20, *Commitment and Contingences*, related to an indemnified legal matter.

Results of Operations

The following table summarizes the results of operations classified as (loss) income from discontinued operations, net of tax, for the years ended December 31, 2018, 2017 and 2016. The HA Services segment column in the table below for the year ended December 31, 2016 reflects the financial results for HA Services from January 1, 2016 through October 19, 2016.

	Year ended December 31, 2018		
	Human Services Segment	**WD Services Segment**	**Total Discontinued Operations**
Service revenue, net	$ —	$ 264,553	$ 264,553
Operating expenses:			
Service expense	—	248,824	248,824
General and administrative expense	(495)	26,895	26,400
Asset impairment charge	—	9,203	9,203
Depreciation and amortization	—	11,864	11,864
Total operating expenses (benefits)	(495)	296,786	296,291
Operating income (loss)	495	(32,233)	(31,738)
Other expenses:			
Interest expense, net	—	35	35
Gain on foreign currency transactions	—	(388)	(388)
Other gain	—	(87)	(87)
Income (loss) from discontinued operations before gain on disposition and income taxes	495	(31,793)	(31,298)
Loss on disposition	—	(53,692)	(53,692)
(Provision) benefit for income taxes	(545)	48,482	47,937
(Loss) income from discontinued operations, net of tax	$ (50)	$ (37,003)	$ (37,053)

The loss on disposition in the table above includes the reclassification of translation loss realized upon sale of subsidiaries of $29,973. The benefit for income taxes in the table above for the WD Services segment includes tax benefits on the WD Services Sale of $51,861 and income tax expense on WD Services operations of $3,379.

	Year ended December 31, 2017		
	Human Services Segment	WD Services Segment	Total Discontinued Operations
Service revenue, net	$ —	$ 305,662	$ 305,662
Operating expenses:			
Service expense	—	265,417	265,417
General and administrative expense	9,674	28,845	38,519
Depreciation and amortization	—	12,851	12,851
Total operating expenses	9,674	307,113	316,787
Operating loss	(9,674)	(1,451)	(11,125)
Other expenses:			
Interest expense, net	—	74	74
Equity in net loss of investees	—	1,391	1,391
Gain on sale of equity investment	—	(12,377)	(12,377)
Loss on foreign currency transactions	—	345	345
(Loss) income from discontinued operations before gain on disposition and income taxes	(9,674)	9,116	(558)
Benefit for income taxes	3,691	(398)	3,293
(Loss) income from discontinued operations, net of tax	$ (5,983)	$ 8,718	$ 2,735

	Year ended December 31, 2016			
	Human Services Segment	HA Services Segment	WD Services Segment	Total Discontinued Operations
Service revenue, net	$ —	$ 166,090	$ 344,403	$ 510,493
Operating expenses:				
Service expense	—	120,906	320,147	441,053
General and administrative expense	7,966	2,148	30,384	40,498
Asset impairment charge	—	—	19,588	19,588
Depreciation and amortization	—	21,121	13,823	34,944
Total operating expenses	7,966	144,175	383,942	536,083
Operating (loss) income	(7,966)	21,915	(39,539)	(25,590)
Other expenses:				
Interest expense, net	—	9,929	68	9,997
Equity in net loss of investees	—	—	8,498	8,498
Write-off of deferred financing fees	—	2,302	—	2,302
Gain on foreign currency transactions	—	—	(1,374)	(1,374)
(Loss) income from discontinued operations before gain on disposition and income taxes	(7,966)	9,684	(46,731)	(45,013)
Gain on disposition	—	167,895	—	167,895
Benefit (provision) for income taxes	2,401	(63,254)	936	(59,917)
(Loss) income from discontinued operations, net of tax	$ (5,565)	$ 114,325	$ (45,795)	$ 62,965

Asset impairment charges

In connection with classifying the assets and liabilities of Ingeus France as held for sale during the three months ended June 30, 2018, the carrying value of the assets and liabilities was reduced to its estimated fair value less selling costs. As a result, an impairment charge of $9,203 was recorded during the year ended December 31, 2018 and is included in "Asset impairment charge" in the table above.

During the fourth quarter of 2016, the Company reviewed WD Services for impairment, primarily due to lower than expected volumes and unfavorable service mix shifts under a large contract in the United Kingdom ("UK") impacting future projections; additional clarity into the anticipated size and structure of the Work and Health Programme in the UK; the absence of additional details regarding the restructuring of the offender rehabilitation contract in the UK; and a change in senior management at WD Services during the fourth quarter. As a result, the Company performed a quantitative test comparing the fair value of the asset groupings comprising WD Services with the carrying amounts and recorded an asset impairment charge of $4,381 to definite-lived customer relationship intangible assets and an asset impairment charge of $9,983 to property and equipment, which are recorded in "Asset impairment charge" in the table above. In addition, the Company reviewed the carrying value of goodwill of WD Services, noting the carrying value exceeded the fair value. Therefore, the Company performed the second step of the impairment test, in which the fair value of the reporting unit is allocated to all of the assets and liabilities, on a fair value basis, with any excess representing the implied value of goodwill of the reporting unit. The fair value was determined using an income approach, which estimates the present value of future cash flows based on management's forecast of revenue growth rates and operating margins, working capital requirements and capital expenditures. Based on this analysis, the carrying value of goodwill of the WD Services reporting unit exceeded the implied fair value and the Company recorded an asset impairment charge of $5,224, which is included in "Asset impairment charge" on the Company's consolidated statement of operations.

Interest expense, net

The Company allocated interest expense, including amortization of deferred financing fees, to discontinued operations based on the portion of the debt that was required to be paid with the proceeds from the sale of the Matrix Transaction. The total allocated interest expense is included in "Interest expense, net" in the tables above. The total allocated interest expense for the year ended December 31, 2016 for the HA Services segment was $9,939.

Loss on disposition, net of tax

The total loss on disposition, net of tax, related to the sale of WD Services subsidiaries during the year ended December 31, 2018 is calculated as follows:

Total cash received, net of transaction costs and cash sold	$	12,780
Total WD Services net asset value as of transaction date, net of cash sold		(36,499)
Income tax benefit		51,861
Gain on sale before reclassification of currency translation, net of tax		28,142
Adjustment for reclassification of currency translation		(29,973)
Loss on disposition, net of tax	$	(1,831)

Assets and liabilities

The following table summarizes the carrying amounts of the major classes of assets and liabilities of discontinued operations in the consolidated balance sheets as of December 31, 2018 and 2017. Amounts as of December 31, 2018 represent the accounts of WD Services operations in Saudi Arabia, which were not sold as part of the WD Services Sale.

	December 31,	
	2018	**2017**
Cash and cash equivalents	$ 2,321	$ 42,512
Accounts receivable, net of allowance of $3,460 and $500 in 2018 and 2017, respectively	4,316	48,718
Other receivables	—	10
Prepaid expenses and other	414	12,784
Current assets of discontinued operations	$ 7,051	$ 104,024
Property and equipment, net	$ —	$ 12,705
Goodwill	—	26,453
Intangible assets, net	—	29,774
Equity investments	—	213
Other assets	—	51
Deferred tax asset	—	4,632
Noncurrent assets of discontinued operations	$ —	$ 73,828
Accounts payable	$ 486	$ 15,086
Accrued expenses	2,771	32,195
Deferred revenue	—	14,362
Current liabilities of discontinued operations	$ 3,257	$ 61,643
Other long-term liabilities	$ —	$ 5,170
Deferred tax liabilities	—	2,395
Noncurrent liabilities of discontinued operations	$ —	$ 7,565

Cash Flow Information

The following table presents depreciation, amortization, capital expenditures and significant operating noncash items of the discontinued operations for the years ended December 31, 2018, 2017 and 2016:

	For the year ended December 31, 2018		
	Human Services Segment	**WD Services Segment**	**Total Discontinued Operations**
Cash flows from discontinued operating activities:			
Depreciation	$ —	$ 6,711	$ 6,711
Amortization	—	5,153	5,153
Asset impairment charge	—	9,203	9,203
Stock-based compensation	—	6	6
Deferred income taxes	419	(74)	345

Cash flows from discontinued investing activities:			
Purchase of property and equipment	$ —	$ 6,725	$ 6,725

	For the year ended December 31, 2017		
	Human Services Segment	WD Services Segment	Total Discontinued Operations
Cash flows from discontinued operating activities:			
Depreciation	$ —	$ 7,825	$ 7,825
Amortization	—	5,026	5,026
Stock-based compensation	—	57	57
Deferred income taxes	(3,433)	(507)	(3,940)
Cash flows from discontinued investing activities:			
Purchase of property and equipment	$ —	$ 4,527	$ 4,527

	For the year ended December 31, 2016		
	HA Services Segment	WD Services Segment	Total Discontinued Operations
Cash flows from discontinued operating activities:			
Depreciation	$ 3,661	$ 8,138	$ 11,799
Amortization	17,460	5,685	23,145
Asset impairment charge	—	19,588	19,588
Stock-based compensation	(18)	(11)	(29)
Deferred income taxes	52,338	(6,638)	45,700
Cash flows from discontinued investing activities:			
Purchase of property and equipment	$ 9,174	$ 19,810	$ 28,984

24. Segments

The Company owns subsidiaries and investments primarily engaged in the provision of healthcare services in the United States. The Company's *NET Services* segment, which primarily operates under the brands LogistiCare and Circulation, since its acquisition in September 2018, is the largest manager of NET programs for state governments and MCOs in the U.S. On September 21, 2018, we completed the acquisition of Circulation, which offers a full suite of logistics solutions to manage NET programs across all areas of healthcare, powered by its HIPAA-compliant digital platform. Circulation's technology expands LogistiCare's existing capabilities to manage transportation benefits, integrating all transportation capabilities while proactively monitoring for fraud, waste and abuse and emphasizing member convenience and satisfaction.

The Company's *Matrix Investment* segment consists of a minority investment in Matrix, a nationwide provider of home and mobile-based healthcare services for health plans in the U.S., including CHAs, quality gap closure visits, "level of service" needs assessments, and post-acute and chronic care management, providing such services through a network of community-based clinicians, and a fleet of mobile health clinics with advanced diagnostics capabilities. On October 19, 2016, affiliates of Frazier Healthcare Partners purchased a controlling equity interest in Matrix, with the Company retaining a non-controlling equity interest. Matrix's financial results prior to October 19, 2016 are presented as a discontinued operation.

The Company's *Corporate and Other* segment includes the Company's executive, accounting, finance, internal audit, tax, legal, public reporting and corporate development functions, as well as the results of the Company's captive insurance company. On April 11, 2018, the Company announced an Organizational Consolidation. See Note 10, *Restructuring and Related Reorganization Costs,* for further information.

Our segments are determined based on how the Company's chief operating decision maker ("CODM") manages the Company's business, makes operating decisions and evaluates operating performance. The operating results of the segments

include revenue and expenses incurred by the segment, as well as an allocation of direct expenses incurred by Corporate on behalf of the segment. Indirect expenses, including unallocated corporate functions and expenses, such as executive, accounting, finance, internal audit, tax, legal, public reporting, certain strategic and corporate development functions and the results of the Company's captive insurance company as well as elimination entries recorded in consolidation are reflected in Corporate and Other.

The following table sets forth certain financial information from continuing operations attributable to the Company's business segments for the years ended December 31, 2018, 2017 and 2016.

	Year Ended December 31, 2018			
	NET Services	Matrix Investment	Corporate and Other	Total
Service revenue, net	$ 1,384,965	$ —	$ —	$ 1,384,965
Service expense	1,285,029	—	(426)	1,284,603
General and administrative expense	14,247	—	31,851	46,098
Asset impairment charge	14,175	—	—	14,175
Depreciation and amortization	15,026	—	787	15,813
Operating income (loss)	$ 56,488	$ —	$ (32,212)	$ 24,276
Equity in net (gain) loss of investees	$ —	$ 6,158	$ —	$ 6,158
Investment in equity method investee	$ —	$ 161,503	$ —	$ 161,503
Total assets	$ 349,567	$ 161,503	$ 54,125	$ 565,195
Long-lived asset expenditures	$ 10,796	$ —	$ —	$ 10,796

	Year Ended December 31, 2017			
	NET Services	Matrix Investment	Corporate and Other	Total
Service revenue, net	$ 1,318,220	$ —	$ —	$ 1,318,220
Service expense	1,227,426	—	(3,799)	1,223,627
General and administrative expense	11,779	—	31,712	43,491
Asset impairment charge	—	—	—	—
Depreciation and amortization	13,275	—	343	13,618
Operating income (loss)	$ 65,740	$ —	$ (28,256)	$ 37,484
Equity in net (gain) loss of investees	$ —	$ (13,445)	$ —	$ (13,445)
Investment in equity method investee		$ 169,699		$ 169,699
Total assets	$ 294,127	$ 169,699	$ 62,412	$ 526,238
Long-lived asset expenditures	$ 15,319	$ —	$ 77	$ 15,396

	Year Ended December 31, 2016			
	NET Services	Matrix Investment	Corporate and Other	Total
Service revenue, net	$ 1,233,720	$ —	$ 122	$ 1,233,842
Service expense	1,132,857	—	(894)	1,131,963
General and administrative expense	11,406	—	28,121	39,527
Asset impairment charge	—	—	1,415	1,415
Depreciation and amortization	12,375	—	405	12,780
Operating income (loss)	$ 77,082	$ —	$ (28,925)	$ 48,157
Equity in net (gain) loss of investees	$ —	$ 1,789	$ —	$ 1,789
Long-lived asset expenditures	$ 10,845	$ —	$ 1,387	$ 12,232

Customer Information

12.6%, 13.8% and 13.1% of the Company's consolidated revenue was derived from one U.S. state Medicaid program for the years ended December 31, 2018, 2017 and 2016, respectively. In addition, substantially all of the Company's revenues are generated from domestic governmental agencies or entities that contract with governmental agencies.

25. Quarterly Results (Unaudited)

The quarterly consolidated financial statements presented below reflect WD Services and Human Services as discontinued operations for all periods presented. Additionally, certain costs incurred by the Corporate and Other segment which directly related to the WD Services Sale are also included as discontinued operations.

	Quarter ended			
	March 31, 2018	June 30, 2018 (1) (2)	September 30, 2018 (3)	December 31, 2018 (4)
Service revenue, net	$ 336,696	$ 343,736	$ 343,771	$ 360,762
Operating income	12,103	3,431	9,435	(693)
Income from continuing operations, net of tax	7,423	1,964	10,295	(1,454)
(Loss) income from discontinued operations, net of tax	(1,697)	(13,366)	(2,964)	(19,026)
Net income (loss) attributable to Providence	5,430	(11,215)	7,154	(20,350)
Earnings (loss) per common share (10):				
Basic	$ 0.27	$ (0.96)	$ 0.37	$ (1.67)
Diluted	$ 0.26	$ (0.95)	$ 0.37	$ (1.67)

	Quarter ended			
	March 31, 2017 (5)	June 30, 2017	September 30, 2017 (6)	December 31, 2017(6)(7)(8)(9)
Service revenue, net	$ 324,033	$ 338,805	$ 324,824	$ 330,558
Operating income	4,707	11,333	7,271	14,173
Income from continuing operations, net of tax	2,046	7,658	3,374	38,008
(Loss) income from discontinued operations, net of tax	(5,997)	(3,917)	11,575	1,074
Net (loss) income attributable to Providence	(4,325)	3,915	14,853	38,926
(Loss) earnings per common share (10):				
Basic	$ (0.40)	$ 0.15	$ 0.88	$ 2.44
Diluted	$ (0.40)	$ 0.14	$ 0.88	$ 2.42

(1) Operating income in the quarter ending June 30, 2018 was negatively impacted by higher transportation costs on a per trip basis as NET Services saw a shift in service mix to higher cost modes of transportation and higher average mileage per trip.

(2) Due to the disposition of Ingeus France in July 2018, the carrying value of its assets and liabilities were reduced to their estimated fair value less selling costs during the quarter ending June 30, 2018. As a result, an impairment charge of $9,203 was recorded during the quarter ending June 30, 2018, which is included in (loss) income from discontinued operations, net of tax.

(3) During the quarter ending September 30, 2018, the Company acquired all of the outstanding equity of Circulation. The Company's initial investment in Circulation was $3,000. As a result of the transaction, the fair value of this pre-acquisition interest increased to $9,577, and thus the Company recognized a gain of $6,577.

(4) (Loss) income from discontinued operations, net of tax in the quarter ending December 31, 2018, includes a loss on the disposition of substantially all of the WD Services segment of $1,056, net of tax. This sale was completed on December 21, 2018.

(5) The Company recorded expenses, net of tax, of $5,866 in (loss) income from discontinued operations, net of tax, in the quarter ending March 31, 2017 related to the Company's former Human Services segment, which are principally related to a settled legal matter.

(6) The Company recorded a gain on sale of equity investment of $12,606, net of tax, related to the sale of its equity interest in Mission Providence during the quarter ended September 30, 2017, which is reflected in (loss) income from discontinued operations, net of tax. During the quarter ended December 31, 2017, the Company recorded a reduction to the gain on sale of $229, related to the finalization of the working capital adjustment per the sale agreement.

(7) Operating income for the quarter ended December 31, 2017 increased as compared to the prior quarters in 2017 as a result of a decrease in service expense as a percentage of revenue for NET Services. This was primarily a result of lower operating costs as well as certain NET Services contractual adjustments recorded in the fourth quarter of 2017.

(8) The quarter ended December 31, 2017 includes the receipt of the Haverhill Litigation settlement of $5,363.

(9) The quarter ended December 31, 2017 includes a net tax benefit of $15,925 related to the enactment of the Tax Reform Act during the fourth quarter of 2017, due to the re-measurement of deferred tax liabilities by Providence as a result of the reduction in the U.S. corporate tax rate. Providence realized a tax benefit of $19,304, partially offset by $3,379 of increased tax expense resulting from additional equity in net gain of Matrix, due to Matrix' re-measurement of its deferred tax liabilities. The equity in net gain from Matrix for the quarter ended December 31, 2017 includes a tax benefit of $13,610 related to Matrix's re-measurement of deferred tax liabilities as a result of the Tax Reform Act.

(10) Earnings per share is computed independently for each of the quarters presented. Therefore, the sum of quarterly earnings per share may not equal the total computed for the year.

Item 9. ***Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.***

None.

Item 9A. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures

The Company, under the supervision and with the participation of its management (including its principal executive officer and principal financial officer), evaluated the effectiveness of the design and operation of the Company's disclosure controls and procedures, as defined in Rule 13a-15(e) of the Exchange Act as of the end of the period covered by this Annual Report on Form 10-K (December 31, 2018). Based upon this evaluation, the Company's principal executive and financial officers have concluded that such disclosure controls and procedures were effective to provide reasonable assurance that (i) information required to be disclosed by the Company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and (ii) information required to be disclosed by the Company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the Company's management, including its principal executive and financial officers, or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure.

Management's Report on Internal Control Over Financial Reporting

Management's report on internal control over financial reporting is presented in Part II, Item 8, of this Annual Report and is hereby incorporated by reference.

We acquired Circulation on September 21, 2018, as discussed in Note 22, *Acquisitions*, to the Consolidated Financial Statements. As permitted by the SEC staff's Frequently Asked Question 3 on Management's Report on Internal Control Over Financial Reporting and Certification of Disclosure in Exchange Act Periodic Reports (revised September 24, 2007), our management excluded from our assessment of internal control over financial reporting effectiveness as of December 31, 2018, Circulation's internal control over financial reporting associated with consolidated total assets of approximately 1.1%, and consolidated total revenues of approximately 0.2%, included in our Consolidated Financial Statements as of and for the year ended December 31, 2018. We will include Circulation in our assessment of the effectiveness of internal control over financial reporting starting in the third quarter of 2019.

Report of Independent Registered Public Accounting Firm

The attestation report of the registered public accounting firm on the Company's internal control over financial reporting is presented in Part II, Item 8, of this Annual Report and is hereby incorporated by reference.

Changes in Internal Control Over Financial Reporting

The principal executive and financial officers also conducted an evaluation of whether any changes in the Company's internal control over financial reporting occurred during the quarter ended December 31, 2018 that have materially affected or which are reasonably likely to materially affect such control. Such officers have concluded that no such changes have occurred.

Item 9B. ***Other Information.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance.***

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2019 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2019, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

Code of Ethics

We have adopted a code of ethics that applies to our senior management, including our chief executive officer, chief financial officer, controller and persons performing similar functions, as well as our directors, officers and employees. This code of ethics is part of our broader Compliance and Ethics Plan and Code of Conduct, which is available free of charge in the Investor Relations section of our website at www.prscholdings.com. We intend to disclose any amendment to, or waiver from, a provision of the code of ethics that applies to our principal executive officer, principal financial officer or principal accounting officer on our website. The information contained on our website is not part of, and is not incorporated in, this Annual Report on Form 10-K or any other report we file with or furnish to the SEC.

Item 11. ***Executive Compensation.***

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2019 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2019, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.***

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2019 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2019, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence.***

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2019 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2019, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

Item 14. ***Principal Accounting Fees and Services.***

This Item is incorporated by reference from our definitive proxy statement on Schedule 14A to be filed with the SEC and delivered to stockholders in connection with our 2019 annual meeting of stockholders; provided that if such proxy statement is not filed on or before April 30, 2019, such information will be included in an amendment to this Annual Report on Form 10-K filed on or before such date.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules.***

(a)(1) Financial Statements

The following consolidated financial statements including footnotes are included in Item 8.

- Consolidated Balance Sheets at December 31, 2018 and 2017;
- Consolidated Statements of Operations for the years ended December 31, 2018, 2017 and 2016;
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017 and 2016;
- Consolidated Statements of Stockholders' Equity for the years ended December 31, 2018, 2017 and 2016; and
- Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017 and 2016.

(2) Financial Statement Schedules

Schedule II Valuation and Qualifying Accounts

	Balance at beginning of period	Additions: Charged to costs and expenses	Additions: Charged to other accounts	Deductions	Balance at end of period
Year Ended December 31, 2018:					
Allowance for doubtful accounts	$ 5,262	$ 338	$ (523) (1)	$ 3,223 (2)	$ 1,854
Year Ended December 31, 2017:					
Allowance for doubtful accounts	$ 5,164	$ 765	$ (537) (1)	$ 130 (2)	$ 5,262
Year Ended December 31, 2016:					
Allowance for doubtful accounts	$ 3,879	$ 2,903	$ 1,172 (1)	$ 2,790 (2)	$ 5,164

Notes:

Schedule above has been recast from prior year to exclude activity related to discontinued operations.

(1) Amounts primarily include the allowance for contractual adjustments related to our non-emergency transportation services operating segment that are recorded as adjustments to non-emergency transportation services revenue.

(2) Write-offs, net of recoveries.

All other schedules are omitted because they are not applicable or the required information is shown in our financial statements or the related notes thereto.

(3) Exhibits

Exhibit Number	Description
2.1	Share Sale Agreement, dated as of March 31, 2014, by and among The Providence Service Corporation, Pinnacle Australia Holdco Pty Ltd, Thérèse Virginia Rein, Gregory Kenneth Ashmead and GK Ashmead Holdings Pty Limited (as trustee of the GK Ashmead Nominees Trust) (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on April 1, 2014).
2.2	Australian Share Sale Agreement Side Deed, dated as of March 31, 2014, by and among The Providence Service Corporation, Pinnacle Australia Holdco Pty Ltd, Thérèse Virginia Rein, Gregory Kenneth Ashmead, GK Ashmead Holdings Pty Limited (as trustee of the GK Ashmead Nominees Trust) and Deloitte LLP (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on April 1, 2014).
2.3	Stock Subscription Agreement, dated as of August 28, 2016, by and among The Providence Service Corporation, CCHN Group Holdings, Inc. and Mercury Fortuna Buyer, LLC (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 31, 2016).
2.4	Amendment No. 1, dated as of October 19, 2016, to the Stock Subscription Agreement, dated August 28, 2016, by and among The Providence Service Corporation, CCHN Group Holdings, Inc. and Mercury Fortuna Buyer, LLC (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on October 25, 2016).
2.5	Agreement and Plan of Merger, dated as of September 14, 2018, among The Providence Service Corporation, LogistiCare Solutions, LLC, Catapult Merger Sub, Circulation, Inc. and Fortis Advisors LLC (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on September 17, 2018).
2.6	Share Purchase Agreement, dated November 7, 2018, among The Providence Service Corporation, Ingeus UK Holdings Limited, Advanced Personnel Management Group Pty Ltd, APM UK Holdings Limited and International APM Group Pty Limited (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended September 30, 2018 filed with the SEC on November 8, 2018).
3.1	Second Amended and Restated Certificate of Incorporation of The Providence Service Corporation, including Certificate of Designation of Series A Junior Participating Preferred Stock, as filed with the Secretary of State of Delaware on December 9, 2011 (Incorporated by reference from an exhibit to the registrant's annual report on Form 10-K for the year ended December 31, 2011 filed with the SEC on March 15, 2012).
3.2	Certificate of Amendment of the Certificate of Incorporation of The Providence Service Corporation, dated as of May 6, 2015 (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on May 7, 2015).
3.3	Amended and Restated Bylaws of The Providence Service Corporation, effective March 10, 2010 (Incorporated by reference from an exhibit to the registrant's annual report on Form 10-K for the year ended December 31, 2009 filed with the SEC on March 12, 2010).
4.1	Certificate of Designations of Series A Convertible Preferred Stock of The Providence Service Corporation, dated as of February 6, 2015 (Incorporated by reference from an exhibit to Amendment No. 1 to the registrant's annual report on Form 10-K/A for the year ended December 31, 2014 filed with the SEC on April 30, 2015).
10.1	Amended and Restated Credit and Guaranty Agreement, dated as of August 2, 2013, by and among The Providence Service Corporation and certain of its subsidiaries party thereto, Bank of America, N.A., SunTrust Bank, BMO Harris Bank, Merrill Lynch, Pierce, Fenner & Smith Incorporated and SunTrust Robinson

	Humphrey, Inc. and the lenders party thereto (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 5, 2013).
10.2	Amended and Restated Pledge Agreement, dated as of August 2, 2013, by and among The Providence Service Corporation, certain of its subsidiaries party thereto, and Bank of America, N.A., as administrative agent (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 5, 2013).
10.3	Amended and Restated Security Agreement, dated as of August 2, 2013, by and among The Providence Service Corporation, certain of its subsidiaries party thereto, and Bank of America, N.A., as administrative agent (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 5, 2013).

10.4	First Amendment to Amended and Restated Credit and Guaranty Agreement and Consent, dated as of May 28, 2014, by and among The Providence Service Corporation, the Guarantors named therein, the New Subsidiaries named therein, the Lenders and New Lender named therein and Bank of America, N.A., as administrative agent (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on June 3, 2014).
10.5	Second Amendment to the Amended and Restated Credit and Guaranty Agreement and Consent, dated as of October 23, 2014, by and among The Providence Service Corporation, certain of its subsidiaries party thereto, Bank of America, N.A., SunTrust Bank, Royal Bank of Canada, BMO Harris Bank, N.A., HSBC Bank USA, National Association, the other Lenders party thereto, Merrill Lynch, Pierce, Fenner & Smith Incorporated, SunTrust Robinson Humphrey, Inc., and RBC Capital Markets (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on October 24, 2014).
10.6	Third Amendment and Consent to the Amended and Restated Credit and Guaranty Agreement, dated as of September 3, 2015, by and among The Providence Service Corporation, certain of its subsidiaries party thereto, Bank of America, N.A., Sun Trust Bank, Royal Bank of Canada, BMO Harris Bank, N.A., HSBC Bank USA, National Association, the other lenders party thereto, Merrill Lynch Pierce, Fenner & Smith Incorporated, Sun Trust Robinson Humphrey, Inc. and RBC Capital Markets (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on September 8, 2015).
10.7	Fourth Amendment and Consent to the Amended and Restated Credit and Guaranty Agreement, dated as of August 28, 2016, by and among The Providence Service Corporation, the guarantors party thereto, the lenders party thereto and Bank of America, N.A., as Administrative Agent (Incorporated by reference to an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 31, 2016).
10.8	Employment Agreement, dated January 14, 2015, by and between The Providence Service Corporation and James Lindstrom (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on January 21, 2015).
10.9+	Employment Agreement, dated as of September 28, 2015, by and between The Providence Service Corporation and David Shackelton (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on November 20, 2015).
10.10+	Amended & Restated Employment Agreement, dated January 9, 2018, by and between The Providence Service Corporation and David Shackelton (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on January 16, 2018).
10.11+	Employment Agreement, dated April 4, 2016, between The Providence Service Corporation and Sophia Tawil (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended March 31, 2016 filed with the SEC on May 6, 2016).
10.12+	Amended & Restated Employment Agreement, dated January 9, 2018, by and between The Providence Service Corporation and Sophia Tawil (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on January 16, 2018).
10.13+	Employment Agreement, dated November 15, 2017, between The Providence Service Corporation and R. Carter Pate (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on November 15, 2017).
10.14+	Letter Agreement, dated January 10, 2018, by and between The Providence Service Corporation and William Severance (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on January 16, 2018).
10.15+	The Providence Service Corporation Non-Qualified Stock Option Agreement, dated April 9, 2018, between The

	Providence Service Corporation and R. Carter Pate (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on April 11, 2018).
10.16+	Amendment No. 1 to The Providence Service Corporation Non-Qualified Stock Option Agreement, dated May 1, 2018, between The Providence Service Corporation and R. Carter Pate (Incorporated by reference from an exhibit to the registrant's Registration Statement on Form S-1 filed with the SEC on May 9, 2018).
10.17+	Employment Agreement, dated August 18, 2018, by and among The Providence Service Corporation, LogistiCare Solutions, LLC and Kevin M. Dotts (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 22, 2018).
10.18+	The Providence Service Corporation 2006 Long-Term Incentive Plan, as amended and restated effective July 27, 2016 (Incorporated by reference from an appendix to the registrant's definitive proxy statement on Schedule 14A filed with the SEC on June 14, 2016).

10.19+	Form of Restricted Stock Agreements (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended March 31, 2011 filed with the SEC on May 6, 2011).
10.20+	Form of Stock Option Agreements (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended March 31, 2011 filed with the SEC on May 6, 2011).
10.21+	Form of Special Incentive Stock Option Award Agreement (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 11, 2015).
10.22+	Form of Matching Incentive Stock Option Award Agreement (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on August 11, 2015).
10.23	Amended and Restated Limited Liability Company Agreement of Mercury Parent, LLC, by and between Prometheus Holdco, LLC and Mercury Fortuna Buyer, LLC, dated as of October 19, 2016 (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on October 25, 2016).
10.24	Second Amended and Restated Limited Liability Company Agreement of Mercury Parent, LLC, by and between Prometheus Holdco, LLC and Mercury Fortuna Buyer, LLC, dated February 16, 2018 (Incorporated by reference from an exhibit to the registrant's annual report on Form 10-K for the year ended December 31, 2017 filed with the SEC on March 9, 2018).
10.25+	Form of Matching Stock Option Agreement (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended March 31, 2017 filed with the SEC on May 10, 2017).
10.26+	Form of Stock Option Agreement (Incorporated by reference from an exhibit to the registrant's annual report on Form 10-K for the year ended December 31, 2017 filed with the SEC on March 9, 2018).
10.27+	Letter agreement, dated September 21, 2015, between The Providence Service Corporation and Matthew Umscheid (Incorporated by reference from an exhibit to the registrant's annual report on Form 10-K for the year ended December 31, 2017 filed with the SEC on March 9, 2018).
10.28+	The Providence Service Corporation Employee Retention Plan (Incorporated by reference from an exhibit to the registrant's current report on Form 8-K filed with the SEC on April 11, 2018).
10.29	Registration Indemnification Agreement, dated May 9, 2018, between The Providence Service Corporation, Coliseum Capital Partners, L.P., Coliseum Capital Partners II, L.P., Coliseum Capital Co-Invest, L.P. and Blackwell Partners, LLC - Series A (Incorporated by reference from an exhibit to the registrant's Registration Statement on Form S-1 filed with the SEC on May 9, 2018).
10.30+	Form of Deferred Share Unit Agreement (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended June 30, 2018 filed with the SEC on August 8, 2018).
10.31+	Form of Amendment to Retention Letter under The Providence Service Corporation Employee Retention Plan (Incorporated by reference from an exhibit to the registrant's quarterly report on Form 10-Q for the quarter ended September 30, 2018 filed with the SEC on November 8, 2018).
21.1*	Subsidiaries of the Registrant.
23.1*	Consent of KPMG LLP.
23.2*	Consent of Deloitte & Touche LLP (Mercury Parent, LLC financial statements).
23.3*	Consent of KPMG LLP (Mercury Parent, LLC financial statements).
31.1*	Certification pursuant to Securities Exchange Act Rules 13a-14 and 15d-14 of the Chief Executive Officer.

31.2*	Certification pursuant to Securities Exchange Act Rules 13a-14 and 15d-14 of the Chief Financial Officer.
32.1*	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, of the Chief Executive Officer.
32.2*	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, of the Chief Financial Officer.
99.1*	Financial Statements of Mercury Parent, LLC.
101. INS*	XBRL Instance Document
101.SCH*	XBRL Schema Document

101.CAL*	XBRL Calculation Linkbase Document
101.LAB*	XBRL Label Linkbase Document
101.PRE*	XBRL Presentation Linkbase Document
101.DEF*	XBRL Definition Linkbase Document

+ Management contract or compensatory plan or arrangement.

* Filed herewith.

Item 16. Form 10-K Summary.

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

THE PROVIDENCE SERVICE CORPORATION

By: /s/ R. Carter Pate
R. Carter Pate
Interim Chief Executive Officer

Dated: March 1, 2019

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/S/ R. CARTER PATE R. Carter Pate	Interim Chief Executive Officer (Principal Executive Officer)	March 1, 2019
/S/ KEVIN DOTTS Kevin Dotts	Chief Financial Officer (Principal Financial Officer)	March 1, 2019
/S/ LAURENCE ORTON Laurence Orton	Senior Vice President, Finance (Principal Accounting Officer)	March 1, 2019
/S/ CHRISTOPHER S. SHACKELTON Christopher S. Shackelton	Chairman of the Board	March 1, 2019
/S/ TODD J. CARTER Todd J. Carter	Director	March 1, 2019
/S/ DAVID A. COULTER David A. Coulter	Director	March 1, 2019
/S/ RICHARD A. KERLEY Richard A. Kerley	Director	March 1, 2019
/S/ LESLIE V. NORWALK Leslie V. Norwalk	Director	March 1, 2019
/S/ FRANK J. WRIGHT Frank J. Wright	Director	March 1, 2019

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Superior Vision Financials

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Tax Authority Certificate

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LOUISIANA
DEPARTMENT *of* REVENUE
Post Office Box 66658
Baton Rouge, LA 70896-6658

AETNA BETTER HEALTH INC
151 FARMINGTON AVE STE RT21
HARTFORD CT 06156-0001

Date of Notice: 12-Apr-2019
Letter ID: L1149790432
Account ID: 5790795-001-200
Tax Type: Corporation Income & Franchise

Re: Letter of Good Standing
AETNA BETTER HEALTH INC

Dear Louisiana Taxpayer:

This letter is to certify that as of this date, the above referenced taxpayer is in good standing for business taxes collected by the Louisiana Department of Revenue.

Please contact us if you have any questions.

Sincerely,

Reva Williams
Tax Officer
Collections Division
(225) 219-7448

Post Office Box 66658
Baton Rouge, LA 70896-6658
(855) 307-3893 • (225) 219-0864 Fax
www.revenue.louisiana.gov

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Attachment C

Louisiana | Transforming Health Care | **Aetna**

Attachment C: Resumes

This attachment contains data identified as confidential information and has been redacted in its entirety.

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Attachment D

Louisiana | Transforming Health Care | **Aetna**

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Aetna Better Health of Louisiana

Medicaid HMO

an accreditation status of

ACCREDITED

for service and clinical quality that meet or exceed

NCQA's rigorous requirements for consumer

protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN ACCREDITED

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

August 31, 2018	*July 25, 2021*
DATE GRANTED	EXPIRATION DATE

Attachment E

Louisiana | Transforming Health Care | **Aetna**

Attachment E: Quality Response Template and Sample Clinical Practice Guideline

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Sample Clinical Practice Guideline

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Guidance for the Clinician in Rendering Pediatric Care

CLINICAL PRACTICE GUIDELINE

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

SUBCOMMITTEE ON ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT

KEY WORDS
attention-deficit/hyperactivity disorder, children, adolescents, preschool, behavioral therapy, medication

ABBREVIATIONS
AAP—American Academy of Pediatrics
ADHD—attention-deficit/hyperactivity disorder
DSM-PC—*Diagnostic and Statistical Manual for Primary Care*
CDC—Centers for Disease Control and Prevention
FDA—Food and Drug Administration
DSM-IV—*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*
MTA—Multimodal Therapy of ADHD

www.pediatrics.org/cgi/doi/10.1542/peds.2011-2654

doi:10.1542/peds.2011-2654

All clinical practice guidelines from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

abstract

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood and can profoundly affect the academic achievement, well-being, and social interactions of children; the American Academy of Pediatrics first published clinical recommendations for the diagnosis and evaluation of ADHD in children in 2000; recommendations for treatment followed in 2001. *Pediatrics* 2011;128:1007–1022

Summary of key action statements:

1. The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).
2. To make a diagnosis of ADHD, the primary care clinician should determine that *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria have been met (including documentation of impairment in more than 1 major setting); information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).
3. In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders), developmental (eg, learning and language disorders or other neurodevelopmental disorders), and physical (eg, tics, sleep apnea) conditions (quality of evidence B/strong recommendation).
4. The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).

5. Recommendations for treatment of children and youth with ADHD vary depending on the patient's age:
   a. For *preschool-aged children (4–5 years of age)*, the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/recommendation).
   b. For *elementary school–aged children (6–11 years of age)*, the primary care clinician should prescribe US Food and Drug Administration–approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) (quality of evidence A/strong recommendation). The school environment, program, or placement is a part of any treatment plan.
   c. For *adolescents (12–18 years of age)*, the primary care clinician should prescribe Food and Drug Administration–approved medications for ADHD with the assent of the adolescent (quality of evidence A/strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/recommendation), preferably both.
6. The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects (quality of evidence B/strong recommendation).

INTRODUCTION

This document updates and replaces 2 previously published clinical guidelines from the American Academy of Pediatrics (AAP) on the diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD) in children: "Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder" (2000)[1] and "Clinical Practice Guideline: Treatment of the School-aged Child With Attention-Deficit/Hyperactivity Disorder" (2001).[2] Since these guidelines were published, new information and evidence regarding the diagnosis and treatment of ADHD has become available. Surveys conducted before and after the publication of the previous guidelines have also provided insight into pediatricians' attitudes and practices regarding ADHD. On the basis of an increased understanding regarding ADHD and the challenges it raises for children and families and as a source for clinicians seeking to diagnose and treat children, this guideline pays particular attention to a number of areas.

Expanded Age Range

The previous guidelines addressed diagnosis and treatment of ADHD in children 6 through 12 years of age. There is now emerging evidence to expand the age range of the recommendations to include preschool-aged children and adolescents. This guideline addresses the diagnosis and treatment of ADHD in children 4 through 18 years of age, and attention is brought to special circumstances or concerns in particular age groups when appropriate.

Expanded Scope

Behavioral interventions might help families of children with hyperactive/impulsive behaviors that do not meet full diagnostic criteria for ADHD. Guidance regarding the diagnosis of problem-level concerns in children based on the *Diagnostic and Statistical Manual for Primary Care* (DSM-PC), *Child and Adolescent Version*,[3] as well as suggestions for treatment and care of children and families with problem-level concerns, are provided here. The current DSM-PC was published in 1996 and, therefore, is not consistent with intervening changes to *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). Although this version of the DSM-PC should not be used as a definitive source for diagnostic codes related to ADHD and comorbid conditions, it certainly may continue to be used as a resource for enriching the understanding of ADHD manifestations. The DSM-PC will be revised when both the DSM-V and ICD-10 are available for use.

A Process of Care for Diagnosis and Treatment

This guideline and process-of-care algorithm (see Supplemental Fig 2 and Supplemental Appendix) recognizes evaluation, diagnosis, and treatment as a continuous process and provides recommendations for both the guideline and the algorithm in this single publication. In addition to the formal recommendations for assessment, diagnosis, and treatment, this guideline

provides a single algorithm to guide the clinical process.

Integration With the Task Force on Mental Health

This guideline fits into the broader mission of the AAP Task Force on Mental Health and its efforts to provide a base from which primary care providers can develop alliances with families, work to prevent mental health conditions and identify them early, and collaborate with mental health clinicians.

The diagnosis and management of ADHD in children and youth has been particularly challenging for primary care clinicians because of the limited payment provided for what requires more time than most of the other conditions they typically address. The procedures recommended in this guideline necessitate spending more time with patients and families, developing a system of contacts with school and other personnel, and providing continuous, coordinated care, all of which is time demanding. In addition, relegating mental health conditions exclusively to mental health clinicians also is not a viable solution for many clinicians, because in many areas access to mental health clinicians to whom they can refer patients is limited. Access in many areas is also limited to psychologists when further assessment of cognitive issues is required and not available through the education system because of restrictions from third-party payers in paying for the evaluations on the basis of them being educational and not health related.

Cultural differences in the diagnosis and treatment of ADHD are an important issue, as they are for all pediatric conditions. Because the diagnosis and treatment of ADHD depends to a great extent on family and teacher perceptions, these issues might be even more prominent an issue for ADHD. Specific cultural issues are beyond the scope of this guideline but are important to consider.

METHODOLOGY

As with the 2 previously published clinical guidelines, the AAP collaborated with several organizations to develop a working subcommittee that represented a wide range of primary care and subspecialty groups. The subcommittee included primary care pediatricians, developmental-behavioral pediatricians, and representatives from the American Academy of Child and Adolescent Psychiatry, the Child Neurology Society, the Society for Pediatric Psychology, the National Association of School Psychologists, the Society for Developmental and Behavioral Pediatrics, the American Academy of Family Physicians, and Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD), as well as an epidemiologist from the Centers for Disease Control and Prevention (CDC).

This group met over a 2-year period, during which it reviewed the changes in practice that have occurred and issues that have been identified since the previous guidelines were published. Delay in completing the process led to further conference calls and extended the years of literature reviewed in order to remain as current as possible. The AAP funded the development of this guideline; potential financial conflicts of the participants were identified and taken into consideration in the deliberations. The guideline will be reviewed and/or revised in 5 years unless new evidence emerges that warrants revision sooner.

The subcommittee developed a series of research questions to direct an extensive evidence-based review in partnership with the CDC and the University of Oklahoma Health Sciences Center. The diagnostic review was conducted by the CDC, and the evidence was evaluated in a combined effort of the AAP, CDC, and University of Oklahoma Health Sciences Center staff. The treatment-related evidence relied on a recent evidence review by the Agency for Healthcare Research and Quality and was supplemented by evidence identified through the CDC review.

The diagnostic issues were focused on 5 areas:

1. ADHD prevalence—specifically: (*a*) What percentage of the general US population aged 21 years or younger has ADHD? (*b*) What percentage of patients presenting at pediatricians' or family physicians' offices in the United States meet diagnostic criteria for ADHD?
2. Co-occurring mental disorders—of people with ADHD, what percentage has 1 or more of the following co-occurring conditions: sleep disorders, learning disabilities, depression, anxiety, conduct disorder, and oppositional defiant disorder?
3. What are the functional impairments of children and youth diagnosed with ADHD? Specifically, in what domains and to what degree do youth with ADHD demonstrate impairments in functional domains, including peer relations, academic performance, adaptive skills, and family functioning?
4. Do behavior rating scales remain the standard of care in assessing the diagnostic criteria for ADHD?
5. What is the prevalence of abnormal findings on selected medical screening tests commonly recommended as standard components of an evaluation of a child with suspected ADHD? How accurate are these tests in the diagnosis of ADHD compared with a reference standard (ie, what are the psychometric properties of these tests)?

The treatment issues were focused on 3 areas:

1. What new information is available

regarding the long-term efficacy and safety of medications approved by the US Food and Drug Administration (FDA) for the treatment of ADHD (stimulants and nonstimulants), and specifically, what information is available about the efficacy and safety of these medications in preschool-aged and adolescent patients?

2. What evidence is available about the long-term efficacy and safety of psychosocial interventions (behavioral modification) for the treatment of ADHD for children, and specifically, what information is available about the efficacy and safety of these interventions in preschool-aged and adolescent patients?
3. Are there any additional therapies that reach the level of consideration as evidence based?

Evidence-Review Process for Diagnosis

A multilevel, systematic approach was taken to identify the literature that built the evidence base for both diagnosis and treatment. To increase the likelihood that relevant articles were included in the final evidence base, the reviewers first conducted a scoping review of the literature by systematically searching literature using relevant key words and then summarized the primary findings of articles that met standard inclusion criteria. The reviewers then created evidence tables that were reviewed by content-area experts who were best able to identify articles that might have been missed through the scoping review. Articles that were missed were reviewed carefully to determine where the abstraction methodology failed, and adjustments to the search strategy were made as required (see technical report to be published). Finally, although published literature reviews did not contribute directly to the evidence base, the articles included in review articles were cross-referenced with the final evidence tables to ensure that all relevant articles were included in the final evidence tables.

For the scoping review, articles were abstracted in a stratified fashion from 3 article-retrieval systems that provided access to articles in the domains of medicine, psychology, and education: PubMed (www.ncbi.nlm.nih.gov/sites/entrez), PsycINFO (www.apa.org/pubs/databases/psycinfo/index.aspx), and ERIC (www.eric.ed.gov). English-language, peer-reviewed articles published between 1998 and 2009 were queried in the 3 search engines. Key words were selected with the intent of including all possible articles that might have been relevant to 1 or more of the questions of interest (see the technical report to be published). The primary abstraction included the following terms: "attention deficit hyperactivity disorder" or "attention deficit disorder" or "hyperkinesis" and "child." A second, independent abstraction was conducted to identify articles related to medical screening tests for ADHD. For this abstraction, the same search terms were used as in the previous procedure along with the additional condition term "behavioral problems" to allow for the inclusion of studies of youth that sought to diagnose ADHD by using medical screening tests. Abstractions were conducted in parallel fashion across each of the 3 databases; the results from each abstraction (complete reference, abstract, and key words) were exported and compiled into a common reference database using EndNote 10.0.[4] References were subsequently and systematically deduplicated by using the software's deduplication procedure. References for books, chapters, and theses were also deleted from the library. Once a deduplicated library was developed, the semifinal database of 8267 references was reviewed for inclusion on the basis of inclusion criteria listed in the technical report. Included articles were then pulled in their entirety, the inclusion criteria were reconfirmed, and then the study findings were summarized in evidence tables. The articles included in relevant review articles were revisited to ensure their inclusion in the final evidence base. The evidence tables were then presented to the committee for expert review.

Evidence-Review Process for Treatment

In addition to this systematic review, for treatment we used the review from the Agency for Healthcare Research and Quality (AHRQ) Effective Healthcare Program "Attention Deficit Hyperactivity Disorder: Effectiveness of Treatment in At-Risk Preschoolers; Long-term Effectiveness in All Ages; and Variability in Prevalence, Diagnosis, and Treatment."[5] This review addressed a number of key questions for the committee, including the efficacy of medications and behavioral interventions for preschoolers, children, and adolescents. Evidence identified through the systematic evidence review for diagnosis was also used as a secondary data source to supplement the evidence presented in the AHRQ report. The draft practice guidelines were developed by consensus of the committee regarding the evidence. It was decided to create 2 separate components. The guideline recommendations were based on clear characterization of the evidence. The second component is a practice-of-care algorithm (see Supplemental Fig 2) that provides considerably more detail about how to implement the guidelines but is, necessarily, based less on available evidence and more on consensus of the committee members. When data were lacking, particularly in the

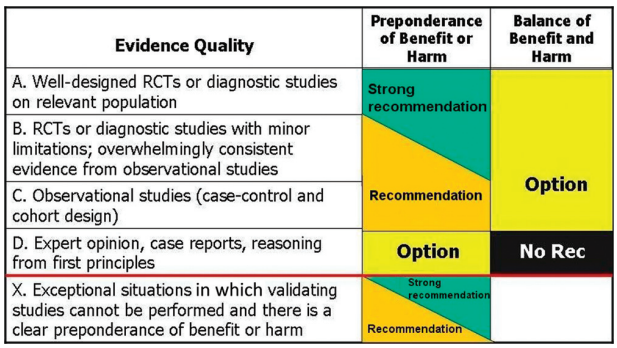

FIGURE 1

Integrating evidence-quality appraisal with an assessment of the anticipated balance between benefits and harms if a policy is conducted leads to designation of a policy as a strong recommendation, recommendation, option, or no recommendation. The evidence is discussed in more detail in a technical report that will follow in a later publication. RCT indicates randomized controlled trial; Rec, recommendation.

process-of-care algorithmic portion of the guidelines, a combination of evidence and expert consensus was used. Action statements labeled "strong recommendation" or "recommendation" were based on high- to moderate-quality scientific evidence and a preponderance of benefit over harm.[6] Option-level action statements were based on lesser-quality or limited data and expert consensus or high-quality evidence with a balance between benefits and harms. These clinical options are interventions that a reasonable health care provider might or might not wish to implement in his or her practice. The quality of evidence supporting each recommendation and the strength of each recommendation were assessed by the committee member most experienced in epidemiology and graded according to AAP policy (Fig 1).[6]

The guidelines and process-of-care algorithm underwent extensive peer review by committees, sections, councils, and task forces within the AAP; numerous outside organizations; and other individuals identified by the subcommittee. Liaisons to the subcommittee also were invited to distribute the draft to entities within their organizations. The resulting comments were compiled and reviewed by the chairperson, and relevant changes were incorporated into the draft, which was then reviewed by the full committee.

ABOUT THIS GUIDELINE

Key Action Statements

In light of the concerns highlighted previously and informed by the available evidence, the AAP has developed 6 action statements for the evaluation, diagnosis, and treatment of ADHD in children. These action statements provide for consistent and quality care for children and families with concerns about or symptoms that suggest attention disorders or problems.

Context

This guideline is intended to be integrated with the broader algorithms developed as part of the mission of the AAP Task Force on Mental Health.[7]

Implementation: A Process-of-Care Algorithm

The AAP recognizes the challenge of instituting practice changes and adopting new recommendations for care. To address the need, a process-of-care algorithm has been developed and has been used in the revision of the AAP ADHD toolkit.

Implementation: Preparing the Practice

Full implementation of the action statements described in this guideline and the process-of-care algorithm might require changes in office procedures and/or preparatory efforts to identify community resources. The section titled "Preparing the Practice" in the process-of-care algorithm and further information can be found in the supplement to the Task Force on Mental Health report.[7] It is important to document all aspects of the diagnostic and treatment procedures in the patients' records. Use of rating scales for the diagnosis of ADHD and assessment for comorbid conditions and as a method for monitoring treatment as described in the process algorithm (see Supplemental Fig 2), as well as information provided to parents such as management plans, can help facilitate a clinician's accurate documentation of his or her process.

Note

The AAP acknowledges that some primary care clinicians might not be confident of their ability to successfully diagnose and treat ADHD in a child because of the child's age, coexisting conditions, or other concerns. At any point at which a clinician feels that he or she is not adequately trained or is uncertain about making a diagnosis or continuing with treatment, a referral to a pediatric or mental health subspecialist should be made. If a diagnosis of ADHD or other condition is made by a subspecialist, the primary care clinician should develop a management strategy with the subspecialist that ensures that the child will continue to receive appropriate care consistent with a medical home model wherein the pediatrician part-

ners with parents so that both health and mental health needs are integrated.

KEY ACTION STATEMENTS FOR THE EVALUATION, DIAGNOSIS, TREATMENT, AND MONITORING OF ADHD IN CHILDREN AND ADOLESCENTS

Action statement 1: The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** In a considerable number of children, ADHD goes undiagnosed. Primary care clinicians' systematic identification of children with these problems will likely decrease the rate of undiagnosed and untreated ADHD in children.
- **Harms/risks/costs:** Children in whom ADHD is inappropriately diagnosed might be labeled inappropriately, or another condition might be missed, and they might receive treatments that will not benefit them.
- **Benefits-harms assessment:** The high prevalence of ADHD and limited mental health resources require primary care pediatricians to play a significant role in the care of their patients with ADHD so that children with this condition receive the appropriate diagnosis and treatment. Treatments available have shown good evidence of efficacy, and lack of treatment results in a risk for impaired outcomes.
- **Value judgments:** The committee considered the requirements for establishing the diagnosis, the prevalence of ADHD, and the efficacy and adverse effects of treatment as well as the long-term outcomes.
- **Role of patient preferences:** Success with treatment depends on patient and family preference, which has to be taken into account.
- **Exclusions:** None.
- **Intentional vagueness:** The limits between what can be handled by a primary care clinician and what should be referred to a subspecialist because of the varying degrees of skills among primary care clinicians.
- **Strength: strong recommendation.**

The basis for this recommendation is essentially unchanged from that in the previous guideline. ADHD is the most common neurobehavioral disorder in children and occurs in approximately 8% of children and youth[8–10]; the number of children with this condition is far greater than can be managed by the mental health system. There is now increased evidence that appropriate diagnosis can be provided for preschool-aged children[11] (4–5 years of age) and for adolescents.[12]

Action statement 2: To make a diagnosis of ADHD, the primary care clinician should determine that *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV-TR) criteria have been met (including documentation of impairment in more than 1 major setting), and information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** The use of DSM-IV criteria has lead to more uniform categorization of the condition across professional disciplines.
- **Harms/risks/costs:** The DSM-IV system does not specifically provide for developmental-level differences and might lead to some misdiagnoses.
- **Benefits-harms assessment:** The benefits far outweigh the harm.
- **Value judgments:** The committee took into consideration the importance of coordination between pediatric and mental health services.
- **Role of patient preferences:** Although there is some stigma associated with mental disorder diagnoses resulting in some families preferring other diagnoses, the need for better clarity in diagnoses was felt to outweigh this preference.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

As with the findings in the previous guideline, the DSM-IV criteria continue to be the criteria best supported by evidence and consensus. Developed through several iterations by the American Psychiatric Association, the DSM-IV criteria were created through use of consensus and an expanding research foundation.[13] The DSM-IV system is used by professionals in psychiatry, psychology, health care systems, and primary care. Use of DSM-IV criteria, in addition to having the best evidence to date for criteria for ADHD, also affords the best method for communication across clinicians and is established with third-party payers. The criteria are under review for the development of the DSM-V, but these changes will not be available until at least 1 year after the publication of this current guideline. The diagnostic criteria have not changed since the previous guideline and are presented in Supplemental Table 2. An anticipated change in the DSM-V is increasing the age limit for when ADHD needs to have first presented from 7 to 12 years.[14]

Special Circumstances: Preschool-aged Children (4–5 Years Old)

There is evidence that the diagnostic criteria for ADHD can be applied to preschool-aged children; however, the subtypes detailed in the DSM-IV might not be valid for this population.[15–21] A review of the literature, including the multisite study of the efficacy of methylphenidate in preschool-aged children, revealed that the criteria could appropriately identify children with the condition.[11] However, there are added challenges in determining the presence of key symptoms. Preschool-aged children are not likely to have a separate observer if they do not attend a preschool or child care program, and even if they do attend, staff in those programs might be less qualified than certified teachers to provide accurate observations. Here, too, focused checklists can help physicians in the diagnostic evaluation, although only the Conners Comprehensive Behavior Rating Scales and the ADHD Rating Scale IV are DSM-IV–based scales that have been validated in preschool-aged children.[22]

When there are concerns about the availability or quality of nonparent observations of a child's behavior, physicians may recommend that parents complete a parent-training program before confirming an ADHD diagnosis for preschool-aged children and consider placement in a qualified preschool program if they have not done so already. Information can be obtained from parents and teachers through the use of validated DSM-IV–based ADHD rating scales. The parent-training program must include helping parents develop age-appropriate developmental expectations and specific management skills for problem behaviors. The clinician may obtain reports from the parenting class instructor about the parents' ability to manage their children, and if the children are in programs in which they are directly observed, instructors can report information about the core symptoms and function of the child directly. Qualified preschool programs include programs such as Head Start or other public prekindergarten programs. Preschool-aged children who display significant emotional or behavioral concerns might also qualify for Early Childhood Special Education services through their local school districts, and the evaluators for these programs and/or Early Childhood Special Education teachers might be excellent reporters of core symptoms.

Special Circumstances: Adolescents

Obtaining teacher reports for adolescents might be more challenging, because many adolescents will have multiple teachers. Likewise, parents might have less opportunity to observe their adolescent's behaviors than they had when their children were younger. Adolescents' reports of their own behaviors often differ from those of other observers, because they tend to minimize their own problematic behaviors.[23–25] Adolescents are less likely to exhibit overt hyperactive behavior. Despite the difficulties, clinicians need to try to obtain (with agreement from the adolescent) information from at least 2 teachers as well as information from other sources such as coaches, school guidance counselors, or leaders of community activities in which the adolescent participates. In addition, it is unusual for adolescents with behavioral/attention problems not to have been previously given a diagnosis of ADHD. Therefore, it is important to establish the younger manifestations of the condition that were missed and to strongly consider substance use, depression, and anxiety as alternative or co-occurring diagnoses. Adolescents with ADHD, especially when untreated, are at greater risk of substance abuse.[26] In addition, the risks of mood and anxiety disorders and risky sexual behaviors increase during adolescence.[12]

Special Circumstances: Inattention or Hyperactivity/Impulsivity (Problem Level)

Teachers, parents, and child health professionals typically encounter children with behaviors relating to activity level, impulsivity, and inattention who might not fully meet DSM-IV criteria. The DSM-PC[3] provides a guide to the more common behaviors seen in pediatrics. The manual describes common variations in behavior as well as more problematic behaviors at levels of less impairment than those specified in the DSM-IV.

The behavioral descriptions of the DSM-PC have not yet been tested in community studies to determine the prevalence or severity of developmental variations and problems in the areas of inattention, hyperactivity, or impulsivity. They do, however, provide guidance to clinicians regarding elements of treatment for children with problems with mild-to-moderate inattention, hyperactivity, or impulsivity. The DSM-PC also considers environmental influences on a child's behavior and provides information on differential diagnosis with a developmental perspective.

Action statement 3: In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders), developmental (eg, learning and language disorders or other neurodevelopmental disorders), and physical (eg, tics, sleep apnea) conditions (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** Identifying coexisting conditions is important for developing the most appropriate treatment plan.
- **Harms/risks/costs:** The major risk is misdiagnosing the conditions and providing inappropriate care.
- **Benefits-harms assessment:** There is a preponderance of benefit over harm.
- **Value judgments:** The committee members took into consideration the common occurrence of coexisting conditions and the importance of addressing them in making this recommendation.
- **Role of patient preferences:** None.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

A variety of other behavioral, developmental, and physical conditions can coexist in children who are evaluated for ADHD. These conditions include, but are not limited to, learning problems, language disorder, disruptive behavior, anxiety, mood disorders, tic disorders, seizures, developmental coordination disorder, or sleep disorders.[23,24,27–38] In some cases, the presence of a coexisting condition will alter the treatment of ADHD. The primary care clinician might benefit from additional support and guidance or might need to refer a child with ADHD and coexisting conditions, such as severe mood or anxiety disorders, to subspecialists for assessment and management. The subspecialists could include child psychiatrists, developmental-behavioral pediatricians, neurodevelopmental disability physicians, child neurologists, or child or school psychologists.

Given the likelihood that another condition exists, primary care clinicians should conduct assessments that determine or at least identify the risk of coexisting conditions. Through its Task Force on Mental Health, the AAP has developed algorithms and a toolkit[39] for assessing and treating (or comanaging) the most common developmental disorders and mental health concerns in children. These resources might be useful in assessing children who are being evaluated for ADHD. Payment for evaluation and treatment must cover the fixed and variable costs of providing the services, as noted in the AAP policy statement "Scope of Health Care Benefits for Children From Birth Through Age 26.[40]

Special Circumstances: Adolescents

Clinicians should assess adolescent patients with newly diagnosed ADHD for symptoms and signs of substance abuse; when these signs and symptoms are found, evaluation and treatment for addiction should precede treatment for ADHD, if possible, or careful treatment for ADHD can begin if necessary.[25]

Action statement 4: The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** The recommendation describes the coordinated services most appropriate for managing the condition.
- **Harms/risks/costs:** Providing the services might be more costly.
- **Benefits-harms assessment:** There is a preponderance of benefit over harm.
- **Value judgments:** The committee members considered the value of medical home services when deciding to make this recommendation.
- **Role of patient preferences:** Family preference in how these services are provided is an important consideration.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

As in the previous guideline, this recommendation is based on the evidence that ADHD continues to cause symptoms and dysfunction in many children who have the condition over long periods of time, even into adulthood, and that the treatments available address symptoms and function but are usually not curative. Although the chronic illness model has not been specifically studied in children and youth with ADHD, it has been effective for other chronic conditions such as asthma,[23] and the medical home model has been accepted as the preferred standard of care.[41] The management process is also helped by encouraging strong family-school partnerships.[42]

Longitudinal studies have found that, frequently, treatments are not sustained despite the fact that long-term outcomes for children with ADHD indicate that they are at greater risk of significant problems if they discontinue treatment.[43] Because a number of parents of children with ADHD also have ADHD, extra support might be necessary to help those parents provide medication on a consistent basis and institute a consistent behavioral program. The medical home and chronic illness approach is provided in the process algorithm (Supplemental Fig 2). An important process in ongoing care is bidirectional communication with teachers and other school and mental health clinicians involved in the child's care as well as with parents and patients.

Special Circumstances: Inattention or Hyperactivity/Impulsivity (Problem Level)

Children with inattention or hyperactivity/impulsivity at the problem level (DSM-PC) and their families might also benefit from the same chronic illness and medical home principles.

Action statement 5: Recommendations for treatment of children and youth with ADHD vary depending on the patient's age.

Action statement 5a: For *preschool-aged children (4–5 years of age)*, the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas in which evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/recommendation).

Evidence Profile

- **Aggregate evidence quality:** A for behavior; B for methylphenidate.
- **Benefits:** Both behavior therapy and methylphenidate have been demonstrated to reduce behaviors associated with ADHD and improve function.
- **Harms/risks/costs:** Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas methylphenidate has some potential adverse effects.
- **Benefits-harms assessment:** Given the risks of untreated ADHD, the benefits outweigh the risks.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** Family preference is essential in determining the treatment plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

Action statement 5b: For *elementary school-aged children (6–11 years of age)*, the primary care clinician should prescribe FDA-approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) (quality of evidence A/strong recommendation). The school environment, program, or placement is a part of any treatment plan.

Evidence Profile

- **Aggregate evidence quality:** A for treatment with FDA-approved medications; B for behavior therapy.
- **Benefits:** Both behavior therapy and FDA-approved medications have been demonstrated to reduce behaviors associated with ADHD and improve function.
- **Harms/risks/costs:** Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas FDA-approved medications have some potential adverse effects.
- **Benefits-harms assessment:** Given the risks of untreated ADHD, the benefits outweigh the risks.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** Family preference, including patient preference, is essential in determining the treatment plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

Action statement 5c: For *adolescents (12–18 years of age)*, the primary care clinician should prescribe FDA-approved medications for ADHD with the assent of the adolescent (quality of evidence A/strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/recommendation), preferably both.

Evidence Profile

- **Aggregate evidence quality:** A for medications; C for behavior therapy.
- **Benefits:** Both behavior therapy and FDA-approved medications have been demonstrated to reduce behaviors associated with ADHD and improve function.
- **Harms/risks/costs:** Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas FDA-approved medications have some potential adverse effects.
- **Benefits-harms assessment:** Given the risks of untreated ADHD, the benefits outweigh the risks.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** Family preference, including patient preference, is essential in determining the treatment plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation/recommendation.**

Medication

Similar to the recommendations from the previous guideline, stimulant medications are highly effective for most children in reducing core symptoms of ADHD.[44] One selective norepinephrine-reuptake inhibitor (atomoxetine[45,46]) and 2 selective α_2-adrenergic agonists (extended-release guanfacine[47,48] and extended-release clonidine[49]) have also demonstrated efficacy in reducing core symptoms. Because norepinephrine-reuptake inhibitors and α_2-adrenergic agonists are newer, the evidence base that supports them—although adequate for FDA approval—is considerably smaller than that for stimulants. None of them have been approved for use in preschool-aged children. Compared with stimulant medications that have an effect size [effect size = (treatment mean − control mean)/control SD] of approximately 1.0,[50] the effects of the nonstimulants are slightly weaker; atomoxetine has an effect size of approximately 0.7, and extended-release guanfacine and extended-release clonidine also have effect sizes of approximately 0.7.

The accompanying process-of-care algorithm provides a list of the currently available FDA-approved medications for ADHD (Supplemental Table 3). Characteristics of each medication are provided to help guide the clinician's choice in prescribing medication.

As was identified in the previous guideline, the most common stimulant adverse effects are appetite loss, abdominal pain, headaches, and sleep disturbance. The results of the Multimodal Therapy of ADHD (MTA) study revealed a more persistent effect of stimulants on decreasing growth velocity than have most previous studies, particularly when children were on higher and more consistently administered doses. The effects diminished by the third year of treatment, but no compensatory rebound effects were found.[51] However, diminished growth was in the range of 1 to 2 cm. An uncommon additional significant adverse effect of stimulants is the occurrence of hallucinations and other psychotic symptoms.[52] Although concerns have been raised about the rare occurrence of sudden cardiac death among children using stimulant medications,[53] sudden death in children on stimulant medication is extremely rare, and evidence is conflicting as to whether stimulant medications increase the risk of sudden death.[54–56] It is important to expand the history to include specific cardiac symptoms, Wolf-Parkinson-White syndrome, sudden death in the family, hypertrophic cardiomyopathy, and long QT syndrome. Preschool-aged children might experience increased mood lability and dysphoria.[57] For the nonstimulant atomoxetine, the adverse effects include initial somnolence and gastrointestinal tract symptoms, particularly if the dosage is increased too rapidly; decrease in appetite; increase in suicidal thoughts (less common); and hepatitis (rare). For the nonstimulant α_2-adrenergic agonists extended-release guanfacine and extended-release clonidine, adverse effects include somnolence and dry mouth.

Only 2 medications have evidence to support their use as adjunctive therapy with stimulant medications sufficient to achieve FDA approval: extended-release guanfacine[26] and extended-release clonidine. Other medications have been used in combination off-label, but there is currently only anecdotal evidence for their safety or efficacy, so their use cannot be recommended at this time.

Special Circumstances: Preschool-aged Children

A number of special circumstances support the recommendation to initiate ADHD treatment in preschool-aged children (ages 4–5 years) with behavioral therapy alone first.[57] These circumstances include:

- The multisite study of methylphenidate[57] was limited to preschool-aged children who had moderate-to-severe dysfunction.
- The study also found that many children (ages 4–5 years) experience improvements in symptoms with behavior therapy alone, and the overall evidence for behavior therapy in preschool-aged children is strong.
- Behavioral programs for children 4 to 5 years of age typically run in the form of group parent-training programs and, although not always compensated by health insurance, have a lower cost. The process algorithm (see Supplemental pages s15-16) contains criteria for the clinician to use in assessing the quality of the behavioral therapy. In addition, programs such as Head Start and Children and Adults With Attention Deficit Hyperactivity Disorder (CHADD) (www.chadd.org) might provide some behavioral supports.

Many young children with ADHD might still require medication to achieve maximum improvement, and medication is not contraindicated for children 4 through 5 years of age. However, only 1 multisite study has carefully assessed medication use in preschool-aged children. Other considerations in the recommendation about treating children 4 to 5 years of age with stimulant medications include:

- The study was limited to preschool-aged children who had moderate-to-severe dysfunction.
- Research has found that a number of young children (4–5 years of age) experience improvements in symptoms with behavior therapy alone.
- There are concerns about the possi-

ble effects on growth during this rapid growth period of preschool-aged children.

- There has been limited information about and experience with the effects of stimulant medication in children between the ages of 4 and 5 years.

Here, the criteria for enrollment (and, therefore, medication use) included measures of severity that distinguished treated children from the larger group of preschool-aged children with ADHD. Thus, before initiating medications, the physician should assess the severity of the child's ADHD. Given current data, only those preschool-aged children with ADHD who have moderate-to-severe dysfunction should be considered for medication. Criteria for this level of severity, based on the multisite-study results,[57] are (1) symptoms that have persisted for at least 9 months, (2) dysfunction that is manifested in both the home and other settings such as preschool or child care, and (3) dysfunction that has not responded adequately to behavior therapy. The decision to consider initiating medication at this age depends in part on the clinician's assessment of the estimated developmental impairment, safety risks, or consequences for school or social participation that could ensue if medications are not initiated. It is often helpful to consult with a mental health specialist who has had specific experience with preschool-aged children if possible.

Dextroamphetamine is the only medication approved by the FDA for use in children younger than 6 years of age. This approval, however, was based on less stringent criteria in force when the medication was approved rather than on empirical evidence of its safety and efficacy in this age group. Most of the evidence for the safety and efficacy of treating preschool-aged children with stimulant medications has been from methylphenidate.[57] Methylphenidate evidence consists of 1 multisite study of 165 children and 10 other smaller single-site studies that included from 11 to 59 children (total of 269 children); 7 of the 10 single-site studies found significant efficacy. It must be noted that although there is moderate evidence that methylphenidate is safe and efficacious in preschool-aged children, its use in this age group remains off-label. Although the use of dextroamphetamine is on-label, the insufficient evidence for its safety and efficacy in this age group does not make it possible to recommend at this time.

If children do not experience adequate symptom improvement with behavior therapy, medication can be prescribed, as described previously. Evidence suggests that the rate of metabolizing stimulant medication is slower in children 4 through 5 years of age, so they should be given a lower dose to start, and the dose can be increased in smaller increments. Maximum doses have not been adequately studied.[57]

Special Circumstances: Adolescents

As noted previously, before beginning medication treatment for adolescents with newly diagnosed ADHD, clinicians should assess these patients for symptoms of substance abuse. When substance use is identified, assessment when off the abusive substances should precede treatment for ADHD (see the Task Force on Mental Health report[7]). Diversion of ADHD medication (use for other than its intended medical purposes) is also a special concern among adolescents[58]; clinicians should monitor symptoms and prescription-refill requests for signs of misuse or diversion of ADHD medication and consider prescribing medications with no abuse potential, such as atomoxetine (Strattera [Ely Lilly Co, Indianapolis, IN]) and extended-release guanfacine (Intuniv [Shire US Inc, Wayne, PA]) or extended-release clonidine (Kapvay [Shionogi Inc, Florham Park, NJ]) (which are not stimulants) or stimulant medications with less abuse potential, such as lisdexamfetamine (Vyvanse [Shire US Inc]), dermal methylphenidate (Daytrana [Noven Therapeutics, LLC, Miami, FL]), or OROS methylphenidate (Concerta [Janssen Pharmaceuticals, Inc, Titusville, NJ]). Because lisdexamfetamine is dextroamphetamine, which contains an additional lysine molecule, it is only activated after ingestion, when it is metabolized by erythrocyte cells to dexamphetamine. The other preparations make extraction of the stimulant medication more difficult.

Given the inherent risks of driving by adolescents with ADHD, special concern should be taken to provide medication coverage for symptom control while driving. Longer-acting or late-afternoon, short-acting medications might be helpful in this regard.[59]

Special Circumstances: Inattention or Hyperactivity/Impulsivity (Problem Level)

Medication is not appropriate for children whose symptoms do not meet DSM-IV criteria for diagnosis of ADHD, although behavior therapy does not require a specific diagnosis, and many of the efficacy studies have included children without specific mental behavioral disorders.

Behavior Therapy

Behavior therapy represents a broad set of specific interventions that have a common goal of modifying the physical and social environment to alter or change behavior. Behavior therapy usually is implemented by training parents in specific techniques that improve their abilities to modify and

TABLE 1 Evidence-Based Behavioral Treatments for ADHD

Intervention Type	Description	Typical Outcome(s)	Median Effect Size[a]
Behavioral parent training (BPT)	Behavior-modification principles provided to parents for implementation in home settings	Improved compliance with parental commands; improved parental understanding of behavioral principles; high levels of parental satisfaction with treatment	0.55
Behavioral classroom management	Behavior-modification principles provided to teachers for implementation in classroom settings	Improved attention to instruction; improved compliance with classroom rules; decreased disruptive behavior; improved work productivity	0.61
Behavioral peer interventions (BPI)[b]	Interventions focused on peer interactions/relationships; these are often group-based interventions provided weekly and include clinic-based social-skills training used either alone or concurrently with behavioral parent training and/or medication	Office-based interventions have produced minimal effects; interventions have been of questionable social validity; some studies of BPI combined with clinic-based BPT found positive effects on parent ratings of ADHD symptoms; no differences on social functioning or parent ratings of social behavior have been revealed	

[a] Effect size = (treatment median − control median)/control SD.
[b] The effect size for behavioral peer interventions is not reported, because the effect sizes for these studies represent outcomes associated with combined interventions. A lower effect size means that they have less of an effect. The effect sizes found are considered moderate.
Adapted from Pelham W, Fabiano GA. *J Clin Child Adolesc Psychol.* 2008;37(1):184–214.

shape their child's behavior and to improve the child's ability to regulate his or her own behavior. The training involves techniques to more effectively provide rewards when their child demonstrates the desired behavior (eg, positive reinforcement), learn what behaviors can be reduced or eliminated by using planned ignoring as an active strategy (or using praising and ignoring in combination), or provide appropriate consequences or punishments when their child fails to meet the goals (eg, punishment). There is a need to consistently apply rewards and consequences as tasks are achieved and then to gradually increase the expectations for each task as they are mastered to shape behaviors. Although behavior therapy shares a set of principles, individual programs introduce different techniques and strategies to achieve the same ends.

Table 1 lists the major behavioral intervention approaches that have been demonstrated to be evidence based for the management of ADHD in 3 different types of settings. The table is based on 22 studies, each completed between 1997 and 2006.

Evidence for the effectiveness of behavior therapy in children with ADHD is derived from a variety of studies[60–62] and an Agency for Healthcare Research and Quality review.[5] The diversity of interventions and outcome measures makes meta-analysis of the effects of behavior therapy alone or in association with medications challenging. The long-term positive effects of behavior therapy have yet to be determined. Ongoing adherence to a behavior program might be important; therefore, implementing a chronic care model for child health might contribute to the long-term effects.[63]

Study results have indicated positive effects of behavior therapy when combined with medications. Most studies that compared behavior therapy to stimulants found a much stronger effect on ADHD core symptoms from stimulants than from behavior therapy. The MTA study found that combined treatment (behavior therapy and stimulant medication) was not significantly more efficacious than treatment with medication alone for the core symptoms of ADHD after correction for multiple tests in the primary analysis.[64] However, a secondary analysis of a combined measure of parent and teacher ratings of ADHD symptoms revealed a significant advantage for the combination with a small effect size of $d = 0.26$.[65] However, the same study also found that the combined treatment compared with medication alone did offer greater improvements on academic and conduct measures when ADHD coexisted with anxiety and when children lived in low socioeconomic environments. In addition, parents and teachers of children who were receiving combined therapy were significantly more satisfied with the treatment plan. Finally, the combination of medication management and behavior therapy allowed for the use of lower dosages of stimulants, which possibly reduced the risk of adverse effects.[66]

School Programming and Supports

Behavior therapy programs coordinating efforts at school as well as home might enhance the effects. School programs can provide classroom adaptations, such as preferred seating, modified work assignments, and test modifications (to the location at which it is administered and time allotted for taking the test), as well as behavior plans as part of a 504 Rehabilitation Act Plan or special education Individualized Education Program (IEP) under the "other health impairment" designation as part of the Individuals With

Disability Education Act (IDEA).[67] It is helpful for clinicians to be aware of the eligibility criteria in their state and school district to advise families of their options. Youths documented to have ADHD can also get permission to take college-readiness tests in an untimed manner by following appropriate documentation guidelines.[68]

The effect of coexisting conditions on ADHD treatment is variable. In some cases, treatment of the ADHD resolves the coexisting condition. For example, treatment of ADHD might resolve oppositional defiant disorder or anxiety.[68] However, sometimes the co-occurring condition might require treatment that is in addition to the treatment for ADHD. Some coexisting conditions can be treated in the primary care setting, but others will require referral and comanagement with a subspecialist.

Action statement 6: Primary care clinicians should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** The optimal dose of medication is required to reduce core symptoms to or as close to the levels of children without ADHD.
- **Harms/risks/costs:** Higher levels of medication increase the chances of adverse effects.
- **Benefits-harms assessment:** The importance of adequately treating ADHD outweighs the risk of adverse effects.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** The families' preferences and comfort need to be taken into consideration in developing a titration plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

The findings from the MTA study suggested that more than 70% of children and youth with ADHD respond to one of the stimulant medications at an optimal dose when a systematic trial is used.[65] Children in the MTA who were treated in the community with care as usual from whomever they chose or to whom they had access received lower doses of stimulants with less frequent monitoring and had less optimal results.[65] Because stimulants might produce positive but suboptimal effects at a low dose in some children and youth, titration to maximum doses that control symptoms without adverse effects is recommended instead of titration strictly on a milligram-per-kilogram basis.

Education of parents is an important component in the chronic illness model to ensure their cooperation in efforts to reach appropriate titration (remembering that the parents themselves might be challenged significantly by ADHD).[69,70] The primary care clinician should alert parents and children that changing medication dose and occasionally changing a medication might be necessary for optimal medication management, that the process might require a few months to achieve optimal success, and that medication efficacy should be systematically monitored at regular intervals.

Because stimulant medication effects are seen immediately, trials of different doses of stimulants can be accomplished in a relatively short time period. Stimulant medications can be effectively titrated on a 3- to 7-day basis.[65]

It is important to note that by the 3-year follow-up of 14-month MTA interventions (optimal medications management, optimal behavioral management, the combination of the 2, or community treatment), all differences among the initial 4 groups were no longer present. After the initial 14-month intervention, the children no longer received the careful monthly monitoring provided by the study and went back to receiving care from their community providers. Their medications and doses varied, and a number of them were no longer taking medication. In children still on medication, the growth deceleration was only seen for the first 2 years and was in the range of 1 to 2 cm.

CONCLUSION

Evidence continues to be fairly clear with regard to the legitimacy of the diagnosis of ADHD and the appropriate diagnostic criteria and procedures required to establish a diagnosis, identify co-occurring conditions, and treat effectively with both behavioral and pharmacologic interventions. However, the steps required to sustain appropriate treatments and achieve successful long-term outcomes still remain a challenge. To provide more detailed information about how the recommendations of this guideline can be accomplished, a more detailed but less strongly evidence-based algorithm is provided as a companion article.

AREAS FOR FUTURE RESEARCH

Some specific research topics pertinent to the diagnosis and treatment of ADHD or developmental variations or problems in children and adolescents in primary care to be explored include:

- identification or development of reliable instruments suitable to use in primary care to assess the nature or degree of functional impairment in children/adolescents with ADHD and monitor improvement over time;
- study of medications and other therapies used clinically but not approved by the FDA for ADHD, such as

electroencephalographic biofeedback;

- determination of the optimal schedule for monitoring children/adolescents with ADHD, including factors for adjusting that schedule according to age, symptom severity, and progress reports;
- evaluation of the effectiveness of various school-based interventions;
- comparisons of medication use and effectiveness in different ages, including both harms and benefits;
- development of methods to involve parents and children/adolescents in their own care and improve adherence to both behavior and medication treatments;
- standardized and documented tools that will help primary care providers in identifying coexisting conditions;
- development and determination of effective electronic and Web-based systems to help gather information to diagnose and monitor children with ADHD;
- improved systems of communication with schools and mental health professionals, as well as other community agencies, to provide effective collaborative care;
- evidence for optimal monitoring by some aspects of severity, disability, or impairment; and
- long-term outcomes of children first identified with ADHD as preschool-aged children.

SUBCOMMITTEE ON ATTENTION DEFICIT HYPERACTIVITY DISORDER (OVERSIGHT BY THE STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT, 2005–2011)

WRITING COMMITTEE

Mark Wolraich, MD, Chair — *(periodic consultant to Shire, Eli Lilly, Shinogi, and Next Wave Pharmaceuticals)*

Lawrence Brown, MD — *(neurologist; AAP Section on Neurology; Child Neurology Society) (Safety Monitoring Board for Best Pharmaceuticals for Children Act for National Institutes of Health)*

Ronald T. Brown, PhD — *(child psychologist; Society for Pediatric Psychology) (no conflicts)*

George DuPaul, PhD — *(school psychologist; National Association of School Psychologists) (participated in clinical trial on Vyvanse effects on college students with ADHD, funded by Shire; published 2 books on ADHD and receives royalties)*

Marian Earls, MD — *(general pediatrician with QI expertise, developmental and behavioral pediatrician) (no conflicts)*

Heidi M. Feldman, MD, PhD — *(developmental and behavioral pediatrician; Society for Developmental and Behavioral Pediatricians) (no conflicts)*

Theodore G. Ganiats, MD — *(family physician; American Academy of Family Physicians) (no conflicts)*

Beth Kaplanek, RN, BSN — *(parent advocate, Children and Adults With Attention Deficit Hyperactivity Disorder [CHADD]) (no conflicts)*

Bruce Meyer, MD — *(general pediatrician) (no conflicts)*

James Perrin, MD — *(general pediatrician; AAP Mental Health Task Force, AAP Council on Children With Disabilities) (consultant to Pfizer not related to ADHD)*

Karen Pierce, MD — *(child psychiatrist; American Academy of Child and Adolescent Psychiatry) (no conflicts)*

Michael Reiff, MD — *(developmental and behavioral pediatrician; AAP Section on Developmental and Behavioral Pediatrics) (no conflicts)*

Martin T. Stein, MD — *(developmental and behavioral pediatrician; AAP Section on Developmental and Behavioral Pediatrics) (no conflicts)*

Susanna Visser, MS — *(epidemiologist) (no conflicts)*

CONSULTANT

Melissa Capers, MA, MFA — *(medical writer) (no conflicts)*

STAFF

Caryn Davidson, MA

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Quality Response Template

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HEDIS Response Template: Instructions

1. On the NCQA Star Ratings sheet, at the top, insert Proposer's name.
2. On the NCQA Star Ratings sheet, enter details for all of the Proposer's Medicaid managed care contracts, including the Overall, Consumer Satisfaction, Prevention, and Treatment sub-ratings from the NCQA Health Insurance Plan Ratings 2018-2019 Summary Report (Medicaid). The Proposer shall provide complete and accurate information in all fields, consistent with the NCQA Summary Report (Medicaid).
3. The Proposer should include the NCQA STAR rating information for all Medicaid managed care plans operating in Louisiana.
4. The Proposer should only include NCQA STAR rating information for Medicaid managed care programs operating outside of LA if the plan's NCQA accreditation is listed as a "YES" on the Medicaid summary report indicating that it has full, non-interim, NCQA Accreditation. The Proposer should NOT include Medicaid plans operating outside of LA: (1) with interim NCQA Accreditation or (2) for which NCQA STAR rating information was issued at the time of interim NCQA Accreditation.

HEDIS Response Template: Aetna Better Health of Louisiana

						2018-2019 NCQA Star Rating Summary (Medicaid)			
Number	State	Medicaid "HMO" Plan Name	Medicaid Enrollment in December 2018	Populations included (e.g., ABD, TANF, Expansion, LTSS)	Benefits provided (e.g., full benefits, behavioral health only, Medicare/Medicaid integrated)	Overall	Consumer Satisfaction	Prevention	Treatment
1	FL	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	MMA - 45,286 Healthy Kids - 49,629 LTSS - 537	LTSS, Florida Healthy Kids (HK), Medicaid Managed Medical Assistance (MMA), Medikids	Rx, vision, behavioral health (BH) for MMA and HK. LTSS has no medical benefits	4.0	3.0	2.5	3.0
2	IL	Aetna Better Health of Illinois	Duals - 7,211	Medicare-Medicaid Plan (MMP) inclusive of LTSS.	Rx, dental, vision, BH	Partial Data Reported	Insufficent data	2.0	2.5
3	KY	Aetna Better Health of Kentucky	Medicaid - 191683	ACA, Duals, Foster Care, SSI Adult, SSI Child, TANF	Rx, dental, vision, BH	3.5	4.0	2.0	3.0
4	LA	Aetna Better Health of Louisiana	Medicaid - 94369	Medicaid Plan, TANF, CHIP, Foster Care, ABD, Expansion	Rx, dental offered to members 21 years and over only, vision, BH	2.5	3.0	2.5	2.0
5	MI	Aetna Better Health of Michigan, Inc.	Duals - 7,048 Medicaid - 36,965	ABD, TANF, Children's Special Health Care Services, ACA Expansion, Duals MMP inclusive of LTSS	Rx, dental, vision, BH for Duals. Rx, vision, mental health unlimited outpatient visits only for Medicaid.	3.0	3.0	2.5	2.5
6	NJ	Aetna Better Health of New Jersey	Medicaid - 41,727	DD, Duals, Other Low Income	Rx, dental, vision, BH for DD and Duals. Rx, dental, and vision for other low income. BH is carved out for other low income.	2.0	2.0	2.0	1.5
7	OH	Aetna Better Health of Ohio	Duals - 16,340	Medicare Duals	Rx, dental, vision, BH	3.5	3.5	2.0	3.0
8	PA	Aetna Better Health Inc, a Pennsylvania Corporation	CHIP - 18,514 Medicaid - 175,402	Breast and Cervical Cancer Prevention and Treatment, CHIP, FGA, MAGI, SSI, TANF	Rx, vision for Medicaid, CHIP, Duals, DD, and other Low Income. CHIP and DD have dental benefit. Medicaid, duals, and other low income benefit when <21 years of age. CHIP has BH benefit. Medicaid, DD, Duals, and other low income have BH carved out	3.5	3.0	2.5	3.0
9	TX	Aetna Better Health of Texas	CHIP - 9,719 Medicaid - 66,465 Star Kids - 4,030	Medicaid, CHIP	TXA has Rx, Vision, BH. Dental carve out to state. TXP has Rx, Vision, BH. Dental carve out to state.	3.0	3.0	3.0	2.5
10	VA	Coventry HealthCare of Virginia, Inc., dba Aetna Better Health of Virginia	D-SNP - 1,495 LTSS - 12,959 Medicaid - 56,479	Medallion Medicaid includes TANF, CHIP, and Expansion. LTSS includes ABD, LTSS, Expansion, and ID/DD membership. Medicare D-SNP.	Rx, vision, and BH benefit	3.5	3.5	2.5	3.0
11	WV	Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia	Medicaid - 109,292	ACA, TANF, and SSI	Rx carved out to State. BH benefit. Vision and dental no benefit over 21 years of age	3.5	3.0	3.0	3.0